U.S. Department of Justice
National Institute of Corrections

A Practitioner's Guide To Treating the Incarcerated Male Sex Offender

Breaking the Cycle of Sexual Abuse

National Institute of Corrections

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U. S. Department of Justice
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Foreword

In recent years, the National Institute of Corrections has received numerous requests from the field for information and assistance regarding treatment modalities and supervision strategies for sex offenders. To meet the needs of practitioners, the Institute collaborated with other federal agencies, conducted planning sessions, sponsored a series of special issue seminars, awarded numerous grants, and provided technical assistance to states regarding development of sex offender treatment programs. As successful treatment depends upon the development and coordination of resources among multiple agencies and departments at the county, state, and federal levels, the Institute sponsored this publication to meet the needs of practitioners in all disciplines who have responsibility for treating and supervising the sex offender.

Public interest in stopping sex offenses has required the criminal justice system to both punish and treat sex offenders for longer periods of time. It is our hope that this monograph will contribute to the development of treatment programs that will ultimately lead to a reduction in sexual victimization.

Raymond C. Brown
Director
National Institute of Corrections

Preface

This volume is devoted to the treatment of the adult male sex offender. Not only does this group form the bulk of the problem for correctional personnel, but this is the group about which the most information is available. This, however, does not diminish the problem or the need to treat adolescents and females. Hopefully, the earlier intervention is begun, the less victimization will occur. A number of excellent programs are available in juvenile correctional facilities and mental health facilities. Female sex offenders represent a great enigma. While a large number of males report having been molested as children by females, few of these individuals are ever reported, much less convicted. The dynamics of this behavior, as well as treatment techniques, need much research as it should not be assumed that treatments developed for males are equally applicable to females.

Although there are a number of problems in using recidivism rates to measure program success in any area, the rate of recidivism of treated sex offenders is fairly consistently estimated to be around 15%. According to Robert Freeman-Longo, Clinical Director of the Oregon State Hospital Sex Offender Treatment Program, the recidivism rate of untreated offenders is around 80%. Even if both of these figures are exaggerated, there would still be a significant difference between treated and untreated individuals.

Without active intervention, the atmosphere of the typical prison aggravates the conditions that motivated the offender to act-out. Secrecy, inappropriate social interaction, poor self-esteem, and deviant sexual arousal are often reinforced within the prison culture. Often, if an individual paroles and reoffends, public opinion may be directed against the corrections department. It will be blamed for releasing a dangerous felon, whether or not the department had any discretion in the matter.

This monograph represents the collected work of experts in the field of sex offender treatment, who offer suggestions for correctional administrators and treatment personnel who wish to establish a state-of-the-art treatment program. As there is not a single solution to this problem, there is not a single type of treatment that would be effective or even possible in every institution. Each corrections department must analyze what resources are available and the priorities that must be considered before a program is established.

Staff members from the National Institute of Corrections, responding to increasing requests for assistance from the field, identified a need for technical assistance and training in the area of sex offender treatment and program design. A primary concern has always been to interrupt the cycle of victimization. In 1986, NIC conducted a series of week-long seminars. These seminars trained professionals from 30 states in administrative procedures and psychotherapeutic techniques. The material presented in these seminars has been compiled and expanded upon to produce this monograph.

The National Institute of Corrections chose to use systems theory as an approach to program design. The systems approach means a coordinated effort to involve all segments of the community in a united effort to plan, institute, and evaluate sex offender treatment programs. There must be support from community groups and legislators. The media must be educated lest they sensationalize the program or focus exclusively on its failures. Judges need to recognize and distinguish between appropriate and inappropriate candidates. In some states, judges have been so enthusiastic about a program that they incarcerated individuals who could be treated more appropriately in the community. On the other hand, if treatment personnel do not have a final say on who is admitted to the program, they may find themselves forced to handle unamenable individuals whose failure rate will be blamed on the program.

Along with educating the public and specific segments of the community, training must be a priority for administration, security, and treatment staffs. Many of the treatment techniques used with sex offenders may seem outrageous to the untrained layman and could give rise to a variety of rumors which could destroy the credibility of the program. The treatment staff must receive extensive, ongoing training. Very few mental health training programs offer specialized experience in the techniques described in this monograph. Finally, treatment personnel and probation/parole officers must be trained to deal with those individuals who either remain in the community under supervision or who return there. A comprehensive program addresses all of these groups in a manner which gains their support and cooperation.

In a field where new treatment techniques are quickly evolving, this monograph may necessarily be somewhat outdated upon publication. The goal of this volume is to encourage correctional administrators and mental health practitioners to consider implementing programs with the potential to reduce sexual victimization. The National Institute of Corrections hopes to continue to update information in this field and provide states with leadership and expertise in improving their programs.

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Introduction

During the past 20 years, the issue of sexual assault has been the focus of public attention. Movies, television specials, talk shows, and books have brought the problem out into the open. Citizens live with facts such as: one in four girls will be assaulted before they are eighteen years of age, while one in six boys will be victimized.

Society can respond in a number of ways. The historical response has been to impose restrictions on potential victims. The Israeli Parliament, for example, suggested that the increasing incidence of rape be addressed by enforcing a curfew on women. Golda Meier, then a member of Parliament, suggested that surely the curfew should be imposed on men rather than women.

Another response is represented by groups such as Society's League Against Molesters (SLAM), which advocates long prison sentences as retribution and deterrent. Many victims' groups have traditionally taken a similar position, advocating longer and harsher prison sentences.

Experts in this field suggest that a large percentage of offenders were molested during their childhood. However, this phenomenon, known as "The Dracula Syndrome," in which the victim becomes the assailant, is unique to sex offenders and means that the crime grows exponentially. Patterned child molesters frequently have tragically high numbers of victims, often numbering several hundred. If even a small percentage of the victims later became offenders, the rate of growth of this crime would be staggering. Indeed the growth of the number of incarcerated sex offenders presents a major problem for corrections officials.

The May 1987 issue of *Corrections Compendium* reveals that 33 states have reported marked increases in the number of incarcerated sex offenders, with over 55,000 individuals now in state prisons. In some states, sex offenders now represent one-third of the offender population. The increased rate is due to a variety of factors which combine to place an added burden on correctional systems. These factors include:

- Increased public attention has led to increased reporting rates.
- Victim groups have been instrumental in changing the way victims are treated by members of the criminal justice system. Thus, victims are more likely to report crimes.
- Teachers and youth workers are much more aware of the possibility of sexual abuse and, in many states, are mandated by law to report suspicious circumstances.
- Many courts are handing out stiffer sentences.
- Where they have that discretion, parole boards are becoming more reluctant to release sex offenders.
- In many states, offenders refusing treatment serve longer sentences. Treatment while incarcerated is mandatory prior to parole.

STATES WITH HIGHEST NUMBERS OF SEX OFFENDERS

California	5,984
Texas	3,836
Florida	3,569
Ohio	2,515
Michigan	2,416
New York	2,395
Illinois	2,048
Georgia	1,907
Washington	1,865
North Carolina	1,800

INCREASE IN NUMBER OF SEX OFFENDERS IN PRISON

Number of prison systems reporting increase	37
Number reporting decrease	1
Number reporting no change	13
No data	3

(Reprinted, with permission of Contact Center, Inc., from the May 1987 issue of *Corrections Compendium*, page 5.)

In the past, corrections departments were reluctant to undertake the challenge of treating these individuals. Courts have clearly mandated treatment of psychotic individuals (see Part Five, Legal Issues). However, to choose a group associated with highly sensational crimes and then to define its members as deserving rehabilitation may be considered quite controversial. Corrections officials, often even treatment personnel, may find the behavior of the sex offender so repugnant that they choose not to provide treatment opportunities. Strong emotional reactions of many corrections professionals may interfere with their ability to take an objective stance on this issue.

If a correctional system decides to offer specialized treatment to sex offenders, should it not also offer specialized treatment to alcoholics, drug addicts, check forgers, arson-

ists, etc.? It is unrealistic to offer specialized treatment to every specific subgroup. Not only are funds limited, but modern mental health techniques have not been developed to treat every condition with equal efficacy.

Various forces, however, are at work to pressure corrections departments toward instituting sex offender treatment programs. Traditionally, sex offenders have been defined as "sick." Beginning in the 1940's, many states passed Sexually Dangerous Persons Laws which hospitalized many sex offenders in state mental institutions rather than prisons. This often resulted in much longer periods of institutionalization, coupled with the loss of many basic civil rights. More often than not, these individuals received no specialized treatment at all. Mental health systems in California and Washington pioneered in developing sophisticated treatment programs. In recent years, both programs have been phased out, largely due to sensational crimes associated with patients in the treatment programs. Responsibility for the treatment of these individuals has shifted from mental health to corrections. This trend is also occurring in other parts of the country.

In many states, victim groups are demanding that correctional facilities treat this population rather than simply lock them away from society. Many judges clearly perceive a need for treatment and resent having to choose between incarcerating a person in a place where therapy is not available or referring him to therapy in a less-than-secure environment.

Fortunately, techniques have been developed to treat this population. Forty-six states offer at least group therapy, while a number of states have highly sophisticated, multimodality programs. Unfortunately, in some states the criminal justice system has overreacted. Officials in one state decided that the drug Depo-Provera™ was a cure-all and attempted to mandate it for all rapists. However, this has been balanced by the number of states where efforts have been made to research and institute state-of-the-art treatment.

This monograph is a collection of papers by noted experts in the field of adult sex offender treatment. The goals of this monograph include:

- Presenting background on the psychological characteristics of the sex offender, including dynamics and typologies, along with a history of approaches to treatment.
- Outlining for the correctional administrator approaches to establishing and evaluating a comprehensive treatment program for the sex offender.
- Addressing the various therapeutic modalities used in a comprehensive treatment program.
- Specifying aftercare approaches for the therapist and field services worker.

It is the purpose of this monograph to promote a better understanding of techniques and technologies available to treat sex offenders and to encourage the implementation of effective treatment programs that will lead to fewer sexual assaults in society.

Part One: Psychodynamics of Sex Offenders

In the Whitechapel District of London in 1888, a number of prostitutes who had been brutally murdered and mutilated were discovered. The crimes were obviously committed by a sexual deviant whose identity has continued to be a source of intrigue. While the crimes were never solved, they apparently stirred an interest in the psychological dynamics behind such acts. In the years that followed, a number of articles were written by physicians such as Krafft-Ebing. Thus began the study of sex offenders and their treatment.

Landmarks in sex offender treatment have been repeatedly preceded by brutal sex crimes. In the 1930's a senile man named Fish kidnapped a six-year-old girl on her birthday and subsequently killed, dismembered, cooked, and ate her. The public outrage over this act added support for Sexual Psychopath Laws. Most recently in the 1970's Ted Frank, a newly released patient from Atascadero State Hospital's Sex Offender Treatment Program, kidnapped, tortured, raped, and murdered a two-year-old girl. California residents banned together to force the closing of the treatment program.

Treatment of sex offenders has followed much the same course as mental health issues in general. Mentally Disordered Sex Offender Laws were the direct outgrowth of Defective Delinquent Laws, both reflecting the belief that certain people committed crimes because they had some type of inherent deficit and, while they should not be imprisoned, they should be institutionalized, often for life (see Chapter 17 on brief history of legal issues). Sex offenders in most states were hospitalized along with the chronically mentally ill. Both groups were initially simply confined, with little effective treatment. However, in the 1950's and '60's, mental health professionals began to develop therapeutic techniques. Florida, California, Wisconsin, New Jersey, and Washington, among others, began to institute specialized programs.

In the late 1960's and '70's, the deinstitutionalization movement began, with the emphasis being placed on treating the mentally ill in community mental health centers, preferably on an outpatient basis. The Joseph Peters Institute in Philadelphia began one of the first outpatient groups for sex offenders. Comprehensive programs such as Positive Approaches to Sex Offenders (PASO) in Albuquerque were developed. Many states began programs for incestuous families.

However, the 1980's has seen less tolerance for community treatment in many areas. With greater rates of reporting, more offenders are being charged. In a number of states, judges are sentencing these individuals to prison rather than to hospital-based programs. The Washington State Legislature recently passed legislation transferring the sex offender treatment programs from Eastern and Western Washington State Hospitals to the Department of Corrections.

Recent studies, not only in the field of sex offender treatment but also in the field of drug treatment, have contradicted the "nothing works" philosophy which has until recently deflated many correctional treatment programs. The federal government has begun funding efforts to revive prison-based treatment of a variety of problems. The President's Commission on Pornography (1986) has recommended treatment of sex offenders. A number of states are initiating or expanding treatment programs.

It is hoped that the next stage in sex offender treatment will be the development of comprehensive treatment programs which are based on well documented and carefully researched interventions. It is also hoped that further developments in the field will be logical outgrowths of new knowledge, rather than emotional reactions to sensational crimes.

Chapter 1: Theories of Sex Offenses

by Barbara Schwartz

Abstract

There are not only numerous definitions of the term "sex offender," but there are numerous theories regarding etiologies. All of the social sciences, as well as some physical sciences, have explored deviant sexual conduct. Dr. Schwartz reviews a variety of explanations ranging from biological to political.

Definitions

There are as many definitions of the term "sex offender" as there are individuals doing the defining. Every state uses the label differently according to its legislative statutes. Perhaps the most useful definition of the term "sex offender" is that offered by Gebhard, Gagnon, Pomeroy and Christenson (1964). They stated that the sex offender is an individual who commits an overt act for his immediate sexual gratification which is contrary to the prevailing sexual mores of his society and is thus legally punishable and for which he is ultimately convicted. This is to be distinguished from the sexually deviant individual who commits the same acts but has never been adjudicated in connection with his behavior. The definition of sex offender has been shaped largely by the sexual mores of the times. This has caused the population of offenders to change constantly and has made a study of the problem more difficult.

Are these individuals suffering from a mental illness? This is a question which has generated considerable controversy. Karpman (1954) stated that sex offenders "are not conscious agents deliberately and viciously perpetuating these acts, they are victims of a disease from which many of them suffer more than their victims (p. 482)." However, DeRiver (1949) maintained that they "are endowed with free will, have equal opportunities to decide that they either will or will not commit certain unlawful and perverted acts (p. x)." A sexual deviance is categorized as a paraphilia, and individuals who are psychotic at the time they committed their acts would usually not be considered sexual deviants.

Legally the definition is equally confusing. An act may be defined as a sex crime depending upon the degree of consent of the partner, his/her age, kinship or sex, the nature of the act, the offender's intention or the setting. A behavior which in itself may be considered perfectly normal can become a serious criminal offense if it violates any of the above qualifiers. Numerous "blue laws" exist which ban what is today considered perfectly acceptable sexual conduct. In some states it is technically illegal to have sex without the intent to procreate. There are laws today dealing with so-called crimes against nature, referring primarily to activities which our culture considers sexually bizarre, but a cross-cultural view of sexual taboos reveals that very few acts have been considered universally offensive (Wortis, 1939).

History of Attitudes Toward Aggressive Sex Offenders

Attitudes Toward Rape

Reports of societal attitudes toward aggressive sexual assaults on both adults and children date back to early Egypt. Susan Brownmiller (1975) has suggested that sexual assault may have been the real basis of monogamous human relations from the earliest time. Women, fearful of gang rape, were forced to subjugate themselves to one man in return for his protection. This fear of rape has maintained women in a state of fear and passivity since that time (Griffin, 1971).

Both Brownmiller (1975) and Griffin (1971) theorized that rape laws exist to protect the rights of the male as the possessor of the female body. The first laws addressed themselves only to the rape of a virgin and existed to compensate the father who, by theft of his daughter's virginity, had been embezzled out of her fair market price. "The violation was first and foremost a violation of the male rights of possession, based on male requirements of virginity, chastity and consent to private access as the female bargain of the marriage contract (Brownmiller, 1975, p. 378)." Perhaps the ultimate use of the female body as a show of political force was the medieval custom *jus primae noctis* or *droit du seigneur*: the right of the manorial lord to devirginate any bride in his political sphere as a reminder of his powers over the lives of his people.

On the other hand there historically has been a prevalent notion that rape does not exist. Amir (1971) pointed out that the theory that it is impossible to rape a woman against her will has been reflected throughout the history of Western civilization in such works as Chaucer's "A Miller's Tale," Shakespeare's *Rape of Luciere*, Blazac's "Droll Stories," and Cervantes' *Don Quixote*. Stories such as Updike's "Couples" and William Murray's "The Americano" illustrate the parallel conception that although rape may have its disadvantages, it can be sexually satisfying. As a jurist in the widely publicized Inez Garcia trial stated, "After all, they weren't trying to kill her; they were just trying to show her a good time (Graduate Student Association, 1975)."

Psychoanalytic literature on rape focuses on the unconscious motivation of the victim. Alexander (1974) stated, "Reflected in women is the tendency for passivity and masochism, and a universal desire to be violently possessed and aggressively handled by a man (p. 10)." A basic Freudian stance, according to Devereux (1939), would be that part of the woman's self is on the side of the rapist. Factor (1954) referred to a woman's guilt following an attempted rape as being related to her desire to aid the man so that he could attack her successfully next time.

Psychiatrists have postulated the phenomenon of "riddance rape" in which the victim seeks to rid herself of anxiety by doing that which is feared most—getting raped. In order to gain control over this fear, some theorists have postulated that occasionally a woman will deliberately expose herself to dangerous situations so that she can feel a sense of power over the assault when it occurs.

Amir (1971) stated, "The psychiatric approach, using psychoanalytic concepts and reasoning, emphasized the pathological and deviant behavior of victims of sex offenses and rape; especially in young or adolescent girls of lower-class origins (p. 297)."

Predominant in the literature on rape prior to 1970 is the assumption, "the ultimate proof of manhood is in sexual violence. . . .Men are aggressive as they take or make women, showing their potency (power) in the conquest. Women on the other hand submit and surrender, allowing themselves to be violated and possessed (Astor, 1974, p. 201)." Rape then may be seen as the logical conclusion of the culturally sanctioned male-female relationship.

Attitudes Toward Child Molestation

Attitudes toward sexual relations with children have varied throughout time and across cultures according to the particular definition of the age of consent. The Trobrianders of British New Guinea expect females to become sexually active between the ages of six and eight (Masters, 1962). In Western literature Dante fell in love with Beatrice when she was nine, and Petrarch's love, Laureen, was twelve.

In ancient Egypt, intercourse with prepubescent children was practiced as a religious ritual (Masters, 1962). Brothels in ancient Persia, China, and Japan retained small boys to satisfy the sexual desires of their clients, while in ancient Rome sadists could utilize infants kept at such establishments (Masters, 1962). Masters also reported that brothels in 18th century England kept prepubescent females for males obsessed with deflowering virgins. Hartwell (1950) pointed out that some cultures have believed that having sex with a child would restore potency or cure venereal disease. The most infamous pedophile was Gilles de Rey, a 15th century nobleman, who simultaneously sodomized and beheaded over 500 children (Revitch & Weiss, 1962).

The pedophile was diagnosed as emotionally disturbed long before the rapist was so identified and was described in the earliest clinical works (Krafft-Ebing, 1892). However, interest in the child molester was largely confined to the chronic offender. Recently, with an increase in attention to child abuse, sexual abuse has emerged as a more prevalent phenomenon than previously imagined.

History of Clinical Attitudes Toward Aggressive Sex Offenders

It would appear that increased interest in the sex offender has typically followed a sensationalistic sex crime. In 1888 a series of bizarre murders was committed in London's Whitechapel District. The killer was never found but his memory remains a source of intrigue. "Jack the Ripper" was the first modern-day sex offender (Rumbelow, 1975). Within the next ten years, four noted psychiatrists (Ellis, 1898; Freud, 1893; Krafft-Ebing, 1892; Schrenck-Notzing, 1895) published pioneer works on sexual abnormalities.

Krafft-Ebing (1892) was the first to offer a classification of sexual problems. He postulated that individuals with these difficulties were genetically tainted, with some suffering from acquired mental or cerebral diseases and others from retardation. Despite his overemphasis on the evils of masturbation and his didacticism, Krafft-Ebing (1892) offered some extremely valuable insights into sexual abnormalities. He was the first person to establish the link between syphilis and insanity (Johnson, 1973). He established the first pathology of sexual disorders. He found some types of sexual malfunctions to be correlated with problems in the limbic system. He urged that a person suffering from retardation, mental illness, "clouded consciousness" or an irresistible impulse should not be held legally responsible for a sex offense. He suggested that sexual abnormalities are partially formed by learning, and he advocated the decriminalization of homosexuality. However, he pessimistically stated, "There is no thought of treatment of an anomaly like these which have developed with the development of the personality (1892, p. 576)." Schrenck-Notzing (1895) offered a lengthy description of the treatment of sexual abnormalities by hypnosis. While he made some rather bizarre therapeutic suggestions, such as "severe mountain walks extending over months (p. 205)," he also made suggestions for the use of hypnosis which are still found valuable. His earnest concern for individuals with these disorders may well be heeded today:

> Thanks to therapeutic nihilism, which unfortunately still finds numerous adherents among physicians, until now such patients have remained the lifelong victims of their imperative feelings, and not infrequently have seen themselves placed before the alternatives of the prison or the asylum (Schrenck-Notzing, 1895, p. x).

During the early part of the 20th century, Freud and his followers laid the foundation for the first highly developed theory of human sexuality. Their contributions will be discussed later. The first American contribution to the literature on sex offenders was made by Karpman (1923) who published a case study of an obscene letter writer.

Research since 1930 can be divided roughly into that which occurred prior to the passage of the Sexual Psychopath Laws in the early 1950's and that which was published after that landmark. The earlier research was largely antecdotal with writers drawing largely from private practice or court experience. The later work was able to draw from large numbers of individuals incarcerated under current statutes.

Early treatment of the sexual deviant was primarily in the form of individual psychotherapy for the privileged few. The first center for the treatment of sexual deviations was the Institute of Sexual Science established in 1918 in Germany by Magnus Hirschfield. This pioneer therapist even urged treatment for the lust murderer (Hirschfield, 1948).

In the United States, early treatment focused on the physical basis of sex and offered such remedies as castration (Kopp, 1938) and large doses of testosterone propinate (Shapiro & Freeman, 1940). Incarceration as a method of treatment was advocated by East and Hubert (1939), who wrote, "Prison acts as a deterrent to crime: It is frequently curative (p. 110)," and by Cook (1949), who stated, "Imprisonment is a valuable therapeutic implement in treating certain types of criminal sexual psychopaths (p. 140)." However, other early theorists disagreed with this position (Karpman, 1954; Kinsey et al., 1948; Mullins, 1941; Richmond, 1933).

In 1947, following several widely publicized sex crimes, J. Edgar Hoover announced:

> The most rapidly increasing type of crime is that by the degenerate sex offender. A criminal assault takes place every 43 minutes, night and day, in the U.S. In the last ten years, arrests for rape increased 62%, commercial vice and prostitution—110%, other sex offenses—142% (p. 15).

Public reaction to this statement demanded that tough laws against any type of sexual misconduct be enacted, the apparent rationale being that since stringent enactments against kidnapping had been followed by a decrease in that crime, harsh sentences could dissuade the sex offender as well. Making reference to a particular case, Guttmacher and Weihofen (1952) responded:

> The fact that the particular crime (sex murder of a child) was carried out by an insane general paretic, who is about as responsive to law as a cat, is of no moment at such times. The supporters of such punitive measures often point to the decrease in kidnapping since more stringent penalties have been enacted. They totally neglect the fact that most crimes of kidnapping have, in part at least, an economic motivation and are largely under rational, conscious control, while brutal sex crimes against children are nearly always carried out in response to twisted unconscious and irrational impulses which the individual is incapable of understanding or controlling (p. 56).

States began passing Sexual Psychopath Laws based on numerous misconceptions. Hoover's statistics had included sexual acts between consenting adults and were in no way representative of serious sex crime (Karpman, 1954). Many believed that serious sex crimes were rampant. East (1946) pointed out that sexual felonies represented only 4% of reported crimes. Sutherland (1950) quoted statistics which indicated that in 1930, of the 324 women between 35 and 40 who were murdered, only 17 involved rape. More women were killed by policemen than by sex offenders. This is not to dismiss the impact of these offenses and certainly sexual crimes were more prevalent than these figures on reported felonies indicated (Wortis, 1939).

Several states in passing Sexual Psychopath Laws mandated that research be conducted on the efficiency of in-prison treatment programs. Studies were conducted at Sing Sing (Abrahamsen, 1950; Glueck, 1952), at the New Jersey State Diagnostic Center at Menlo Park (Ellis & Brancale, 1956), at the state prison in Waupun, Wisconsin (Glover, 1960), and at Atascadero State Hospital in California (Frisbie, 1959). The studies reported a number of characteristics of sex offenders, but their populations differed according to the state laws defining criminal sexual behavior. Ellis and Brancale (1956) concluded that incarcerated sex offenders differ significantly from those convicted but not imprisoned, which seems to indicate that prison studies must not be assumed representative of all adjudicated offenders.

Several of these studies followed the participants after discharge and were able to report recidivism rates. An 8-20% rate has been reported for treated offenders (Gigeroff, Mohr, & Turner, 1964; Guttmacher, 1952; Pacht, Halleck, & Ehrmann, 1962; Schultz, 1965; Selling, 1942; Turner, 1964). Studies of untreated offenders in England yield a 20% rate for untreated offenders and a surprising 33% for those who received treatment (Radzinowicz, 1957). Several authors have noted that sex offenders have lower recidivism rates than other types of criminals (Guttmacher & Weinofen, 1952; Ploscowe, 1951; Sutherland, 1950).

Recent changes have been made in society's attitudes toward the sex offender. Sexual problems of all types are being acknowledged and treated. Perhaps the greatest single advance in attitudes toward sex offenders has been a revised view of homosexuality. The traditional attitude that homosexuality in itself is a form of mental illness or a symptom thereof was first formally questioned in 1969 when Evelyn Hooker published the results of her classic study demonstrating that homosexuals do not differ from heterosexuals in

psychopathology. She concluded, "Homosexuality as a clinical entity does not exist. Its forms are as varied as are those of heterosexuality. Homosexuality may be a deviant sexual pattern that is in the normal range, psychologically (Hoffman, 1969, p. 45)." Paul Gebhard, Director of the Institute of Sex Research, concurred, "The collective opinion of the members of the Institute of Sex Research . . . based on extensive interviewing and other data, is as follows . . . homosexuality is not a pathology in itself nor necessarily a symptom of some other pathology (Hoffman, 1969, p. 44)." Much of the research previously done on sex offenders has been distorted by the inclusion of large numbers of individuals incarcerated for privately committing homosexual acts with a consenting adult.

Studies of large numbers of sex offenders have dispelled several common myths. All sex offenders traditionally have been thought of as dangerous. Harry Kozol (1971) of the Center for the Diagnosis and Treatment of Sexually Dangerous Persons at Bridgewater, MA, having studied over 3700 offenders, concluded that only 700 used any type of force or violence, and that only 200 were "truly dangerous in the sense that they were likely to do physical harm (p. 51)." In his study of child molesters he concluded that two-thirds were not dangerous. He did point out that the dangerous pedophile usually shows a sexual interest in children of either sex, coupled with a gross abnormality of the personality such as psychosis, severe neurosis, or a sociopathic character disorder. He also called attention to the type of rapist who commits an impulsive, opportunistic act but is not emotionally disturbed. He states, "Such persons are least likely to repeat their crimes (p. 61)."

Scandinavia has long been known for its liberal sexual attitudes. Lars Ullerstam (1966) in *The Erotic Minorities* presented a radical view of sexual deviations when he stated, "There is one thing we can be dead certain of: the 'perversions' allow considerable chances to achieve human happiness and therefore they ought to be encouraged (p. 37)." By this he meant that society should provide appropriate outlets for unusual sexual desires, such as theaters for exhibitionists and voyeurs, and should encourage institutionalized individuals of all types to remain sexually active by providing sex surrogates.

Attitudes toward sex offenders have ranged from the belief that these individuals were congenitally malformed or morally depraved to the belief that they are merely expressing a type of behavior subtly approved and even encouraged by their culture. The controversy as to whether these individuals are suffering from some type of mental illness is as heated today as it was 90 years ago. While significant steps have been made in dealing with these individuals, the fact that their disorder arouses fear and disgust in the general public continues to hamper work in this area.

Theoretical Explanations

Biological Determinism

A variety of theories address themselves to the possibility that some type of biological process, be it genetic, hormonal, chromosomal or neurological, is responsible for sexually aberrant behavior.

The first proponent of this "biological" school of thought was Caesare Lombroso. It was his theory that criminals of all types were physically inferior throwbacks to a more primitive and savage man. However, he failed in his analysis to control for such factors as race or to contrast his group of criminals with a group of normals. Nevertheless, his views were echoed as late as 1949 by DeRiver, who included photographs in his book accompanied by statements such as, "The facial structure clearly shows his contrasexual nature . . . . Note the dreamy neuropathic eyes often found among sexual criminals (p. 97)."

Some researchers have indicated that organic dysfunction related to epilepsy or head injuries may have a bearing on sexual misconduct (Radzinowicz, 1957; Selling, 1942; Stekel, 1930). Rosen (1964) reported sexually deviant behavior linked with a variety of neurological disorders.

Tauber (1975) hypothesized that sexual perversions are a form of psychosomatic disturbance resulting from a lack of early touching and embracing, which he felt produced benumbed skin and muscles which do not respond to the common types of erotic stimulation. Lindner (1973) presented the theory that psychogenic seizures are a defense against overwhelming anxieties related to unconscious incestuous desires.

Klinefelter's Syndrome and the XXY chromosome pattern are felt by some to be related to criminal behavior. Baker, Telfer, Richardson, and Clark (1970), however, found no significant differences between the incidence of sex chromosome errors in penal and nonpenal populations when subjects of all heights and chromosome patterns were compared.

Several researchers have found testosterone levels associated with hostility and violence. In a study of rapists, Rada (1978) found that offenders judged to be the most violent had significantly higher testosterone levels, although this did not correlate with individual hostility scores. The highest testosterone level he found was in an individual who had killed his victim.

Perhaps the latest work in this area is being conducted at Johns Hopkins Biosexual Psychohormonal Clinic (see Chapter 12 on Behavioral Techniques). Gaffney, Lurie and Berlin (1984) conducted a double-blind family history study of 33 pedophiles and 33 depressed males. Pedophiles showed a significantly greater history of pedophilia. Nine pedophilic paraphiliacs showed a significantly greater family history of sexual deviancy not involving pedophilia. The authors state, "That

the syndrome is familial suggests, but does not prove, that genetic factors are responsible (p. 547)."

Researchers at Johns Hopkins are actively involved in studying biochemical approaches to the treatment of sexual deviation. The basic theory is to decrease the sexual libido by reducing testosterone levels. The most commonly used medication is MPA—medroxypyrogesterone acetate—more commonly known by its trade name, Depo-Provera™. Berlin (1984) reports a recurrence of sexual behavior in three out of twenty patients (15%). When patients discontinued their medication, however, they tended to relapse.

Instinct Theory

The instinct theory has been primarily expounded by Clifford Allen (1940) and is based on a large amount of animal research. He hypothesized that instincts originate in reflex behavior but can be altered by the environment and that the instinctual response should be allowed to emerge when it appears spontaneously. The human child is born with all physical reactions necessary for sexual behavior. Allen pointed out that as the sexual desires awaken the individual begins a trial-and-error search for satisfaction, and any set of conditions which satisfy these needs will be reinforced. The theory, as expounded by Allen and Pinkava (1971), focuses on the frustration or mischanneling of the sexual instincts, and stresses as prime preventive measures, early marriage, and the satisfaction of oral needs during infancy.

Psychoanalytic Theory

In *Three Contributions to the Theory of Sex*, Sigmund Freud (1938) wrote:

> Popular conception makes definite assumptions concerning the nature of qualities of the sexual instinct. It is supposed to be absent during childhood and to commence about the time of puberty; it is assumed that it manifests itself in irresistible attraction exerted by one sex upon the other, and that its aim is sexual union or at least as would lead to such union.
>
> But we have every reason to see in these assumptions a very untrustworthy picture of reality. Closer examination indicates that they are based on errors, inaccuracies and hasty conclusions (p. 553).

It was Freud's response to these errors that produced the first fully formulated theory of psychosexual development. His explanation of perversion is based on fixations at various psychosexual stages that result in the distortion of a sexual object or a sexual aim.

Psychoanalysts have focused on about six major issues. The most popular causative factor has been "castration anxiety." Freud theorized that when boys, usually during the oedipal stage, discover the difference between themselves and females, they conclude that the jealous fathers of some boys have cut off their penises, thus producing girls. Castration anxiety supposedly produces the resolution of the oedipal conflict as boys decide not to compete with their fathers for their mothers. However, should this fear remain unresolved, a male may develop a permanent aversion to females whose appearance arouses the fear. The individual may act-out sexually in order to symbolically obtain his father's penis by molesting boys or reassure himself of the power of his own organ through rape (Ostrow, 1974).

The image of the seductive mother is also considered to be an important factor in the development of the sexual deviation. Individuals may seek to preserve their childhood impotence in order to refute their incestuous cravings for their mothers. Fear of this seductive mother may produce phobias of pubic hair or of the "vagina dentata." The latter involves the belief that there is a set of teeth within the vaginal canal, an image which arouses severe castration anxiety.

A poorly developed superego may allow the expression of sexually deviant thoughts. The individual may have been so impaired in his development that he can only relate to others as part-objects rather than as whole, as sets of genitals rather than as individuals. Inadequate ego development has also been seen as a contributing factor by Socarides (1959). He felt that pedophiles had experienced early, excessive aggressive and libidinal internal drives. As a defense maneuver against these drives, the child projects the aggression he feels for his mother onto her so that she, the mother, is seen as the aggressor. However, in order to avoid internalizing this "bad" mother, he splits her into "good" and "bad" components. This produces an ego split which allows the individual to identify with a child and then play out the role of an erotic mother.

Gillespie (1956) indicated that the perverse act remains egosyntonic because the ego is able to accept some part of infantile sexuality while repressing the rest. This may be expressed in either rape or child molestation. By accepting some sort of behavior, the ego may be warding off destructive impulses toward the object. Thus, the ego may compromise with hostile impulses by allowing some sort of expression such as "braid cutting" in order to control the rest of the impulse.

A number of analysts have observed that sexual assault may represent a fusion of aggressive and libidinous drives. Gardner (1950) stated that the rapist "enters puberty deriving equal pleasure from aggression and sexual impulses (p. 50)."

The primary difference between traditional Freudians and the neo-Freudians such as the ego psychologists is the former's stress on the role of traumatic sexual experiences as a principal source of fixation. Ostrow (1974) stated, "Anxiety in early experience is libidinized and the traumatic situation is reenacted with certain modifications—under certain conditions in which the person retains control (p. 47)." Stoller (1975) stated, "My hypothesis is that a perversion is the reliving of actual historical sexual trauma aimed precisely at one's sex (an

anatomical state) or one's gender (masculinity or femininity), and that in the perverse act the past is wiped out (p. 10)."

Table 1.1 summarizes these psychoanalytic theories of sexual deviancy.

Table 1.1

SUMMARY OF PSYCHOANALYTIC THEORIES OF SEXUAL DEVIANCY

Theory	Proponent
Castration anxiety.	Fenichel (1945) A. Freud (1965) Bak (1968) Ostrow (1974)
Reaction to seductive mother.	Ostrow (1974)
Inadequate ego/superego.	Gillespie (1956) Socarides (1959) Ostrow (1974)
Reenactment of sexual trauma.	Ostrow (1974) Stoller (1975)
Confusion of aggressive and libidinal drives.	Gardner (1950 Socarides (1959)
Narcissistic representation of self as child.	Fenichel (1945) Bell and Hall (1971)

Ego Psychology

Ego psychologists maintain that the ego, rather than being a secondary growth of the id, is an autonomous structure with inborn processes oriented around perception, thinking, recall, language, object comprehension, motor development, and learning. Sexual deviations are produced by an impairment of one of the ego functions. Fenichel (1945) and Ostrow (1974) theorized that deviants form unusually vivid, eidetic visual experiences of some sexually traumatic event and thus become fixated at that point in psychosexual development. Any breakdown in the perceptual function may result in autistic behavior, a persistent state of primary narcissism, and difficulty in forming object relations (Fenichel, 1945).

Disordered cognitive functions may play a role in perversions by producing primitive thinking characterized by disorganization, tolerance of ambiguity, and emotionality (Fenichel, 1945; Hammer, 1968; Ostrow, 1974). Additionally, thought processes may take on a magical quality so that one believes that by performing a "magical" gesture, one can manipulate another's behavior. The fetishist may be utilizing primitive symbolism, which is another characteristic of archaic thought processes. Ostrow (1974) and Hammer (1968) both pointed out that perverse behavior may be related to an inability to utilize organized abstract thought processes or substitute fantasy for action.

A. Freud (1965) and Glover (1960) have suggested that perversions represent or serve to patch up flaws in reality testing. Fenichel (1945) suggested that a distortion of language development could be related to acting-out in that the individual would be unable to substitute thought for action. This proclivity also could be related to a disturbance of motility so that the individual feels unable to manipulate his environment effectively.

Regarding sex perversions, ego psychologists have also stressed the role of object development. If the mother is unable to act as a need-fulfilling and comforting agent, difficulties arise in individuation and the resultant separation anxiety causes a breakdown in object relations characteristic of the perversions. Blanck and Blanck (1974) stated that a breakdown in the mother-infant dyad may result in an inability to neutralize the sexual and aggressive drives. These drives then fail to become attached to a specific object and an aggressive, sexual perversion develops. Gillespie (1956) hypothesized that the perversion may be a way of dealing with the danger of destructive impulses by allowing for their modified expression. Stoller (1975) felt that all perversions represent eroticization of aggressive impulses.

Ostrow (1974) pointed out that the perversion is expressed because the superego fails to exercise control. This, he stated, is due to its being weakened by the ego's tolerance of inconsistency. Hammer (1968) stated that witnessing the primal scene weakens the superego as the child no longer respects authority figures.

Neurosis Theory

Traditional psychoanalytic theory stresses the difference between the perversion, which is an act, and the neurosis, which represents a repressed conflict. However, other authors have felt that sexually deviant acts are part of a neurotic process usually related to disturbances in the development of the personality, leaving the individual with intrapsychic conflicts and feelings of inferiority and insecurity. Although the term "neurosis" is outdated, this was the term which many authors relied on. These authors have often focused on the role of the seductive mother (Johnson & Robinson, 1957; Karpman, 1954; Littin, Griffin, & Johnson, 1956; Wylie & Delgado, 1958). The parental role in unconsciously granting permission or exercising subtle coercion in the direction of sexual deviancy was stressed by Littin and associates (1956). Mathias (1972) blamed parents who failed to provide appropriate role models.

Feelings of inferiority were stressed by Bromberg (1948) and Mathias (1972), who stated, regarding the rapist, that he "conceives of sexual intercourse as something no individual voluntarily engages in—especially with him (p. 48)." Rada (1978) stated:

> The major motive of the rapist is the desire for control; the means for obtaining this control is the commission of the rape event; the mode by which this control is

effected may, on one end of the continuum be primarily sexual; on the other end of the continuum, primarily aggressive; or when these two meld in the middle, primarily humiliating (Chap. 2, p. 6).

Glueck (1952) related the role of early developmental trauma to pedophilia, stating that pedophiles have experienced a continuously traumatic, prohibiting, and inhibiting sexual environment during their childhoods. They grow up with pervasive difficulties relating to others and have impaired ability to use fantasy as an escape outlet for sexual conflicts due to impaired abstract thought processes.

A general developmental theory was presented by Torbert (1959), who stated that a pedophile is:

> a person who, because of a sense of weakness, inadequacy and low self-regard, not unrelated to severe disruption of his family unit during childhood, finds a solution for his tensions in identification with the physically weaker and emotionally less sophisticated child (p. 278).

Jungian Theory

Robert Stein (1973), in *Incest and Human Love*, presented a modified Jungian approach to sexual disorders. Initially he differentiated Freud's world view, which is basically Cartesian, stressing logic and distrust of the instincts, from the Jungian approach, which theorized that creativity flows from the instincts: "Man's unique course of development, including ethical values and social organization, is based on an instinctively based disposition (p. 14)." Stein went on to say, "Nature, including human nature, contains a directing intelligence which is the source of all knowledge concerning the nature of man's being and becoming (p. 19)."

Stein expanded the concept of the seductive parent's relationship to sexual deviation, stating that the incest taboo functions to make the union between the mother and father sacred, therefore stimulating the formation of such archetypal images as the "sacred union of the divine couple," "the hierosgamos," "the royal marriage," "the sun and the moon," "the mandala" and a number of archetypes representing the union of opposites.

Meaningful sexual love is composed of phallos, "a sudden, powerful surge from within, flowing rapidly with the desire to make contact with another object (Stein, 1973, p. 240)," and eros, "the desire to merge and unite (p. 241)." "In its pure form (phallos) tends to rape and ultimately destroy the object of its fascination . . . . The penetrating, dissecting quality of curiosity becomes destructive and antihuman without eros to preserve the integrity and mystery of the unknown object (p. 83)." While the incest taboo allows archetypes representing this union to emerge, violation of the taboo splits the union. The individual may then identify with phallos and manifest only aggression and force, or he may identify with eros and remain passive, yielding and impotent. The individual remains unaware of his incompleteness and has little desire to seek a love relationship with a nonincestuous female.

Behavior Theories

A good many studies have reported behavior therapy with cases of sexual deviation, but few have dealt with theoretical issues, as sexual deviations are considered to be simply another form of learned behavior. Allen (1940) theorized that sexual conditioning physically influences the hypothalamus, which in turn affects the endocrine mechanisms. The mother conditions the child to hold certain attitudes toward women. Then as the individual matures he experiments with various types of sexual behavior, retaining those most reinforced.

McGuire, Carlisle, and Young (1965) theorized that sexual deviations have been learned as a part of masturbation fantasies. The learning takes place as part of an initial seduction which supplies a basic fantasy. If this seduction is deviant in nature, it is reinforced during each masturbation and may gradually become distorted and develop into more bizarre activities.

Sexual deviation can be the result of classical conditioning in which there is a repetitious or traumatic pairing of sexuality and some negative experience, thus producing some type of intensive emotional response. This might be caused by a sexual assault or molestation in childhood or covert seduction at that time.

Operant conditioning may contribute to the learning of sexually deviant behavior. A child who is repeatedly molested in such a way that he is brought to climax will have that type of sexual conduct powerfully reinforced. As an adult, he may find that only the repetition of the pedophilic scene can produce sexual arousal.

Modeling may produce sexually deviant behaviors. A boy who is aware of his father's incestuous behavior or an adolescent participating in a "gang rape" is following the example of powerful role models.

The relatively new field of cognitive behaviorism has contributed significantly to this field. In looking at such issues as "self-talk," it becomes fairly easy to recognize thinking errors held by many sex offenders. These thoughts, such as "A four-year-old can seduce me" or "All women deserve to be raped," can trigger anger and/or sexual arousal and allow for the acting-out of deviant impulses. This society offers numerous opportunities to learn deviant thought patterns. Media commercials may encourage sexist attitudes. Movies have frequently romanticized rape. Much of the therapeutic work being done today is based on cognitive behaviorism.

Anthropological Theories

As mentioned previously, one of the major difficulties in defining sexual deviation is the variety of cultural attitudes

toward acceptable sexual behavior. Even the various states in this country differ widely in their laws. Incest may be defined as sexual relations with members of the nuclear family, or this may be extended to include third cousins. In some states homosexual marriages are recognized, but in others the same conduct can result in an indeterminant prison sentence.

There is virtually no sexual behavior which some culture in some instance has not condoned (Masters, 1962). The Aranda of Australia and the Nambas of the New Hebrides approve of homosexual relations between adults and male children. The Keraki of New Guinea conduct initiation ceremonies involving the same conduct and allow marriage with prepubescent brides. The Ponapeons of the Caroline Islands use senile men to enlarge the genitals of prepubescent females (McCaghy, 1966). While Kluckholm pointed out that no society permits unlimited sexual contacts between adults and children (McCaghy, 1966), Brown (1952) indicated that only 23 of 110 cultures punish the act. Some groups, such as the Plateau Tonga of New Rhodesia, leave the punishment to divine forces (McCaghy, 1966). The Ba-ila of New Rhodesia put the blame on the child. In studying 200 cultures, Ford (1960) found that there was no relationship between the types of sexual behaviors condoned and the level of development of the culture.

Societal changes may produce changes in the patterns of sex offenses within a culture. Among the Gusii in southwest Kenya, the rape rate in 1959 was 47.2 per 100,000, as opposed to 13.85 per 100,000 in the U.S. (LeVine, 1959). The Gusii typically choose their wives from hostile tribes and their legitimate heterosexual encounters are "aggressive contests, involving force and pain-inflicting behavior related to hostility between clans (p. 10)." Societal forces in Kenya have brought the tribes closer together so that males have more exposure to potential sexual partners. However, the females are under severe formal restrictions against nonmarital relations, while economic factors act as barriers to early marriage. This produces sexual frustration among males in a society which equates sexual behavior with assault and aggression. When the tribes remained physically separated, rape was rare; however, as LeVine indicated, changing societal patterns broke down the cultural barriers which controlled this behavior, resulting in the high 1959 rate.

Societal Theories

As Charles McCaghy (1966) stated, "To violate the mores of society as to partner, time, place and form of sex act is to invite sanctions ranging from ridicule to death (p. 4)." In every society, the power structure is responsible for the formulation and enforcement of the legal code, and often these enforcements are not representative of the dominant values. Lawmakers may be eager to adhere to the most puritanical sexual codes in order to present themselves as beyond reproach in this highly sensitive area and may be unwilling to vote for liberalization of these codes. Our sexual statutes are written so that 99% of adult males could be defined as sex offenders somewhere in this country (Kinsey et al., 1948). As anthropological studies point out, no sexual behavior is universally recognized as deviant. "Deviance" is a label applied by a social group, not an inherent characteristic. As seen previously, characteristics of a society may help to mold the type of sexual offenses prevalent to that culture.

In his study of rapists, Amir (1971) has stressed the role of the "culture of violence" in explaining the predominance of ghetto black offenders. He hypothesized that this culture emphasizes and condones aggressive behavior. Additionally, according to Amir (1971), these individuals may be subjected to early sexual stimulation due to crowded living conditions, and sexual prowess may be used to gain status in the absence of other means. It should be pointed out, however, that Amir's statistics have been drawn from court records. His rapists may be more representative of individuals who are convicted of felonies in urban areas than rapists in general.

Political Theory

The feminist movement has produced a good deal of writing on sex offenses. Dealing with rape as the ultimate sexist act, Susan Brownmiller (1975) stated, "Rather than society's aberrants or 'spoilers of purity,' men who commit rape have served in effect as front line terror guerrillas in the largest sustained battle the world has ever known (p. 210)." Rape is encouraged in this society because, "Molestation isn't regarded seriously. It is winked at, rationalized and allowed to continue through a complex of customs and mores that applauds the male's sexual aggression and denies the female's pain, humiliation and outrage (Rush, cited in Connell & Wilson, 1974)." Rush went on to say:

> Sexual abuse of children is permitted because it is an unspoken but prominent factor in socializing and preparing the woman to accept a subordinate role . . . to submit in later life to the adult forms of sexual abuse heaped on her by her boyfriend, her lover and her husband (p. 163).

The question then becomes not why there are sex offenders, but why aren't there more?

Certainly society has sexually typed women and men into specific roles. Melani and Fodaski (Connell & Wilson, 1974) stated "Men are again and again encouraged to show force and dominance, to disregard the weak refusals of the female, and when persuasion fails, simply overpower the passive partner with aggression and control (p. 84)." Women, on the other hand, are taught to be dependent, passive, weak, and fearful (Griffin, 1971). Men are portrayed as emotionally remote, superpotent playboys. They are subjected to the virility mystique which encourages them to separate their sexual

responsiveness from their needs for love, respect, and affection (Russell, 1975). They are the victims of their own unrealistic sex role.

> Built on the lie of unattainable strength, will, cool, desire and self-realization, many men's egos are understandably fragile . . . . No longer forced to perform, no longer aspiring to emulate this hero or that playboy, perhaps men would learn to integrate sex and emotion, discover sensitivity, communicate deep feelings honestly and experience joy (Russell, 1975, p. 256).

Theories of sexual aberrations reflect the bias represented by the particular discipline of the writer. Psychologists view the act as the product of psychopathology or the learning processes, both of which are intrapsychic processes. The anthropologist sees the behavior as part of cultural processes, while the sociologist and criminologist may seek explanations in subculture mores, differential associations, or a breakdown in societal controls. The political theorist sees the act as a means of subjugating a weaker group in order to control and exploit them.

Recently interdisciplinary efforts have been directed toward the study of sexual assaults. It is hoped that this cross-fertilization will yield suggestions for creative approaches to prevention, public education, and treatment of the victim and the offender.

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Chapter 2: Characteristics and Typologies of Sex Offenders

by Barbara Schwartz

Abstract

In this chapter, Dr. Schwartz explores the incidence of sexual assaults in this country over the past few years as well as the characteristics of sex offenders. A comparison of the various studies is offered.

Rather than listing various characteristics, a number of theorists have found it helpful to divide offenders into types. Types vary according to the use which will be made of them. For example, the FBI has developed a typology which is useful to criminal investigators. Other theorists have developed more dynamic typologies which focus on more individual explanations of deviant behavior.

Sexual assaults are notoriously underreported because society tends to stigmatize the victim. According to MacDonald (1971), there were 31,060 reported forcible rapes in 1968, which represented an increase of 15% over 1967 and 80% over 1960. There is controversy over whether the increase represents a real increase in frequency (MacDonald) or an increase in the reporting rate (*Newsweek*, July 31, 1972). Reported rapes are estimated variously to represent 10% (Griffin, 1971), 30% (MacDonald, 1971), or 50% (Amir, 1971) of the actual rate.

The U. S. Department of Justice, Bureau of Justice Statistics reports that in 1986, 38,490 rapes and attempted rapes were reported to police. Every two years the National Crime Survey interviews 125,000 people to ascertain the relationship between reported crime and actual crime. This study suggests that each reported incident actually represents 1200 rapes or attempted rapes. These figures are limited to assaults on females over 12 years of age.

It has been estimated that 58% of reported sexual assaults involve victims under 17 years of age, with 23.5% involving children under 13 (U.S. Dept. of Justice, 1986). Child molestation shows an even greater disparity between the reported rate and the actual rate as children more frequently keep the assault secret and parents may be reluctant to involve their children with the police or the courts. According to Walters (1975), 21% of his sample of university freshmen reported that they had received verbal or other types of sexual signals during their childhood and 17% had experienced actual physical sexual contact.

New York statistics indicate that two-thirds of all rape cases involve strangers (Astor, 1974), while Amir (1971) stated that 60% of participants in the Philadelphia sample knew their assailants. In a San Diego study of child molestation, 65% of the offenders were known to the child. This is considered to be an underestimate as a family is less likely to report an assault involving a friend or a relative.

Amir (1971) in his study of rape indicated that in 77% of his sample both participants were black, the most common age group for victims was between 15 and 24, 92% of the victims were dependent on someone else for support, and in 82% of the cases the participants lived in the same neighborhood. He reported that the offender had been drinking in 2.9% of the cases, while both parties had been drinking 21% of the time. Most initial encounters were on the street (42%) in the summer and between 10:00 PM and 4:00 AM, Saturday and Sunday. In 71% of the cases the rape was planned; 85% of the time, force was used; and 55% of the victims were submissive.

The traditional classification of rape divided the act into three types—forcible rape, attempted rape, and statutory rape. Burgess and Holmstrom (1974) offered an alternative categorization which divides the act according to the type of nonconsent. They define rape as sex without the victim's consent, further divided into subcategories. The "blitz rape" is the assault "out of the blue" in which there has been no prior interaction between the assailant and the victim. The "confidence rape" is an attack in which the assailant obtains sex under false pretenses by using deceit, betrayal and often violence; the assailant is usually known to the victim. An "accessory to rape" situation arises when a victim is unable to consent due to her level of personality and/or cognitive development. The assailant may pressure the victim with promises of material goods, human contacts, or by convincing her that the act would be appropriate and/or enjoyable. The "sex stress" situation arises when the victim has consented but the assailant exploits the agreement through perversion or violence, especially when the victim becomes too anxious to continue the act. This also encompasses situations in which a prostitute's contract is broken.

Another type of rape is one which involves multiple offenders. Geis (1971) found that 70% of the reported rapes which he studied were of the gang variety. The offenders tended to be younger than the solitary rapists and to have longer criminal records; more use of alcohol was also found. William Blanchard (1959) felt that gang rapes involved a denial of homosexual attraction between gang members. The gang leaders he studied showed sadistic impulses and were often exhibitionists who wished to demonstrate their sexual prowess to their peers. The leader's ability to channel the group's attention to sexual matters was the primary motivating force behind the deed.

Characteristics of Sex Offenders

A number of researchers have studied both the demographic and psychological characteristics of sex offenders. There have been a number of problems with this research. Early studies used hospitalized or incarcerated samples whose descriptions may have been more reflective of individuals who end up in public institutions than of sex offenders as a group. In some states, homosexuals who had never committed what is now considered a sex offense were included in the research. Few studies used comparative samples. This early work is reviewed here for its historical value, but it is generally felt among treatment personnel that when sex offenders in community programs are studied, they resemble the general public in many ways. They are much more likely to be educated, stably employed, and from working or middle-class backgrounds than the typical felon (Van Kirk, 1984).

Research findings related to the nine characteristics discussed below are summarized in Table 2.1.

Because sex offenders are so diverse, typologies have proliferated to account for the varying characteristics. While many of the classification screens are static, more dynamic typologies are emerging which accommodate individual and environmental characteristics. At the end of this chapter, this author describes the concept she has been using for the past 16 years to explain and treat the problem of sexual aggression.

Factors Related to Age

Early studies reporting the age of sex offenders did so merely to report a demographical statistic. Early studies suggested that the mean age fell somewhere between 26 and 32. However, a number of factors could have contributed to this finding. A disproportionate number of youthful rapists might have been represented. Low reporting of incest or molestation by friends or relatives might have protected older offenders. While simply knowing how old the typical sex offender is means little or nothing, there are several related factors which are important. Waggoner and Boyd (1941) reported that in their sample, offenders had established a deviant sexual pattern between the ages of 10 and 16. These researchers were referring to a group of regressed or preferential pedophiles, although this concept had not been developed when their work was published. These individuals represent a significant percentage of sex offenders, and the clinician must always remember the likelihood that this pattern was established in childhood, often through molestation, and may at times be almost intractable. One can frequently estimate the age the pattern was fixated by evaluating the pattern of ages of the victims.

Another feature relevant to the age of the offender is senility. This category was recognized by Krafft-Ebing in 1892. The organic deterioration associated with hardening of the arteries often produces basic personality changes including the inability to control basic impulses such as anger and sexuality. The senile offender who is typically charged with child molestation may choose immature victims because they are vulnerable or because the offender has regressed developmentally to the point where he can no longer distinguish appropriate peers. Treatment is rarely recommended for this group. Placement in a suitable nursing home or other carefully supervised environment usually controls this behavior.

Mohr (1964) found that child molesters fall into three age groups. Adolescent offenders showed retarded maturation, immature social relations, and a lack of judgment. They tended to have unstable relations with other men and few, if any, relationships with females. The middle-aged group came from deteriorating families and ofte were experiencing vocational problems. The senescent group tended to be lonely and socially isolated.

Factors Related to Ethnic Origin

The racial make-up of offenders has varied with the geographical locale of the study. Frosch and Bromberg (1939), Frankel (1950), and Guttmacher (1952) found the majority of offenders to be native-born whites. A California study found the majority to be Spanish-surnamed (California Legislature Assembly, 1950). The racial distribution among sex offenders, as among all offenders, correlates highly with the poverty distribution in the locale for a number of reasons.

Factors Related to Intelligence Quotient

While a number of studies have found below average intelligence quotients among sex offenders, this finding is suspect for a number of reasons. Here again, the sample was drawn from institutionalized individuals and cannot be assumed to be representative of all sex offenders. It should be noted here that these findings refer to IQ scores, not the general concept of intelligence, and that these scores may be derived from different tests and from samples which may show a variation in the individual's test-taking ability due to language and other cultural factors. It has been this author's experience that sex offenders tend to be of above average intelligence, with many having college level or higher educations.

Factors Related to Personal Achievement

Studies relating to personal achievement, such as educational and vocational achievement, are biased according to the population, with those conducted only in institutions showing lower overall functioning. However, even in these studies the findings were sometimes mixed. While Glueck (1952) found that his sample had few job skills and tended to work alone, they also had more honorable discharges from the military, more consistent work histories, and fewer job-related problems than other types of offenders. As more individuals

Table 2.1

RESEARCH FINDINGS ON CHARACTERISTICS OF SEX OFFENDERS

Researcher (Date)	Findings
AGE	
Pollens (1938)	Mean age of 26-32
Henninger (1939)	Senility a contributing factor
Frosch & Bromberg (1939)	Senility a contributing factor
Waggoner & Boyd (1941)	Deviant pattern established between ages 10 and 16
Hirning (1947)	Senility a contributing factor
Frankel (1950)	Mean age of 26-32
Guttmacher (1952)	Mean age of 26-32
Glueck (1952)	Older than average
Langley Porter (1953)	Younger than average
Mohr (1964)	Trimodal age distribution for child molesters: 17, 37, 57.
ETHNIC ORIGIN	
Frosch & Bromberg (1939)	Native-born white
Frankel (1950)	Native-born white
California Legislature Assembly (1950)	Spanish-surnamed
Guttmacher (1952)	Native-born white
INTELLIGENCE QUOTIENT	
Pollens (1938)	Below average
Frankel (1950)	Normal
Abrahamsen (1950)	Normal
Durham (1954)	Above average
Ellis & Brancale (1956)	Below average
PERSONAL ACHIEVEMENT	
Frankel (1950)	Less than 12% high school graduates.
Glueck (1952)	More honorable discharges, personal-service jobs, isolated jobs, consistent work histories. Fewer job skills, fewer job-related problems.
Langley Porter (1953)	Lower educational achievement.
Van Kirk (1984)	33% have one or more years of college. 10% have graduate degrees.
MARITAL STATUS	
Shaskan (1939)	Fewer than average married.
Frankel (1950)	Fewer than average married.
Glueck (1952)	Fewer planned marriages; related to wife as a mother. Children targets of anger at wife.
Durham (1954)	Fewer than average married.
Gebhard et al. (1964)	Higher divorce rates.
Schultz (1965)	Most offenders claimed wives were unfaithful.
Hartman & Nicolay (1966)	Higher incidence among expectant fathers.
Van Kirk (1984)	30-60% are married.
SEXUALITY	
Glueck (1952)	Anxiety over masturbation; fewer but more bizarre fantasies; less sexual satisfaction.
Goldhirsch (1961)	More sexually explicit dreams among imprisoned sex offenders.
Gebhard et al. (1965)	Higher rates of homosexual experience.
Johnson et al. (1970)	Less exposure to pornography during adolescence.
Cook et al. (1971)	Less exposure to pornography during adolescence.
Goldstein et al. (1971)	Less exposure to pornography during adolescence.
Kercher & Walker (1973)	Rapists threatened by sexually explicit materials.
Karacen (1974)	No significant difference in nocturnal penile tumescence between rapists and other prisoners.
Attorney General's Commission on Pornography (1986)	Pornography related to the commission of sex crimes.
Carter et al. (1987)	Subgroups of sex offenders differed markedly in use of pornography.

Table 2.1 (continued)

RESEARCH FINDINGS ON CHARACTERISTICS OF SEX OFFENDERS

Researcher (Date)	Findings
MENTAL ILLNESS, PERSONALITY DISORDERS, AND ALCOHOLISM	
Pollens (1938)	Infantile
Shaskan (1939)	15% psychotic; 1% hysterical; 20% alcoholic
Apfelberg et al. (1944)	39% alcoholic
Fenichel (1945)	Infantile
Abrahamsen (1950)	11% psychopaths
Gardner (1950)	Infantile
Ploscowe (1951)	Immature
Glueck (1952)	79% psychotic, with impaired judgment, reasoning and reality contact
Durham (1954)	Infantile
Karpman (1954)	Infantile
Rada (1978)	Alcoholism significant
SEXUAL ABUSE	
Bowman (1938)	High incidence
Goldstein et al. (1971)	High incidence
Groth (1979)	Estimated 45%
Finkelhor (1984)	25% molested by women
PARENTAL RELATIONSHIPS	
Bowman (1938)	Disturbed
Pollens (1938)	Rejection
Henry & Gross (1938)	Disturbed; rejection
Menaker (1939)	Masculine, depriving mother and weak father
	Neurotic mother and tyrannical father
	Broken home
Waggoner & Boyd (1941)	Disturbed; rejection
Dushay (1943)	Rejection
Hartwell (1950)	Disturbed parental sexual attitudes
Glueck (1952)	Rejection; maternal seduction
Karpman (1954)	Disturbed parental sexual attitudes
Ellis & Brancale (1956)	Disturbed; rejection
Glover (1960)	Disturbed; rejection; maternal seduction
Gebhard et al. (1964)	Disturbed; rejection
Schultz (1965)	Hostile fathers and unrealistic expectations for mothers; rejection
Goldstein et al. (1971)	Disturbed
Fisher & Rivlin (1971)	Maternal seduction

who have been referred to community alternatives are included in studies, it is predicted that overall level of achievement in this group will rise. As shown in Table 2.1, more recent studies reflect this trend.

Factors Related to Marital Status and Sexuality

Research on marital status done with institutionalized offenders shows that fewer than average are married. However, it is not clear whether more were single at the time of institutionalization or whether divorce occurred as the result of this. Several researchers did study the dynamics of sex offenders' marriages.

The more recent research on marital status suggests that while sex offenders may have conflict-ridden relationships, they are able to acquire sexual and marital partners. They are not, as stereotypes suggest, isolated degenerates, sexually frustrated and totally unable to find appropriate outlets. Their sexual crimes do reflect disturbed interpersonal relations. Schultz (1965) found that most married sex offenders claimed that their wives were unfaithful regardless of the actual situation. Gebhard, Gagnon, Pomeroy, and Christianson (1964) found higher divorce rates among offenders. Their general marital adjustment was characterized by fewer planned marriages, and the unions often showed an immature fantasy quality in which the offender related to his wife as if she were his mother (Glueck, 1952). It was also suggested that children were viewed as interfering with the adult relationship and were frequently made targets of the offender's hostility. Hartman and Nicolay (1966) found that in a sample of expectant fathers charged with crimes, 41% had been arrested for

a sex offense compared to 16% of nonexpectant fathers arrested for sexual crimes. Most of those arrested were expecting their first-born. The authors felt that their crimes, rather than being attributable to sexual frustration per se, resulted from the arousal of maternal associations which impaired sexual performance. The rape then served to reduce anxiety about masculinity.

Most of the studies related to the sexual adjustment of sex offenders suggest that they have sexual conflicts or anxieties. The research is in conflict over the relationship of pornography to sexual crimes.

Factors Related to Mental Illness, Alcoholism, and Personality Disorders

The research on prevalence of mental illness again shows the nonrepresentative sample of the populations studied. As shown in Table 2.1, high levels of psychoses were reported by several early researchers. While most sex offenders show traits of personality disorders and while there are subgroups representing the seriously mentally ill and developmentally disabled, most sex offenders do not show major psychiatric disorders. Data is conflicting on the prevalence of alcoholism in this group. Various personality traits have been noted. A more extensive description of personality dynamics is included later in the chapter.

Factors Related to Sexual Abuse

Another characteristic of sex offenders is the high incidence of sexual abuse during their own childhoods. This was first identified by Bowman (1938) and elaborated on by Goldstein and associates (1971). Nicholas Groth (1979), studying incarcerated sex offenders, found that 45% described themselves as victims of sexual assault while an additional 18% remembered being pressured into sexual activity by an adult. Another 18% were involved in a sex-stress situation where the family may have reacted with extreme anxiety to the discovery that the individual was involved in some type of sexual activity, usually childish sex play. Upsetting sexual activity was witnessed by another 39%. Finkelhor (1984) reports that in his study 25% of his sample of sex offenders had been victimized by women. He suggests that this figure is probably an underestimate as abuse by a female is less likely to be perceived as abusive. Often it is perceived by the boy as reflecting a precocious ability on his part to seduce an older woman or as an initiation rite which the woman has done him the favor of performing. Such films as "My Tutor" and "Tea and Sympathy" reinforce this stereotype. Women are also able to mask inappropriate sexual behavior by disguising it as some caretaking function.

Researchers over the years have spent much effort detailing the demographics of sex offenders. More often than not, the samples were not representative. As is true with all crimes, those offenders who are eventually institutionalized in hospitals or prisons reflect the most serious or bizarre acting-out and the fewest resources. Future studies of treatment efficacy should control for the fact that the characteristics of incarcerated sex offenders may vary widely from state to state.

Factors Related to Parental Relationships

A great deal of research has documented the impaired parental relations often found among sex offenders. Unfortunately, no studies could be located which examined the relationship between types of offenders and types of parental dysfunction. Patterns of neglect, physical and sexual abuse, and rejection were found. Disturbed parental sexual attitudes were stressed by Hartwell (1950) and by Karpman (1954), who stated:

> Fault lies with the parents, who, themselves products of unhealthy repression and much involved in sexual problems, do not know and cannot set themselves to be frank and open with the child whose naive and artless curiosity should be handled in an equally simple way (p. 198).

Recent attention has been focused on the types of dysfunction associated with growing up in an alcoholic or otherwise dysfunctional family. While statistics specifically relating this to sex offenders are not immediately available, it has been this author's experience that a large number of offenders grow up in alcoholic homes. Adult children are described as suffering from psychic numbing, survivor guilt, lack of trust, being either totally irresponsible or overly responsible, having a strong need for power and control, and difficulty with intimate relationships. Many of these symptoms are relevant to the dynamics of sexual deviancy.

Typologies of Sex Offenders

As the characteristics of any large population are studied, patterns begin to emerge. Researchers may develop categories based on their personal experience or statistical analysis. Typologies are useful in that they condense information and may form the basis for concepts that can be clinically useful and tested experimentally. The problem with typologies is that few have been subjected to validation studies, and frequently they degenerate into stereotypes. Nick Groth's pioneering work in 1979 made a very understandable differentiation between types of pedophiles. However, people began extrapolating from his theory, drawing unwarranted conclusions. For example, the regressed pedophile is often considered to be a less serious or dangerous individual. However, the FBI's classification system takes into account the fact that a regressed pedophile, offending a child for the first time, may in some cases be quite dangerous as he is more likely to panic than the more patterned offender (Lanning, 1986).

In the opinion of this author, static typologies which simply categorize sex offenders are less useful than dynamic theories which are capable of changing to accommodate individual differences. Examples of the latter include the models developed by Murphy, Coleman, Haynes, and Stalgartis (1979), Carnes (1983), Finkelhor (1984), and this author.

The Pedophile

The pedophile is an individual who turns to prepubescent children for sexual gratification. However, there are a variety of reasons why this occurs. Since the condition was first studied, many researchers have attempted to classify these individuals. (See Table 2.2.)

In 1892, Krafft-Ebing classified pedophiles into those with acquired mental illness, senile individuals, chronic alcoholics, and individuals suffering from paralysis, epilepsy, head injuries, apoplexy, or syphilis. Generally speaking, pedophiles have been divided into several broad categories. Antisocial offenders have been found to have committed sexual offenses with adults as well as children and to have committed more nonsexual crimes (McCaghy, 1966). Fitch (1962) described these individuals as "men with records of instability in many fields of behavior who felt themselves to be deprived and rejected by society and whose sexual offenses, generally committed on complete strangers, were impulsive acting-out of temporary aggressive moods (p. 30)." East (1946) apparently was describing this type of individual when he wrote, "Some sexual offenders appear to belong to the constitutional psychic inferior group of psychopathic personalities and are not necessarily sexual perverts in the narrow sense (p. 46)."

Fehlow (1973) found that 50% of his sample of individuals arrested for the sexual assault of children were suffering from brain damage. This may be related to a high percentage of senile offenders. Henninger (1940) studied this type and theorized that their relations with children were related to a desire to regain their youth. Mohr (1964) found a trimodal distribution in which one peak occurred between the ages of 55 and 59. While these individuals are probably not senile, they may share with the senile offender such characteristics as loneliness, emotional and sexual isolation, and impotence.

Another type of offender is the person who is unable to identify with an adult sexual role (Fitch, 1962). Gebhard and associates (1964) considered this group the most disturbed in their sex offender population. These individuals were characterized as immature, underdeveloped persons who show marked anxiety over potency and inferiority. In retreat from adult challenges, they frequently establish peer relations with children, whom they find less threatening and judgmental (Revitch & Weiss, 1962).

Another group consists of those whose offenses seem to be a reaction against sexual or emotional frustration at an adult level (Fitch, 1962). Often these individuals are incest offenders. Gebhard and associates (1964) found that this type typically was labeled as "heterosexual aggressors against children" and that they had a history of broken marriages marked by restrained sexual activity with their wives. Mohr (1964) found that the group of offenders who first engage in sexual activity with children when they are between 35 and 39 typically have poor marital relations and have been drinking heavily at the time of the offense.

Nicholas Groth (1979) has offered another typology for the pedophile. Actually, Dr. Groth presents two typologies for pedophiles—one concentrating on the degree of entrenchment of the behavior and the other stressing the basis of psychological needs. The fixated pedophile has throughout his life been attracted to children and has been unable to attain any degree of psychosexual maturity. This is in contrast to the regressed pedophile who has at some time in his life related sexually to appropriate peers. However, a variety of situational stressors may undermine his confidence in himself as a man. Frequently the stressor is unemployment, which not only

Table 2.2

TYPOLOGIES OF CHILD MOLESTERS

	RESEARCHERS										
FINDINGS	Krafft- Ebing (1892)	Henninger (1940)	East (1946)	Fitch (1962)	Revetich & Weiss (1962)	Gebhard et al. (1964)	Mohr (1964)	McCaghy (1966)	Fehlow (1973)	Groth (1979)	Lanning (1986)
General Pedophilia	X										
Senility	X										X
Alcoholic	X										
Organic Dysfunction	X	X							X		X
Antisocial			X	X				X			X
Regressed				X	X	X				X	X
Fixated				X		X	X			X	
Sexual Pressure										X	X
Sexual Force										X	X
Sadistic										X	X
Sexually Indiscriminate											X

increases financial problems but undermines the identity which, particularly among males, revolves around a job. Physical illness can also impair his view of himself as a sexually adequate being who can satisfy an adult female. Therefore, he can engage in noncoital sex play with the less-threatening female child. In this individual, the behavior is much less fixated.

The other part of Groth's theory focuses on the degree of force that is related to the psychological needs which the act fulfills. The sex-pressure offense utilizes enticement or entrapment. The offender would prefer that his victim cooperate and usually is dissuaded if the child resists. This type of offender is pursuing love and affection as well as physical contact. These individuals frequently state that they are "in love" with their victims.

In contrast, the sex-force offense utilizes intimidation or physical aggression, which can be subdivided into the exploitative assault which utilizes threat or force and the sadistic assault. The former type of attack represents the use of the child as solely a sexual outlet. Only the amount of force necessary to accomplish the act is utilized, although this may lead to murder. These individuals are drawn to children primarily because they are easily overpowered and may present less resistance than an adult. The most frightening type of individual as well as the most dangerous is the sadistic offender. This individual has eroticized violence. The sadistic child molester must inflict pain, degradation, and even death on the child in order to achieve sexual gratification. His compulsive behavior may involve complex, carefully planned, patterned rituals.

Groth (1979) places incest along this dimension. Incest may be engaged in by the regressed or the fixated individual. It may be situational or it may reflect an effort on the part of the regressed pedophile to gain access to victims by pursuing a woman who has children whom he finds attractive. Incest may take place with one's natural children or with stepchildren. It does not inherently imply pedophilia as the victim could be an adult, even a consenting adult. However, since the latter is rarely reported, the type of incest which comes to the attention of the authorities often shows much pedophilic overlap.

The FBI has developed a typology based loosely on Groth's work but expanded to include seven subgroups (Lanning, 1986). The classification system is designed for use in criminal investigations. Elaborating on the concept of the regressed, Lanning describes the situational child molester as an individual who does not have a defined sexual preference for children. The stereotype that has grown up around this type of individual is that he is a rather benign person who is relatively easy to treat. However, as Lanning points out, this subgroup may include highly predatory individuals. Situational offenders include the following types:

- Regressed—an immature, socially inept individual who relates to children as peers. This individual may be experiencing a brief period of low self-esteem and turn to his own children or other available juveniles. This is the offender whom Groth described in his typology.
- Morally Indiscriminate—this is an antisocial individual who uses and abuses everything he touches. His victims are chosen on the basis of vulnerability and opportunity and only coincidentally because they are children.
- Sexually Indiscriminate—this individual was referred to in the psychoanalytic literature as "polymorphous perverse." This individual has vaguely defined sexual preferences and will experiment with almost any type of sexual behavior.
- Inadequate—this individual is a social misfit. He may be developmentally disabled, psychotic, senile, or organically dysfunctional. He rarely has contact with others and he may use children as vulnerable objects with which to satisfy his sexual curiosity. These individuals have been known to murder their victims. However, any type of molester is capable of murder to avoid detection.

Preferential child molesters correspond to fixated offenders in Groth's system. These individuals show a strong sexual preference for children, which has been with them throughout their lives. The subtypes include:

- Seduction—this individual has exclusive sexual interest in children, and courts and grooms them. He is usually able to identify those children who will not divulge the sexual behavior.
- Introverted—this individual has a fixated interest in children but does not have the social skills to seduce them. Typically, he molests strangers or very young children or he may marry women with children in the age range of his preference.
- Sadistic—this individual's sexual preference for children is coupled with a need to inflict pain in order to obtain sexual gratification. These individuals are obviously very dangerous and, fortunately, very rare.

David Finkelhor (1984) has developed a four-factor theory of child sexual abuse which incorporates not only characteristics of the offender but characteristics of the environment and the victim as well. The first part of his theory focuses on basic motivational factors. The offender may find relating to a child emotionally congruent because it gives him a sense of power and control, while relating to adults produces feelings of inferiority and inadequacy. The offender who has been sexually molested as a child may engage in a reenactment of the trauma, identifying with the aggressor in an attempt to master the shock. Narcissistic identification with the child may cause the offender, in effect, to fall in love with himself. Feminist theorists point out that our society socializes men into being attracted to individuals smaller and younger than themselves.

Offenders frequently show deviant sexual arousal to children. It should be pointed out that, while all paraphiliac pedophiles as defined by the *DSM-III* show deviant arousal, not all convicted child molesters do. Deviant arousal is often the product of sexual victimization of the offender himself. According to Finkelhor (1984), any feature of a sexual event which makes it particularly prominent, including intense pleasure, pain, guilt, or anger, can make it a point of fixation. This fixation is then reinforced by becoming the focal point of a deviant sexual fantasy which is repeatedly reinforced through masturbation. The offender thus becomes the model for the victim, who then also becomes an offender. Particularly in cases of incest, sexual love and parental love may become fused so that any type of emotional arousal is interpreted as being sexual in nature.

Child molesters may be blocked in their attempt to gain peer-appropriate sexual satisfaction. These individuals are often timid, passive, unassertive, and socially awkward. They may come from familial or religious backgrounds which picture sex in sinful terms. The blockage may be developmental as with Groth's fixated offender, or situational as with his regressed offender.

For the motivational features to be translated into behavior, there must be some type of disinhibition. All but the severely mentally retarded or organically impaired offender know what type of behavior is not only culturally taboo but illegal. Self-control is impaired by psychoses, intoxication, or a simple lack of impulse control. Finkelhor (1984) suggests that Groth's categories could be replaced by two continuums—strength and exclusivity. This would allow more flexibility in the theory.

By focusing on environmental and victim characteristics, Finkelhor (1984) incorporates the possibility for a variety of preventative approaches which can be utilized by parents, schools, social services agencies, and the children themselves. The victimized child, according to this theory, may lack supervision which may be the result of the physical absence of a protective adult or an emotional alienation which impairs trust and prevents the child from confiding in someone who could prevent the abuse. If the child is emotionally alienated, he/she may be easy prey to the enticing molester who offers acceptance and affection. The child must be taught that adult behavior is not sacrosanct. It can be questioned and stopped by assertive responses.

Finkelhor's typology represents a dynamic approach rather than a static categorization and has obvious implications for therapy. It also represents a theory that focuses on both the offender and the victim, with strong implications for prevention.

The Rapist

Most researchers who have worked with rapists have been impressed by the heterogeneity of the group. Consequently, they have tried to categorize not only the types of rapes but the types of rapists (see Table 2.3). One of the first to do this was Guttmacher (1952).

Selkin (1975) has divided rapists into two categories. The first category, he said,

> are victims of what analysts call ego splits. They are married, young, employed and living a life that one would not describe as typical of a person who is mentally ill. But their family life is disturbed. They can't relate successfully to their wives or parents; as youngsters they had problems with an older sister or an aunt who they say, "messed on them."
>
> After the crime these men will deny their behavior. Typically they'll say, "I don't remember. It wasn't me" or "I felt like I was watching a movie (p. 76)."

The other type is the predatory rapist. "These men," according to Selkin, "are out to exploit and manipulate others, and sometimes they do it through rape (p. 76)."

Table 2.3

TYPOLOGIES OF RAPISTS

	RESEARCHERS								
FINDINGS	Guttmacher (1955)	Gebhard et al. (1964)	Howell (1972-73)	Cohen & Seghorn (1969)	Burgess & Holmstrom (1974)	Russell (1975)	Rada (1975)	Selkin (1975)	Groth (1979)
Sexual Deprivation	X			X					
Sadism	X			X					X
Antisocial Personality	X	X	X	X				X	
Symbolic Reactions: Defense against homosexuality, incest, political condition	X		X			X	X		
Aggression (Anger)		X			X				X
Stress		X							
Madonna/Whore		X				X	X		
Psychoses; Mental Retardation		X							
Fear of Women			X			X	X		
Power					X	X			X
Ego Splits								X	
Dependency							X		

Karpman (1954) explained the dynamics of rape saying, "In some men only the resistance of the woman makes them potent (p. 358)."

In general, it would appear that researchers, often depending upon their own orientation, have classified the rapist into three motivational systems—situational, emotional and criminal. Some researchers recognize one category, some two, and some three. The situational rapist may be conceived of as a basically normal individual carrying certain preconceptions about women and rape which have been fostered by the culture and who, under certain social situations or conditions of stress, may commit a rape. The emotionally disturbed rapist may be compensating for feelings of inadequacy, expressing pent-up hostility or duplicating a traumatic developmental experience. The criminal rapist is simply a criminal type who takes sex as he would take money, cars, or television sets.

Nicholas Groth (1979), Ann Burgess and Lynda Holmstrom (1974) were among the first theorists to discard the notion that rapists are motivated by sexual desire. Written during the height of the Women's Liberation Movement, their work obviously reflects a sensitivity to ways in which sex is misused to overpower and denigrate women. Due to its importance in ushering in a new interest in the whole topic of rape, it shall be described here in more detail than previous typologies.

Groth (1979) has categorized rape as an act of anger but then subdivides this emotion into:

- a simple discharge of intense anger, frustration, resentment, and rage;
- a panic type of anger usually resulting from rejection;
- aggression used as a way of dominating, controlling, mastering, and conquering a situation; and,
- anger which is eroticized.

This typology is based primarily on the characteristics of the assault rather than the assailant. The anger rape is marked by gratuitous violence with the aim being to hurt, debase, and express contempt for the victim. The act is not sexually satisfying for the rapist, who often views any type of sexuality as offensive and thus an appropriate weapon. Rarely premeditated, this type of assault is usually committed in response to a precipitating stress. The rape serves as a discharge against some type of frustration either associated with the victim or utilizing the victim as a scapegoat.

The power rape, according to Groth (1979), serves as a means of exercising dominance, mastery, strength, authority, and control over the victim. There is little need for excessive physical force. These offenders, while less physically dangerous in their limited use of violence, may show more compulsivity, often engaging in fantasies or elaborate plans. Often these offenders are influenced by the media-reinforced scenario of a victim who initially resists but then becomes aroused and is unable to resist the sexual prowess of the assailant. It is an endless seeking after this distorted fantasy that gives the behavior its compulsive quality. The act may be a way of reaffirming the offender's masculinity and these individuals are often highly homophobic.

The sadistic rape represents the most severe pathology as well as the most dangerous type of assault. The ritual of torturing the victim and the perception of her suffering and degradation becomes eroticized, and as the assailant's arousal builds, so may the violence of his acts, progressing in some cases to lust murder. The pattern of the assault and the characteristics of the victim are repetitious and symbolic of something he wishes to humiliate and destroy.

Murphy and associates (1979) have attempted to combine theories stressing the psychopathology of the sex offender with those stressing a social/cultural model. Traditionally the former group of theorists have stressed such widely diversified etiologies as early incestuous desires and unresolved oedipal complexes to deviant fantasy reinforcement. On the other hand, theories of sexual deviancy growing out of the feminist movement have stressed that rape and child molestation are natural outgrowths of a society which encourages men to dominate and overpower not only women but anyone weaker than themselves. Susan Brownmiller (1975) states, "I believe that rape has played a critical function. It is nothing more or less than a conscious process of intimidation by which **all men** keep **all women** in a state of fear (p. 5)."

Murphy and associates (1979) have combined these theories and added the dimensions of perception and arousal to predict behavior. This is a dynamic model which has implications for assessment and treatment. Each dimension is viewed on a continuum and can be present to a greater or lesser degree in everyone. Four general groups of individuals emerge from this conceptualization with numerous gradations between the groups. First of all there is the highly psychopathological group that harbors intense hostility toward women, inability to express anger appropriately, fear of rejection, or numerous other emotional conflicts. When these individuals accept myths regarding rape and violence, experience misperception of female behavior, and demonstrate arousal to aggressive sexual cues, rape is quite likely.

The next group is similar to the first group in all dimensions, but the degree of psychopathology is less. This second group is quite likely to engage in criminal behavior, and the committal of rapes may represent just one of the many incidents of taking by force. Another group, referred to as situational offenders in other systems, shows little psychopathology and limited antisocial inclinations. These individuals may occasionally rape but more frequently engage in coercive sexual behavior. This theory is refreshing in that it includes an explanation as to why there are men who are not rapists. The authors do not explicitly differentiate rapists from other types

of sex offenders. The theory, however, can be easily adapted to explain a variety of deviant behaviors.

The Addictions Model

Growing out of the strong interest in addictive disorders with its new emphasis on family systems and codependency is Patrick Carnes' theory of sexual addictions, which can also be seen as a typology as it categorizes sexual addicts on three different levels, depending on the degree of criminality of the offense (1983).

Level One includes masturbation, heterosexual relationships, pornography, prostitution, and homosexuality. This category includes a wide range of behaviors with various cultural reactions. Many of these behaviors are appropriate in moderation but may take on a compulsive quality. Carnes (1983) states that for some behaviors there is a competing negative hero image of glamorous decadence. These crimes lack a direct victim; however, psychological exploitation of a partner may be part of addiction.

Level Two includes misdemeanor crimes such as voyeurism and exhibitionism, as well as obscene phone calls and indecent liberties. While these individuals will be prosecuted if apprehended, they are often the butt of jokes including "flasher dolls" that can be bought in novelty shops. Especially where there is a pattern which escalates in terms of involvement with the victim, these activities may be a dire forewarning of more serious crime.

Level Three is marked by the felony sex offenses—rape, child molestation, incest. There is a subgroup of sex offenders who clearly progress from Level One, through Two, to Level Three. It should be cautioned, however, that there is little indication of the number of sex offenders who show the compulsive pattern compatible with this construct.

Defining sexual addiction as "the substitution of a sick relationship to an event or process for a healthy relationship," Carnes points out that sex addicts subscribe to a set of core beliefs that distort reality (1983, p. 5). They believe, for example, that as individuals they aren't worthwhile enough that other people would care for them or satisfy their needs; additionally, they believe that sex is the most important need in their life—their only source of nurturance, the origin of their excitement, the remedy for pain, and their reason for being.

The addictive cycle is a vicious cycle which begins with distorted beliefs, progresses to impaired thinking, and then leads to an acting-out pattern similar to substance abuse, gambling, and/or eating disorders. While the acting-out is followed by despair, the guilt and remorse do not lead to reformation but to an escape back into the addictive cycle. Both men and women can become sexual addicts, although many more men progress to the third level. A vivid dramatization of the first level is presented in the movie *Looking for Mr. Goodbar*.

The suggested treatment for the sexual addict is the utilization of self-help groups and the Twelve-Step Program, originating with Alcoholics Anonymous and now widely used with a number of disorders. The individual must first admit his behavior and admit that he is powerless to overcome it alone. The very admission of the problem removes the secrecy which has significantly contributed to the excitement. The addict then works on relating to a source of higher power. He shares his experiences, asks for forgiveness, and begins to make restitution—not only for his sexual misconduct but for all his past abuses of others.

Sexaholics Anonymous and Sex Addicts Anonymous groups are springing up all over the country and may be used as a valuable resource for sex offenders in the community. These groups use an acronym to remind them when their sexuality is taking on a deviant or compulsive behavior—**SAFE:**

1. It is a **S**ecret.
2. It is **A**busive to self or others.
3. It is used to avoid or is a source of painful **F**eelings.
4. It is **E**mpty of caring.

In treating thousands of offenders of all types, it has become apparent to this author that there are two components of any criminal act—a motive and a releasor which allows the motive to transcend personal and societal sanctions and be expressed. This theory uses the visual image of a dam and applies to all types of sex offenders (see Figure 2.1). It can also be modified to be used with any behavioral disorder. The reservoir of motivation can include a vast, complex network of beliefs, values, thoughts, feelings, and behaviors which set the stage for a variety of deviant sexual behaviors. What is perceived as comprising the reservoir will largely depend on the theoretical orientation of the therapist. The widest possible orientation will allow for the widest possible exploration of the motivational reservoir. The anger, power, core beliefs, and deviant arousal of the sex offender may be explored by looking at issues around the dysfunctional family, the offender's own sexual victimization, family and peer attitudes and models, societal stereotypes, and origin and quality of sexual victimization. He may feel that he has been victimized by women. Significant role models in the offender's life may have been abusive towards others. Sexually deviant behavior may have been reinforced in a variety of ways. Each sex offender's motivational reservoir is unique to him.

This motivational reservoir is held in check by floodgates or control factors, which may be opened by various influences. Stress impairs the ability to maintain control by depriving one of the physical and psychological energy to exercise good judgment and maintain emotional equilibrium and a realistic perspective on the situation. Intoxication through either drugs or alcohol, on either an acute or chronic basis, impairs judgment and enhances impulsivity. Mental retardation or organic brain damage can cause an individual to misread social

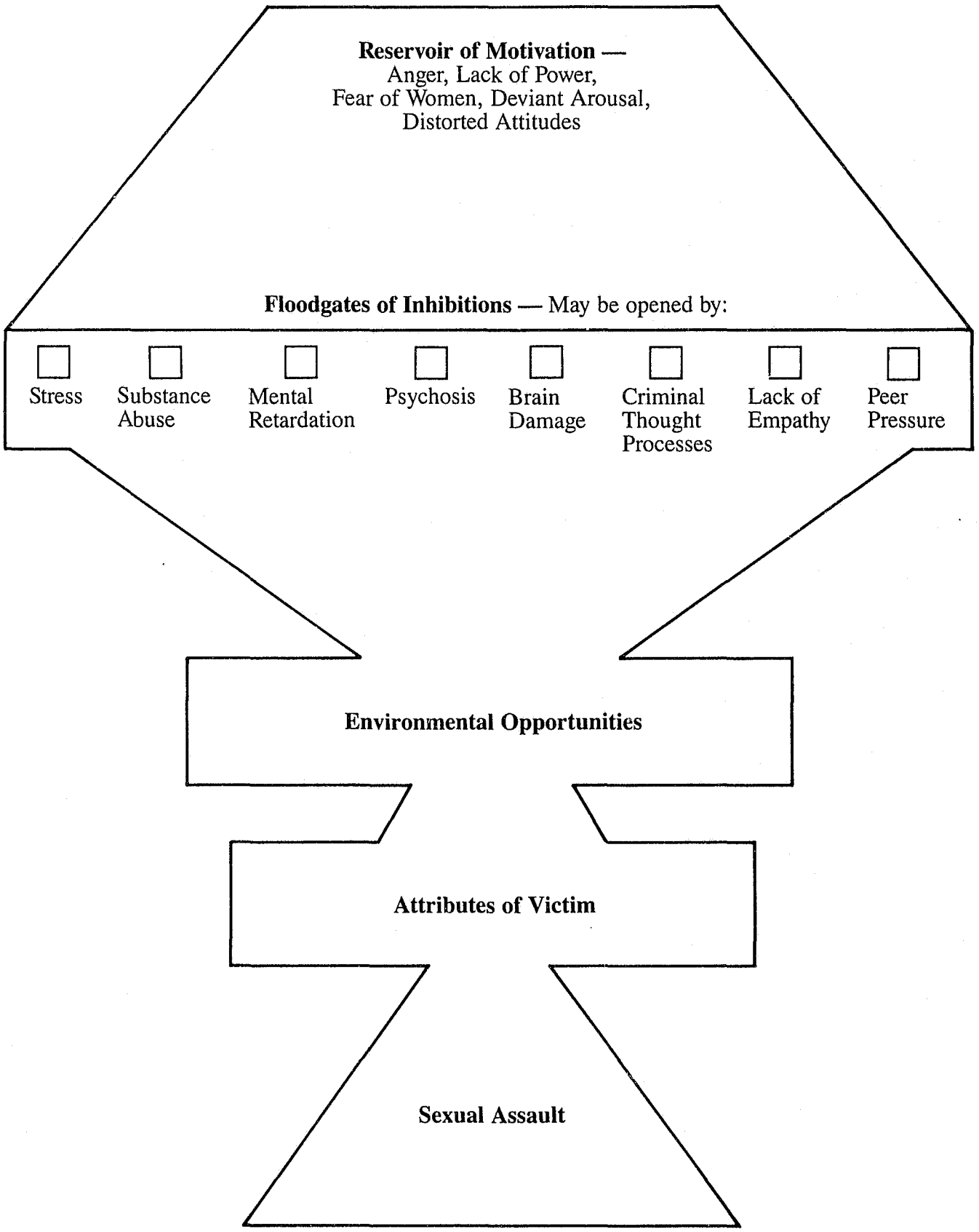

Figure 2.1. **AN ALTERNATIVE TYPOLOGY FOR SEX OFFENDERS**

cues or misjudge who is an appropriate peer. These conditions can also lead to feelings of inferiority, inadequacy and isolation, which may increase stress and contribute to the reservoir as well as to the opening of the floodgates. Some organic conditions impair impulse control.

Reality testing may be impaired by psychoses. Criminal thought patterns, first introduced in *The Criminal Personality* (Yochelson and Samenow, 1976), present a variety of rationalizations for antisocial behavior. Individuals with these thinking errors take a victim stance—"She's rejecting me." "She asked for it." They may take an "I can't" approach—"I can't control myself when I'm aroused." They lack both a concept of injury to others and empathy and may lack the willingness to put forth the effort to pursue their goals in a socially sanctioned manner. Entitlement, irresponsibility, mistrust, and unrealistic expectations play into the belief that one can simply take what one wants. These individuals have difficulty making decisions, establishing long-range goals and evaluating progress towards them. They show an inordinate fear of being "put down" and, when they perceive this as happening, release concomitant amounts of anger. They can't acknowledge fear or deal with anger, and they are excited by power struggles. Any of these distorted beliefs can contribute to the acting out of deviant sexual motivation.

A lack of empathy can be generalized or quite specific. Empathy may vanish when one is angry or frustrated by another, or the basic ability may have generally failed to develop. Peer pressure can impair empathy, but it can also cause individuals to act in inappropriate ways through social or physical fear, need for power, or the inability to exercise independent judgment.

When the floodgates open, varying amounts of motivational energy are released. When there is minimal energy, almost any type of environmental resistance will serve to halt the flow. For example, if the potential offender is not with a female whom he might readily assault, he may lack the motivational energy to seek one out and may content himself with a fantasy. When the amount of motivational energy is great, however, almost no environmental obstacle will deter him. The time-honored test of lack of control which is used in competency trials, known as the "policeman at the elbow" measure, is failed by this individual.

If there is sufficient energy to overcome environmental barriers, the would-be offender may still be stopped by certain attributes of the victim. Many potential rapists stalk the streets looking for such a particular victim with such specific attributes that they fail to find anyone before their motivational push recedes. On the other hand, when the amount of motivational energy is vast, there may be no attribute of the victim that can stop the individual. He will assault literally anyone, which may explain why male rape may be committed by offenders with little, if any, homosexual orientation.

What other authors have referred to as "situational offenders" (Gebhard et al., 1964; Groth, 1979; Rada, 1978) may have a problem primarily with the floodgate portion of this system. There may be individuals who are under extreme chronic stress or chronic alcoholism. Any accumulation of anger, resentment, misreading of cues, or encouragement from society may be expressed through a sexually deviant act but usually only where there is little environmental hindrance and where a victim is handy. With the situational offender, the lack of control may be enhanced in an additive manner by failures at many separate points, e.g., stress + intoxication + a momentary lack of empathy, or by one control area remaining out of commission for a long period of time as is the case with chronic alcoholism.

The patterned offender has so much built-up motivational energy that the slightest weakness or the most momentary failure of his control system may unleash the compulsive drive. In a few cases, the control system is almost totally destroyed so that the offender is always either committing a sexually deviant act or in the process of preparing to commit one.

This theory implies that there are many more potential sex offenders than actual ones. There are many men and women as well whose control systems have remained intact perhaps only through luck but who harbor tremendous amounts of deviant motivational energy. This conceptualization can also be used to explain the differences between the "expectant father" assailant suffering from a specific stress, the mentally ill or retarded offender, the criminal who takes a woman as he takes an object, the unexpectedly rejected college student with his empathy perhaps impaired by societal myths and stereotypes, and the gang rapist.

Treatment implications revolve around draining the reservoir and strengthening the offender's floodgates, analyzing the environment to erect as many blockades to assault as possible, and continuing to study what a victim may do to dissuade her assailant. What comprises the source of the motivational energy must be evaluated and dealt with therapeutically. It is here, in attacking the root of the problem, that behavioral techniques and group therapy come into play. Controls must be strengthened by equipping the individual with techniques to deal with stress, particularly social stress. Techniques such as social skills training, assertiveness training, and anger management are useful. Substance abuse treatment must be part of the program where applicable. For the retarded and organically damaged, educational approaches dealing not only with sexual and social issues but also drawn from the vocational rehabilitation field, teaching basic cognitive processes such as analyzing, sequencing, etc., may be utilized. The psychotic offender may need proper medication. Victim empathy training may also be used to enhance control. Rape prevention programs in the schools may weaken peer pressure to act-out sexually. Relapse Prevention training can assist the offender in recognizing the building up of motivational energy or the weakening of control, enabling

him to utilize appropriate techniques to deal with these problems.

There is a continuing need for research in a wide variety of areas. There is a need to replicate these studies with many types of offenders in a variety of environments including prisons, hospitals, and community settings. This will require the cooperation of large numbers of professionals and their patients.

These issues must be responded to with knowledge rather than with hysteria. The theories, characteristics and typologies of the sexual deviant continue to expand and become more complex as the social sciences mature. There are many theories but, as yet, few hard facts.

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Part Two: Implementation and Administration of Programs

In the following chapters, the authors offer suggestions for establishing sex offender treatment programs in prisons. Suggestions are offered for establishing programs from scratch. In those few situations where there is a mandate either from the legislature, media, citizens groups or from within a department of corrections, administrators may be able to carefully lay a firm foundation of support by working with concerned community groups, interested professionals and the media. Systematic training can precede the beginning of treatment. Policies and procedures will be carefully established.

It is fully recognized, however, that many programs begin with one mental health professional who simply starts treating sex offenders with no resources but his/her own motivation. Some of the most famous programs have developed in that fashion. Dr. George MacDonald of Fort Steilacoom, Washington, Dr. Geraldine Boozer in Florida, and Dr. Nicholas Groth of Connecticut certainly did not have the luxury of large budgets or trained staffs. These pioneers faced doubting critics, if not public ridicule, to establish the initial treatment efforts with this unpopular clientele. Therefore, states that have a few scattered groups conducted by a few mental health professionals should not feel that they must wait for large funding or statewide coordination to establish their programs. Certainly the various components from training to various treatment modalities to aftercare can be added gradually. A plan of action, agreed upon by top-level administrators, will aid in guiding this growth.

Given the high profile of anything which has to do with sex crimes, administrators and therapists must accept the fact that their efforts in this field will be under close public scrutiny. Rarely is there a public outcry if check forgers recidivate. Heroin addicts who return to drugs are seen by the community as doing just what they were expected to do. However, if a sex offender reoffends, many state legislatures call for massive investigations.

Every correctional administrator must first recognize that sex offenders reoffend. They reoffend following the worst treatment and following the best. Therapists can only be motivated to undertake the difficult task of treating these individuals if they know that their professional efforts will be supported in the face of inevitable failures. The correctional administrator might well wonder why a sex offender program should even be established if it is going to result in public inquiry and possible criticism.

Sex offenders are a woman's constant fear and a parent's dread. Such offenders are regarded as "sick" as well as criminal, and, therefore, the public expects that prisons should "do something" with them. Currently there are cases in the courts of victims or their families suing correctional departments for failure to treat sex offenders. Regardless of the outcome, such cases raise public expectations. While it is acknowledged that there are many problems with recidivism figures, the statistics in this volume suggest that treatment programs are reducing sexual victimization in states where they are in place.

The first step a correctional administrator should take is to inventory what is presently available in the state, both within the department of corrections and in the community. What is available at the state hospital? Can this be utilized by corrections or can it be a source of consultation, training, or of experienced staff that might be recruited? Technical assistance is available through the National Institute of Corrections to evaluate current programs and advise on the specifics of program expansion. Often, unexpected resources such as trained but unutilized staff members are discovered within the department once a survey is conducted.

It is helpful to harness the interests of influential community leaders who can advise the department on the climate of the community regarding certain treatment modalities. Often public attitudes are based on ignorance or misunderstanding and can be changed through the judicious use of training.

There are a variety of training opportunities for staff. National Institute of Corrections technical assistance grants can provide trainers or send teams to model programs. Throughout this monograph are references to a wide range of materials which can be utilized. Workshops are available throughout the country on varying aspects of sex offender treatment. Training must be an ongoing proposition as this field is constantly changing. Training must also extend on some level to all institutional and administrative staff so that they have at least some knowledge of the program's aims and objectives.

Program evaluation is another crucial area for the correctional administrator and the treatment provider. This is the information that can forestall a witch hunt when a released

offender reoffends. Careful, ongoing evaluation can also inform the staff of the program's strengths and weaknesses and facilitate improvement.

The suggestions offered in the following chapters should be studied and then modified to suit the needs of individual states. Each program will emerge as a unique entity due to a variety of factors, but this variety should be the source of constant development in the treatment of sex offenders.

Chapter 3: Program Planning and Implementation

by Roger C. Smith

Abstract

In this chapter, Dr. Smith provides a guide for implementing new programs and for supplementing and enhancing existing ones. Topics range from building good public relations to training all concerned segments of the community to hiring and training staff. Special programs for mentally ill and mentally retarded offenders are suggested. The special cooperative relationship which exists between the Oregon Corrections Department and the Mental Health Bureau is highlighted.

This chapter addresses issues which correctional administrators and others will face in planning and implementing sex offender programs. This chapter emphasizes that services ideally should be planned on a statewide, comprehensive basis, involving the organizations and individuals most concerned with reducing sexual violence in our society. It can be argued that a state will vastly improve its process of sex offender treatment by regarding all concerned resources as part of a total system. Sex offender programs have often been implemented in correctional or mental health institutions in response to court orders, new legislation, or even local efforts by both clinicians and offenders. Isolated from other elements of a system, these programs can be overwhelmed or destroyed by lack of community support or poor funding (Brecher, 1978).

Because of the rapidly changing nature of this field, it is important that there be ongoing contact between both public and private treatment programs, corrections and mental health officials, lawmakers, judges, academics, victim assistance agencies, and law enforcement. Each has much to teach the others. Networking is important from a program standpoint. It is also important for professional growth and staff development at all levels.

Sex offender treatment systems on a statewide basis are relatively rare. There is currently very little in the professional literature which specifically addresses the unique organizational problems associated with planning and organizing sex offender treatment programs. Brecher (1978) realized the importance of statewide planning over a decade ago when he visited 20 sex offender treatment programs in 12 states. Most programs, he reported, came into being without extensive planning. Sometimes a corrections or mental health institution was struggling to manage this population in a more effective manner by developing a specialized program. In other instances, individual clinicians became fascinated by the unique clinical needs of sex offenders and began to offer limited treatment services which later grew into full programs. It is not surprising that many states are now evaluating which agencies might most appropriately assume responsibility for coordinating and integrating treatment services.

How broad a perspective should state planners take when considering the design of a comprehensive, statewide system for sex offenders? Brecher (1978) argued that there are at least eight categories of offenders which must be taken into consideration:

- juvenile sex offenders,
- volunteers (i.e., offenders not identified by the criminal justice system who voluntarily seek treatment),
- nuisance offenders,
- rapists, child molesters, and other serious offenders placed on probation,
- serious offenders incarcerated for treatment in state mental hospitals,
- serious offenders incarcerated in medium and minimum security correctional institutions,
- serious offenders incarcerated in maximum security correctional institutions, and
- offenders released on parole or aftercare status following incarceration in a correctional institution or state hospital.

It is apparent that planning for sex offenders in all of the above categories should involve public and private agencies on both the state and local levels. City and county officials are traditionally most concerned about offenders on probation or parole. State agencies are usually most concerned about offender assessment or evaluation mechanisms and residential programs within corrections or mental health institutions.

Interagency Coordination

One of the first statewide sex offender planning efforts was undertaken in Minnesota in 1972 (Brecher, 1978). The University of Minnesota conducted a study of the problems of sex offenders in that state. This study triggered wide public interest and debate, and in 1976 the Minnesota legislature ordered that a statewide plan be developed.

This planning effort was greatly enhanced by the availability of information from the first study which surveyed

- laws relating to sexual offenses,
- treatment resources available in both the public and private sectors,
- the numbers of offenders convicted of sexual crimes and their disposition,

Oregon: A Case Study of Interagency Cooperation

In 1975 the Oregon legislature took the lead in promoting a cooperative relationship between mental health and corrections systems. After an extensive formal inquiry into the mental health needs of inmates, the legislature created the Mental Health in Corrections Program. They mandated the establishment of mental health services for inmates within correctional institutions and a drug and alcohol treatment program for inmates to be located at the Oregon State Hospital.

Reflecting its commitment to this initiative, the legislature requested that corrections and mental health submit ideas for future programs to address their goal of providing mental health services to specific offender groups.

In framing this legislation, the historical lack of cooperation between these two agencies was taken into consideration. The legislature required the two agencies to work out methods to manage these inmates cooperatively. The two agencies established the Mental Health in Corrections Policy Board to oversee the development of the hospital-based programs. By 1979 four separate treatment units were housed at the Oregon State Hospital. The Policy Board developed administrative rules governing every aspect of interagency transfer, including dispute resolution. The Policy Board was comprised of institutional superintendents, assistant administrators from both agencies, representatives from community mental health organizations, and a mental health administrator.

The administrative rules drafted by the Policy Board reflect the security concerns of the corrections members, as well as the clinical philosophy of those representing mental health. All programs were voluntary. The program was to be transitional in nature, with strict aftercare obligations. Participation would not reduce length of sentence. Custodial levels required for participation would be commensurate with the level of security which the hospital could provide, with corrections determining custody classification. To avoid the possibility of a correctional institution "dumping" problem inmates with no motivation for treatment, the program screened and selected treatment candidates.

The following is a summary of the key provisions of the administrative rules governing transfer:

Criteria for Transfer

Participation in the sex offender unit requires that the inmate be from eighteen months to three years from parole release. In special instances, timeframes may be waived with consent of both agencies. Because of the determinate sentencing structure in Oregon, release dates are set by the parole board within a few months after incarceration, and participation in treatment does not alter the release date. In the view of the program staff, this rule would lessen the extent of manipulation or "looking good" by inmates seeking to impress the parole board.

The decision to establish timeframes is linked to the belief of mental health staff that intensive residential treatment is more efficiently delivered during the last few years of incarceration where parole supervision may include continued treatment and specialized supervision techniques. Those who are not within the required timeframes for participation do have the option of participating in treatment programs within their parent institutions.

Inmates who seek to qualify for transfer must meet several broad clinical criteria including a documented history of sexual deviance. The broad clinical criteria permit clinicians to evaluate and accept inmates who are deemed most likely to profit from treatment.

In a transitional model, aftercare is of critical importance. Thus, inmates must give reasonable assurance that they intend to remain in the state during parole and agree to participate in aftercare treatment.

Finally, inmates must sign a release of information which allows transfer of specified clinical information from mental health back to corrections. All other information requests require separate signed releases of information.

Dispute Resolution

The Policy Board established the Interagency Case Disposition Review Committee as a formal mechanism for resolving disputes regarding inmate transfers between the two systems. The committee has the authority to solicit testimony from staff of either division. This procedure has been used infrequently; however, its existence provides an impetus for resolution of disputes on the operational level.

Confidentiality

The rule spells out the limitations on sharing privileged clinical information. Mental health institutions must follow both state and federal regulations concerning the divulging of clinical information. This limitation is regarded by clinicians as necessary for the development of trust and open communication. Corrections has no real need to know intimate clinical details except when an inmate reveals information which may impact safety or security. The primary interest of corrections is in knowing the general progress of the inmate in treatment. Thus, each applicant signs a release of information permitting treatment summaries to be sent to corrections. This facilitates appropriate management of the inmate if returned to his parent institution without completing treatment.

Leaves

The rule spells out the conditions under which an inmate is permitted to leave the secure area of the hospital or to go on temporary pass to the community. All such passes are approved by the superintendent of the correctional institution, who may impose special stipulations, e.g., urinalysis testing upon return from leave.

Other Issues

Anticipating the need to avoid squabbles over procedural matters, the administrative rule spells out the more routine aspects of interagency transfer including how money and property is handled, responsibility for transportation of inmates, payment of medical expenses, or how visitor lists are approved.

Program

The program is multimodal. All inmates are required to complete psycho-educational classes. Groups meet daily within the therapeutic community format, and much of the time is devoted to exploring and developing the participants' deviant cycles. This program pioneered in the use of behavioral techniques including counterconditioning and does use Depo-Provera™ with selected cases. The transitional stage is considered crucial and participants share living quarters after completing the work release phase. They are required to come back onto the ward for a number of months following release. This program represents the quality of treatment that can result from interagency cooperation.

- profiles of the various types of sex offenders, and
- recidivism data.

In surveying various resources around the state, the survey teams found a surprising number of programs already providing sex offender treatment services. However, there was little coordination among these services.

In 1979, staff of the Massachusetts Treatment Center, a sex offender treatment program housed within the Bridgewater State Hospital, was requested to develop a comprehensive plan for that state. This opportunity arose because the mental health department was unable to isolate specific budget requests for the program within its departmental budget. The program was administered by mental health and corrections. In 1975, a consent decree was signed by the commissioners of both mental health and corrections which gave both administrative and operational control of the program to mental health. The comprehensive plan they developed operated within a regional mental health structure, with a range of institutional and community services. Elements of the program included an evaluation and observation program, an inpatient treatment program with a wide range of therapeutic and educational services, a graduated release process, and regional community programs to treat those released from the inpatient program as well as others deemed appropriate for community treatment.

Statewide planning activities would ideally gather all pertinent data including numbers and types of offenders arrested, convicted, and sentenced. Recidivism data should be compiled on treated and untreated offenders. The range of existing public and private treatment services for offenders should be researched and their role in providing services understood. The relative costs and effectiveness of each program should be assessed. The physical and staff resources needed and available should be detailed, including space available in correctional or mental health institutions suitable for housing treatment programs.

It is necessary to include in planning representatives of the various segments of the community with a stake in minimizing sexual victimization. The involvement of such disparate groups can provide a valuable perspective for correctional officials because these groups are exposed to the problems of managing sex offenders in a variety of different situations. For example, judges are often concerned about getting clinically relevant information regarding an offender's dangerousness and amenability to treatment before imposing a sentence. Judicial input provides a valuable perspective when considering the elements of a system for effectively managing sex offenders. Community-based programs may be valuable resources for probation and parole officers, as well as institutional programs which require treatment after release. Legislators and judges often give valuable insight into laws pertaining to sex offenders which either inhibit or assist the treatment process. Their participation during the initial phases of a statewide planning effort can be critical in establishing a legal framework which promotes the goals of treatment.

During the early stages of planning, it is important that all parties realistically assess the most current treatment techniques in the field of sexual deviancy. It is important that planners understand the limitations of current treatment technology to avoid unrealistic program expectations. During early phases of planning, broad system goals and objectives should be formulated.

Statewide planning efforts may be initiated for a variety of reasons by any number of groups and agencies. In some states the legislature has mandated statewide improvement in sex offender treatment and thus forced agencies into cooperative planning efforts. In other instances, planning is court mandated. Whatever the impetus for comprehensive planning, either mental health or corrections agencies will probably assume primary operational responsibility for these programs. Which agency is most appropriate for assuming leadership? Presently, this appears to be an open question. In some states, interagency agreements have been developed which serve to facilitate the flow of clients between agencies. In other states, poorly defined interagency relationships and competition for funds and resources inhibit the effective delivery of offender services.

In a nationwide study of jail mental health services, researchers reviewed a variety of organizational arrangements for delivery of mental health services to jail inmates (Steadman, McCarty, & Morrisey, 1986). The problems described are analagous to those encountered in delivering sex offender treatment services. No single organizational model emerges as clearly superior to others as it relates to establishing interagency cooperation and reducing conflict. On a practical level, jails regard security as their primary mission, while the concern of mental health is primarily treatment. In some jails it was reported that interagency agreements to provide services resulted in the largest range of mental health services but generated much interagency conflict. One factor to consider when contemplating an interagency model of service delivery is the extent to which each agency can tolerate or deal with ongoing negotiation and conflict.

McCarthy (1985), in a survey of correctional systems seeking to transfer mentally ill inmates to mental hospitals, points out many problems which might relate to sex offenders as well. Many of the respondents to this survey urged a greater degree of cooperation between agencies, as well as a thorough acquaintance with the goals, methods, and operational realities under which each agency operates.

Pre-Implementation Considerations

There are many factors to consider before implementing a comprehensive treatment delivery system.

Resource Allocation

Residential sex offender treatment programs in correctional or mental health institutions may be significantly more expensive than normal prison beds. Thus, it is important that planners are critical in their analysis of various treatment strategies and models. In a monograph on economic analysis techniques in corrections, Wayson, Funke, and Talkin (1984) assert that governmental decision makers must employ a variety of economic analysis techniques to make four distinct decisions relating to program planning:

- how much to allocate to a single program;
- whether to allocate to one or more program(s);
- how effectively will the objectives of the program be achieved; and
- how efficient is the expenditure.

The focus of the first decision is whether to fund a single program. The focus of the second decision involves alternative service delivery approaches which might deliver effective services to larger numbers of offenders at a lower cost.

Planners must also consider the following issues when evaluating current resources:

- Are there facilities within either correctional or mental health institutions suitable for programs?
- Can prison environments be modified sufficiently to promote the goals and methods of a sex offender treatment program?
- What is the availability of clinical and management expertise in this area?
- Will it be necessary to recruit large numbers of specially trained and qualified professionals to manage and staff the program?
- How can the corrections department present an image that supports treatment programming?

Initial System Components

The range and type of sex offender assessment and treatment resources in a comprehensive system depend on several basic judgments by planners. A system may wish to target offenders at different stages of the criminal justice process. For example, it may regard as its highest priority the first-time offender who can be safely treated on probation. This decision would make it important to have the capability to determine offender dangerousness and amenability to treatment before sentencing. It might also require referral to public and private outpatient or residential programs in the community. If the focus of planning is on institutionalized inmates or patients in state hospitals or prisons, there are decisions to be made regarding the model of treatment and at which stage of incarceration or commitment treatment should be provided. Many institutions focus treatment efforts on inmates who are in transition between institution and community. Others may choose to provide treatment only as a condition of parole.

The following describes program elements which might comprise a comprehensive statewide system for treating adult sex offenders in both community and institutional settings.

Presentence Assessment

The cornerstone of a quality treatment system for sex offenders is assessment. Presentence assessment occurs in a variety of settings. Some counties have diagnostic centers which provide clinical assessment services for the court and probation officers. In other states, forensic programs are designated by law as the agency responsible for conducting court-ordered evaluations for sexual dangerousness and amenability to treatment. Increasingly, courts are contracting for assessment services from private clinicians specializing in the treatment of sex offenders.

The availability of clinical assessment before sentencing makes possible appropriate offender referrals to treatment programs based on potential risk to the community and an offender's ability to profit from a particular treatment program. A sophisticated classification process also reduces the burden imposed on programs as a result of the court's "dumping" unmotivated and inappropriate offenders into treatment. Classification can also create a more cost-effective system because those who are adjudged to be minimal reoffense risks can be treated effectively in less costly community-based programs, while more dangerous offenders are relegated to programs within secure institutions.

Alternatives to Incarceration

The proliferation of both public and private agencies and clinicians in the community treating sex offenders offers the court an option of mandating treatment as a condition of probation. This treatment option can be a powerful motivator for an offender facing incarceration. Offenders requiring secure residential treatment may be placed on probation and required to participate in a forensic program in a state mental hospital. Private residential treatment programs for sex offenders may become a viable option for courts in the future.

Role of the State Mental Hospital

State mental hospitals have functioned for many decades as an alternative to imprisonment for many sex offenders by the replacement of criminal penalties with civil commitment laws. In the past, most states mandated a special legal status for sex offenders under Sexual Psychopath or Sexually Dan-

gerous Offender Laws. This led to the development of sex offender treatment programs in several state hospitals during the 1960's and '70s. Often programs were housed in unused mental hospital wards, readily available following the deinstitutionalization movement in the '60's (Morrisey & Goldman, 1986).

Within recent years many significant administrative, legal, and program changes have occurred on the state level which impacts on how sexual offenders are evaluated, sentenced, and treated. The relationship between state hospitals and correctional institutions has not been an easy one historically and is still often problematical (McCarthy, 1985). However, in some states there are examples of interdepartment cooperation in dealing with sex offenders. While such efforts are rare, they do offer some hope for better collaborative efforts.

A comprehensive system should include a diverse range of facilities and programs in a variety of settings. Service delivery systems should include community-based programs, secure residential facilities in mental hospitals and prisons, or transitional programs, parole and aftercare services.

Most of the state hospital programs described here have gone through many evolutionary changes in the years since sex offenders were first thrust upon hospital clinicians and administrators. From the early efforts to simply cope with this puzzling patient, a much more sophisticated treatment delivery system has evolved. There are currently a few interesting hybrid programs housed in state mental hospitals. There are several advantages to being located in a hospital setting. In a hospital, clinicians can more easily implement treatment procedures which might be suspect in the traditional prison

Mentally Ill and Mentally Retarded Sex Offenders

Traditionally, offenders with significant mental illness or mental retardation are committed to mental health institutions under civil commitment or criminal responsibility laws. Unfortunately, there are few specialized programs for such offenders. The experience of programs that integrate low-functioning or mentally ill men into confrontative or cognitively oriented programs has not been promising. The etiology of sexual deviance in the mentally retarded or mentally ill offender is often significantly different from the normal or nonpsychotic offender. Retarded or low-functioning offenders often lack appropriate social and sexual skills, which in turn becomes a primary factor in selecting children as sexual targets. The mentally ill offender may be acting-out on hallucinations.

There are unique programs which provide some optimism regarding the treatability of this group, particularly the low-functioning offender. In New Jersey, the Moderate Security Counseling and Treatment Unit (MSU) was initiated in 1965 under the auspices of the New Jersey Division of Developmental Disabilities. Although not a correctional institution, individuals may be placed there by the court as a condition of probation. The facility houses approximately 50 clients. These clients have criminal histories ranging from assault to sexual crimes. All participate in a highly controlled and structured milieu which utilizes a variety of behavioral modification techniques. Education is an integral aspect of the treatment strategy. While this program is not exclusively designed for the sex offender, specialized sex offender treatment and education is available.

Another program serving the low-functioning offender is the Social Skills Unit of the Correctional Treatment Program at the Oregon State Hospital. This unit treats inmates with low social and intellectual levels who volunteer for transfer from their parent correctional institution. Unit director James Haaven (personal communication, 1983) describes some of the critical differences between normal and low-functioning sex offenders:

> *At first they look so hopeless, but when you start peeling it apart there is much you can do. After you work through the maze, you often find a very inadequate person, deficient in heterosocial skills, sexually dysfunctional, and lacking sexual knowledge. These offenders have difficulty in their ability to discriminate sexual from nonsexual behavior, and deviant from nondeviant behavior. These offenders are no less dangerous than the higher functioning sex offender, but the makeup of the problem is different. I believe there is less anger and aggression directed in a calculated fashion involved in the acts, but more striking out from frustration.*

Most of the major treatment modalities are employed in this program, although often in modified form. Clients tend to be very concrete in their thinking. Since reading skills are low, there is an emphasis on basic skill development. Offenders are taught basic social, interpersonal, and sexual skills. Techniques for controlling impulses require time and repetition. There is a high level of program structure and direction with continuity of supervision from the institution to the community.

The low-functioning offender in corrections has, in many respects, been ignored. As the number of intellectually and socially deficient individuals who find their way into corrections increases, their needs must be addressed. The models represented by the above two programs could serve to provide direction in the future.

environment. This would include those procedures which require informed consent on the part of the patient, such as aversive conditioning or antiandrogenic medications such as Depo-Provera™. Hospitals also have the advantage of being physically separate from the prison environment with all its anti-therapeutic values.

However, it should be noted that state hospital programs may be subject to much more rigid and often uninformed scrutiny by the public. If an offender escapes or recidivates, pressure may be brought to close down the programs, as happened in the pioneering California and Washington sex offender programs. Additionally, it may be harder to fund state hospital sex offender programs, as the monies may need to be diverted from other mental health clientele. Also to be considered, the environment of any state mental hospital is not automatically better than any prison. State hospitals certainly have their share of violence, ill-trained staff, and lack of administrative support for controversial programs. In many prisons, particularly those with consent decrees, rights to treatment, confidentiality, and ethical, professional care are rigorously enforced.

Historical Role of State Mental Hospitals

State mental hospitals have played an important historical role in developing new approaches to the treatment of sexual deviancy. Many of these approaches have become the basis for both correctional and community treatment programs. Brecher (1978) surveyed twenty community- and institution-based sex offender programs, of which six were located in state mental hospitals. The development of sex offender programs in state mental hospitals began with the introduction of Sexual Psychopath Laws in Michigan in 1937. Other states quickly followed. Brecher (1978) summarizes the major flaws in most such legislation:

> On their face, these Sexual Psychopath Laws looked like liberal reform measures. They provided that persons found to be "sexual psychopaths," a term derived from Krafft-Ebing, should be provided with treatment in an effort to cure them of this dread disease. In fact, however, the state legislatures which passed these laws, often by very large majorities and with little or no debate, neglected thereafter to establish or fund any treatment programs. Some have still not established a treatment program (p. 12).

Sex offenders who found themselves sentenced to state hospitals instead of prisons enjoyed far fewer legal rights than their criminally committed counterparts. If found to fit the criteria for sexual psychopathy, offenders could be held in these institutions for long periods of time without jury trial or other rights accorded defendants in a criminal proceeding. Their sentence was often indeterminate, with release based upon a medical opinion that the offender was no longer dangerous and could function safely in the community. Sentenced for reasons of both punishment and treatment, sex offenders were not provided assistance with their problems, which in turn decreased the possibilities of their eventual release.

Weiner (1985) sees the initial premise of these statutes as being flawed. Sexual psychopathy is not, as believed, a psychiatric diagnosis which yields to traditional psychiatric treatment techniques. Instead, sex offenders are a highly diverse population who rarely respond to traditional psychiatric therapies. With no effective treatment available, these statutes became constitutionally suspect, vulnerable to legal challenge, and most were either altered or abandoned.

Voorhees and Saylor (1977) recount the history of Western State Hospital:

> In 1951 the Washington State Legislature passed a law providing for the legal commitment of sexual offenders to state mental hospitals for 90 day evaluation or for treatment until they were judged safe to be at large in the community. The law became known as the Sexual Psychopath Law and for several years after its passage the three state hospitals admitted habitual sex offenders but regarded them as dangerous and unwelcome criminal intruders into the communities for sick people. They were kept in securely locked wards and isolated from the rest of the patients and their care was largely custodial.
>
> With no treatment available and little hope of regaining their freedom, the offenders were discontented and restless and many managed to escape. The resulting public clamor and a general investigation of hospital conditions led to the allocation of increased funds and major reforms (p. 7).

Many of the initial attempts to provide effective treatment to sex offenders reflected a traditional medical approach, with poor results. The radical transformation in sex offender treatment began with the introduction of such innovations as self-help, peer confrontation, and a variety of behavioral and social learning techniques. Dr. George MacDonald, a psychiatrist who became director of the sex offender unit at Western State Hospital in Ft. Steilacoom, Washington, revolutionized the treatment approach of that program by emphasizing client responsibility, developing peer self-help groups, defining steps of progress through the treatment process, and implementing a graduated release program.

At the South Florida State Hospital, Dr. Geraldine Boozer, a forensic psychologist, became interested in the unique treatment needs of sex offenders. After a period in which she began leading weekly therapy groups, morale among sex

offenders increased and they demanded a separate treatment facility within the hospital. In response, Dr. Boozer built a group-oriented program which called for an offender's wholehearted participation in order to remain. The offenders also did much to gain public and political support by providing educational programs for local officials and citizen groups.

As these programs and others became more effective in their treatment methods, they were increasingly viewed as a preferable sentencing option. Brecher (1978) describes a dilemma which surfaced in these new programs:

> Late in 1976, both the South Florida program and the Florida State Hospital program faced a new and potentially disastrous threat. As these programs earned increasing community respect, and as public concern with sex offenders swelled, judges during 1976 began sending more and more offenders to these treatment programs rather than sentencing them to prison or probation. (Much the same process was also reported during 1976 from the program at Ft. Steilacoom.) No compensating increases in building space, staff, or budgets were available. The familiar results which have ruined so many sound treatment programs in other settings—overcrowding and understaffing—were beginning to make their appearance. Thus, success might itself prove destructive to the successful programs (p. 14).

Environmental Issues

In 1984 Faye Honey Knopp, researcher for the Safer Society, visited sex offender treatment programs nationwide. She interviewed clients, clinicians, and correctional and mental health administrators. Few viewed a maximum security prison as the ideal environment for sex offender treatment. Mental health settings were cited as having distinct environmental advantages. Knopp (1984) quoted Dr. A. Nicholas Groth, a clinical psychologist operating a program within a maximum security institution in Connecticut, on treatment barriers within a prison setting:

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.
2. The sex offender's exposure to the prison's value system is at cross-purposes with treatment.
3. Prison structure and supervision create dependency and an unreal environment for the sex offender (p. 23).

However, the realities of correctional budgets and legislative mandates have resulted in the majority of sex offender programs being housed within secure correctional settings. Many such programs have attempted to develop semiautonomous units where many traditional prison pressures can be controlled or minimized.

There are other issues relevant to treatment which are better resolved in a hospital setting than in a prison. In hospital-based programs operating under mental health jurisdiction, the limitations on patient treatment information is clearly delineated in confidentiality regulations. Limits on sharing clinical information encourage trust and openness in the hospital setting, but such restrictions may not be desirable in the context of a prison. However, many states have adopted community standards of confidentiality for their prison mental health programs. Oregon has clearly spelled out the limits on sharing of clinical information between corrections and mental health. Prior to transfer, inmates seeking to enter the program operated by mental health must sign a release of information which permits mental health to share limited information on treatment progress with corrections. All other requests for clinical information require a signed release.

Mental health settings make possible the utilization of a wide range of therapeutic modalities that may be impractical or undesirable in some prison settings, particularly if the program operates within the general inmate population. This would include many of the behavioral assessment and treatment modalities, antiandrogenic medication, family or couples counseling, and masturbatory reconditioning. There is probably no form of sex offender treatment offered in mental hospitals, however, that is not also being offered in some prison programs.

Security

State mental hospitals nationwide have experienced security problems with sex offenders. The history of state hospital programs frequently includes many escapes, often with high profile reoffenses. Escapes incite public concern and often lead to outside-agency investigations and program reform, including the imposition of inappropriate security regulations. Freeman-Longo (1983) asserts that these programs may be best suited to lower escape-risk offenders who do not minimize their offenses and are deemed to be both highly motivated and amenable to treatment.

Correctional expertise in establishing and maintaining adequate security systems in the mental hospital setting is of critical importance. Although hospitals normally have security procedures to deal with violent mentally ill patients, these systems often do not contain the more sophisticated, higher functioning sex offenders. In Oregon, state corrections staff worked closely with mental health staff to design and implement a security system. They also provided training in basic security procedures before beginning the hospital sex offender program. This ongoing cooperative interaction, coupled with an emphasis within the hospital program on security responsibilities, has resulted in an excellent record over eight years. This, in turn, has quelled fears that mental health staff were not attentive to security issues.

It is important to note that mental hospital programs which

have been closed or reassigned to correctional jurisdictions have had security disasters, often involving inmates on release programs into the community. It is clear that public tolerance for escapes involving sex offenders is limited. Hospital programs at Atascadero State Hospital in California and Western State Hospital in Washington have been shut down largely because of public and legislative concern over the escape of offenders. In Washington, as elsewhere, overall security records were very good. Nevertheless, a public perception was created that highly dangerous offenders were being accorded special treatment in institutions which were not secure and which, therefore, endangered the public.

Programs within mental hospitals will be a viable option for the treatment of convicted sex offenders only if security issues become as important as clinical issues. To insure that level of security awareness, it is important that corrections and mental health staff maintain ongoing consultation and communication regarding security problems.

Institution-Based Programs

Most large sex offender treatment programs are located within secure institutions (Knopp, 1984). They represent a diverse range of program models. Within institutions are found outpatient educational and therapeutic programs, programs housed in special units—some of which are operating on a therapeutic community model—programs housed in their own separate facilities, and programs located in state mental hospitals.

Transitional Programs

In some states, programs are available to sex offenders only at the end of their sentence. They are often located within minimum security institutions or in their own separate facilities. Most of these models feature an intensive residential treatment phase, followed by graduated release and aftercare in the community.

Aftercare Treatment and Supervision

There are many choices to be made regarding the form which aftercare programs take. Some sex offender programs operate their own aftercare services. In others, this is the responsibility of parole officers, community clinics, or private clinicians under contract with the parole system to provide treatment.

In some states, parole officers directly participate in treatment activities, often in conjunction with institutional program staff. In others, they are responsible primarily for referral or linkage services. In some jurisdictions, specialized teams of trained parole officers manage caseloads composed entirely of sex offenders.

The goal of statewide planning must be to integrate this array of public and private services into a system which meets the multiple treatment and security needs of this diverse population of offenders. The increase in private clinicians willing to treat convicted sex offenders represents a promising new resource for corrections clients. It is important that the services provided by therapists providing aftercare be consistent with the treatment goals and strategies of the institutional programs.

Planning for Legislative Change

Statutes relating to sexual offenses are often passed during periods of public outrage, often in the wake of a particularly tragic sexual offense. Often these statutes only compromise or inhibit the delivery of effective treatment, or overload programs and make them dysfunctional. As a state begins to plan for delivering sex offender services, all laws relating to sex offenders must be carefully examined and analyzed as to their impact on treatment efforts.

Laws in some states mandate that convicted offenders will participate in specific treatment programs regardless of their motivation, their willingness to admit and accept responsibility for their crimes, or their intellectual and emotional amenability to treatment. These mandated clients tend to overload programs, undermine efforts of other clients, and destroy staff morale. In some states, minimum mandatory sentences for sex offenders allow no flexibility in release and may therefore discourage offenders from participation in treatment. Finally, many states have provisions in their laws which prohibit sex offenders from taking advantage of work release or other transitional programs. This is a critical problem since most program managers agree that some form of graduated transition back into the community is necessary to test new skills and behavior and is needed to reassess treatment goals.

To change laws inhibiting sex offender treatment efforts requires a well informed legislature which supports the goals and methods of treatment. The involvement of decision makers in the planning process is important when significant legislative changes must be made prior to program implementation.

Implementing Institutional Programs

Leadership

Program leadership is an important facet of sex offender program implementation. As in all programs, effective leadership is critical. Leaders should have a broad range of clinical, managerial, interpersonal, and political skills. Quality

leadership can provide programs with credibility and promote interagency cooperation and involvement.

When establishing institutional programs, it is advisable to hire the program leadership before other program staff and to permit these leaders to formulate program treatment philosophy and methods. They can identify the barriers, either administrative or procedural, which prohibit effective programming. In many instances it is program managers who articulate program goals and methods to legislators, correctional and mental health administrators, and institutional leadership. When possible, program managers should have the authority to identify and negotiate for those changes within an institution or system which are necessary to maximize program success.

Effective leadership of sex offender programs requires both management and clinical expertise. In many states, program directors have been hired who have clinical skills but have no management expertise or experience. Conversely, many managers skilled at program administration within a bureaucratic system find themselves directing rapidly evolving and volatile clinical programs. Each skill is important.

Staffing Levels and Types

Staffing is the primary cost of a sex offender program. The type and number of staff available within a program determines the range and quality of the treatment services delivered. The specific roles of staff are also an important consideration. In some programs, security staff assume no clinical roles within a program while in others, security staff assume the dual roles of treatment and security.

Strong clinical skills are mandatory within a sex offender treatment program. There must be trained staff in the areas of assessment, treatment planning, group methods, behavioral treatment, and psycho-educational training. While the type and number of trained clinicians necessary to operate a program will be determined by the treatment methods employed, there are other factors which also influence staffing.

Appropriately staffing institutional sex offender programs may be accomplished in many ways. It is not desirable to involuntarily transfer security staff into these programs. Volunteers are much less likely to exhibit the antagonistic attitudes toward sex offenders which undermine program effectiveness. All potential staff, whether professional or paraprofessional, should be carefully interviewed and screened. They should clearly understand the characteristics of the population, the goals and methods of the program, and the expected standards of staff performance.

Many programs regard female staff interactions with sex offenders as an important aspect of treatment. Many offenders are not skilled or comfortable in relating to women, particularly those in nonsexual roles or in authority positions. Female staff members are invaluable in assisting offenders in improving their social and interpersonal skill levels. Assigning female security or line staff to a unit for male sex offenders may, in some situations, raise concern regarding their personal safety. While there is little data currently available relating to sexual or other physical assaults on female staff, the widespread involvement of females in programs, coupled with anecdotal reports from program managers, suggests no extra security risks for female staff (NIC National Academy of Corrections seminar, 1986).

Many programs make extensive use of volunteers to augment aspects of treatment. In some programs female volunteers teach offenders a range of social and dating skills (Knopp, 1984). Sex offender treatment programs are also valuable training practicums for graduate students in social work, psychology, theology, and psychiatry. This training, however, may represent a departure from institutional practice and may require the development of policies governing students and volunteer workers. Properly supervised, their inclusion may add much to the treatment process.

Sex offender programs require staff with specialized experience and training, who often do not fall within the scope of existing position descriptions. Managers must review job descriptions to determine whether requirements must be altered or new position descriptions created to accommodate unique program needs. The flexibility of personnel managers in meeting the special needs of sex offender programs may be a factor in the program's ability to recruit and retain qualified clinicians and managers. It is imperative that a quality orientation program be designed and implemented for all new staff members. Quality orientation training coupled with ongoing training and supervision will insure consistent, timely and appropriate treatment (see Chapter 5, A Systems Approach to Training and Education).

Issues of Eligibility and Inclusion

When developing sex offender treatment programs, one must decide on the type of offender who will be eligible for services. It is widely recognized that certain types of offenders do not respond well to treatment. In particular, clinicians point to their ineffectiveness with sadistic rapists, antisocial personalities, and certain mentally ill and intellectually low-functioning offenders.

Offenders in treatment should be motivated for treatment to change their behavior and acknowledge their guilt to some degree. Additionally, there are a number of characteristics which may be associated with successful treatment outcome. Candidates with the best prognosis have few nonsexual crimes in their history, have little history of drug or alcohol depen-

dence, and have normal intelligence, without the presence of major mental illness. Further, they would have arousal to age-appropriate sexual partners, have a supportive family, and have a good work history. Rarely, however, do such offenders find their way into institutional programs.

This author advocates what might be labeled a triage concept for program inclusion. Programs should target for intensive treatment those offenders who have the greatest need for treatment and the best chance for success. Others may be provided an opportunity to participate in less intensive educational and treatment activities. This permits more detailed screening of the former group and assists the program to identify offenders who may eventually profit through intensive treatment. If not legally mandated, participation in treatment should be voluntary. Offenders should acknowledge their criminal behavior and accept responsibility for it. However, the acceptance of responsibility is an aim of the therapeutic process. They should have a commitment to continue with treatment in the aftercare period. Those with long histories of antisocial behavior, in addition to sexual deviancy, should be most carefully screened.

Most programs recognize the limitations of the clinical methods currently used with sex offenders. Thus, they impose eligibility criteria which reflect the perceived strengths and limitations of their treatment programs.

In some states eligibility is defined by law. In California, for example, inmates must be within two years of release, consent to participate in both inpatient and community treatment, have less than three prior felony convictions, be in good mental and physical health, be between 18 and 40 years of age, and have no history of behavioral problems in prison (Marques, 1984).

Strict eligibility criteria for admission to sex offender treatment are viewed by some clinicians as unwarranted. Dr. Nicholas Groth, former director of a sex offender program at Connecticut Correctional Institution, insists that no sex offender who voluntarily seeks treatment should be refused (Knopp, 1984). Groth contends that the field, as it stands, does not currently know enough about sex offenders to accurately predict who will successfully complete treatment. He welcomes difficult clients because they present an opportunity to learn more about treatment in general. Further, he feels that selecting only the best candidates for treatment skews outcome data and gives a misleading picture about a program's effectiveness. Despite Groth's policy of almost total inclusiveness, few programs appear willing to use limited resources to include inmates whom they regard as poor candidates for successful treatment.

Post-Implementation Issues

Staff Issues

Despite careful screening of applicants for employment in sex offender treatment programs, many employees find themselves in a situation to which they are totally unsuited. This creates emotional distress and difficulties in relating therapeutically with offenders.

Most program managers and clinicians can recall staff who were unable to control negative feelings toward sex offenders, finding sexual crimes so personally revolting that they could not deal rationally and fairly with their clients. Many staff members have had traumatic sexual experiences themselves, often involving childhood molestation or rape. Working in close proximity to offenders may trigger debilitating emotional responses. Many staff have unresolved sexual issues of their own which may be exacerbated in this environment. Cohen and Boucher (1979) describe several typical staff/client relationship problems which occur in an intense therapeutic environment. Patients develop erotic fantasies about their therapists. In some instances staff have become romantically or sexually involved with offenders. A variety of transference and countertransference relationships emerge as a result of the intense interactions between the two groups.

It must be anticipated that staff will experience personal and philosophical discomfort in relating to certain offenders or in responding to situations to which they are particularly sensitive. Programs often establish group meetings which encourage staff to express their feelings regarding their own sexual lives or their feelings towards certain clients.

Client Phase-In and Culture Building

In a beginning residential treatment program, the manner in which clients are selected and integrated into that program significantly influences how well and how quickly the program evolves in a therapeutic environment. Most programs attempt to start a treatment culture by selecting offenders for treatment who appear to be the most motivated and amenable. This practice of "creaming" is typical of most new therapeutic programs in correctional and mental health institutions. These promising treatment candidates are expected to adopt a set of values and behavioral expectations which support the achievement of treatment goals. In an environment free of violence or threats of violence, programs seek to instill openness and honesty in interpersonal communication, where offenders may freely confront the inappropriate or deviant behaviors of others. Clients of treatment programs are their most effective spokesmen and culture carriers. Sex offenders who believe in the efficacy of a program and accept its values and behavioral expectations are powerful role models for offenders reluctant to admit or discuss their sexual deviance.

When possible, programs should have an initial start-up phase of several weeks in which only a select group of offenders is admitted to the program. Limiting admissions while a core group of offenders is being trained and acculturated will hasten the development of a therapeutic culture capable of

subsequently absorbing those less motivated or amenable to treatment.

Networking

Programs have much to gain by aggressively seeking out the assistance and interest of others involved in providing treatment services to sex offenders. These sources can be invaluable in training staff, implementing specific treatment techniques, or even in the acquisition of trained personnel. Finally, interaction with these programs is important in developing a range of options available for clients in the aftercare phase of treatment.

As programs evolve, ongoing dialogue with judges, legislators, and other decision makers is important. It may become apparent that statutory change is needed to improve the management of sex offenders. Sentencing practices may be imposing undue pressure on certain elements of a program. Inappropriate treatment candidates may fill up a program and make it dysfunctional. Programs cannot operate in isolation from an outside professional network if they intend to refine and improve treatment methods.

It should be anticipated that sex offender treatment programs will go through a series of developmental phases. Ongoing training and education of staff will produce new and innovative treatment methodologies. Organizational structures will change and evolve. The legal or administrative structure within which programs operate may also change. This constant cycle of change and renewal is perhaps inevitable at this time.

Sex offender programs do survive organizational transformations and crisis situations. The vulnerability of such programs is a major reason why it is important that a professional network be established and nurtured and that mutual support is available at times of crisis.

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Chapter 4: Decision-Making with Incarcerated Sex Offenders

by Barbara Schwartz

Abstract

In this chapter, Dr. Schwartz discusses the many policy decisions which must be made by correctional administrators and therapists. From presentence evaluations to parole board recommendations, choices must be made and conclusions drawn by professionals which will directly impact on public safety. In devising treatment programs, a number of options are available, each with its own pros and cons. In summary, Dr. Schwartz stresses that programmatic decisions must be based on a thorough knowledge of each state's own characteristics, needs, and resources.

Deinstitutionalization of the mentally ill and mentally retarded has resulted in new demands being made on correctional departments. Likewise sex offenders, once hospitalized under various sex offender statutes, are now being incarcerated. Special legislation, court actions, community pressure and/or a desire to be responsive to the needs of a growing subgroup of the prison population have initiated various treatment programs for this population.

Although the treatment of sex offenders remains at an early developmental stage as a technique and continues to be highly controversial, a number of states have been active in the field for many years and have devoted substantial resources to the development of innovative programs. As mentioned in other chapters, the type of program developed may depend upon the type of physical facilities available, the characteristics of the prison population, the department's classification system, and the state statutes.

Whether the program will be housed in a maximum, medium or minimum security prison, or all three simultaneously, will impact the type of treatment offered. State laws may limit sex offenders' participation in community release programs. This presents a major obstacle as these individuals are particularly in need of transitional programs.

If the individual correctional department decides to segregate sex offenders or to offer a segregated treatment program, there may be both positive and negative repercussions. Segregation is probably the most economical approach as establishing physiological assessment laboratories at a number of institutions could be quite costly. At a segregated program, the entire staff can be specially trained. Correctional officers involved with this population can serve as part of the therapeutic team. The professional staff can devote their full energies to this particular problem. Segregated programs can provide a therapeutic atmosphere. Residents need not be concerned about hiding their crimes or about ridicule or physical assault upon revelation. However, segregated programs may be limited in the range of rehabilitative programs they can offer. The participants may not be eligible to participate in educational or vocational programs due to security, classification, or location. The stigma of participation in sex offender treatment programs may be so great that these individuals cannot be returned to the general population and they must remain in the program regardless of their adjustment. Creative efforts will be needed to overcome these problems and establish suitable alternatives.

Correctional departments are faced with other problems in establishing treatment programs. Sentencing structure may be of crucial importance in designing treatment programs. Basically, states have either indeterminate sentencing in which an individual's sentence represents a range of time (e.g., 2-10 years, 10-50 years, 25-100 years) which may be shortened by parole, or he receives a fixed period of time which may be shortened by the accrual of "good time," or there may be a mixture of the two. If the state has indeterminate sentencing, sex offenders will view participation in therapy as a prerequisite to parole. Their participation will be based much more on an interest in gaining their freedom than in treating their problem. They may become quite involved in manipulating the staff and presenting the image of the "ideal inmate," as the issue of freedom is paramount. Treatment will never succeed with all patients, and inevitably some individuals will leave a treatment program and commit another sex offense. If the media picks up on this, the treatment program may be blamed for recommending release. It is imperative that treatment personnel refrain from advocating the parole of participants. Completion of treatment must be rigidly and objectively defined and parole boards continuously cautioned that completion of treatment does not guarantee success in the community. Outside consultants may be used to evaluate an inmate's progress in treatment and readiness for parole. While indeterminate sentences have their own set of problems, they also provide the opportunity to keep incarcerated those individuals who are obviously dangerous. They also serve initially to motivate individuals who can respond well to treatment. They may provide more control and more leverage for encouraging appropriate behavior.

Determinate sentencing automatically screens out individuals who see treatment as the path to release because this person knows he will be released at a specific time. Treatment programs should be quite cautious about awarding time off an individual's sentence for participation as this usually leads to the same manipulation associated with the indeterminate sentence but without the control over release. When time is up for this individual, he is released regardless of his

potential dangerousness. Since treatment is time-based rather than criteria-based, the failure rate is probably higher. While presently no research is available to confirm this, it would not be unrealistic to assume that a program whose participants must successfully complete a course of treatment would do better than one where some patients complete 100%, some 50%, and some 25% of the same program.

Numerous problems exist with any attempt to provide psychological treatment in prison. Faye Honey Knopp, in *Retraining Adult Sex Offenders* (1984), points to the attitudes of secrecy, defensiveness, and denial which the prison value system encourages. Idle time is spent reinforcing deviant attitudes and fantasies. Expressing emotions or admitting problems is perceived as weakness. The individual is exposed to a variety of problems which he may not have entered prison with but may have acquired—drug abuse, alcoholism, criminal thought patterns, bitterness, and anger towards the system. Prisons encourage dependency, while treatment focuses on responsibility. Prisons often isolate men from women, while treatment tries to facilitate more appropriate interaction with women. Prisons encourage distrust, while treatment encourages trust.

With these inherent problems, one might be tempted to completely abandon the idea of treating the sex offender. However, Freeman-Longo (1986) states that 80% of untreated incarcerated sex offenders recidivate, while the figure is reversed for treated offenders. Mental hospitals may not be able to accommodate sex offenders for either the length of time or at the level of security that the crime warrants. Judges may resent being placed in the position of having to choose between treatment and incarceration. The community may perceive commitment to a hospital program as exoneration of the offender. Correctional departments, however, are obligated to respond to all of these situations.

Not only are corrections officials faced with decisions regarding treatment methods, sites and resources, but professionals involved with this group must make very critical decisions. Specialized knowledge is necessary to identify which sex offenders are too dangerous to be referred to community programs. Each treatment program within a prison must also make the decision whether or not it will exclude individuals who wish to participate in the program but whose degree of dangerousness makes them extreme treatment risks. The recidivism of one notorious sex offender can destroy a treatment program regardless of how conscientious program staff were in dealing with him and whether or not they had input into his release. On the other hand, individual state policies, court orders, legislative mandates, and/or consent decrees may demand that treatment be offered to everyone who does not specifically refuse it.

Amenability to treatment is another issue which calls for astute professional judgment. One individual may be amenable but judged too dangerous to participate, while another individual may be considered to be less dangerous but not amenable. Both of these clinical decisions will influence program participation.

Decisions relating to classification will also have significant program impact. If the treatment program exists in only one facility, then a prospective participant must meet certain security-rating criteria or the criteria must be written to allow for this. Once a program participant is at the appropriate facility, decisions must be made about specific housing assignments. In many institutions, a sex offender is at risk for abuse by other inmates. His housing assignment may make the difference whether he can participate in programs or whether he will go into protective custody.

Perhaps the most risky decision the treatment professional makes in working with sex offenders is when, and even if, to terminate treatment. Unsuccessful termination can be a fairly objective process. The individual fails to attend or actively participate. He is disruptive or violates confidentiality. However, when the therapist is called upon to state whether the person has successfully completed treatment and is therefore ready for release, then it is vital to be able to rely on a set of objective criteria.

For the evaluator, the most crucial decisions come at three different times during the offender's incarceration and focus on three different issues.

Evaluating for Community Placement

Most states offer an option to judges which allows them to bring convicted felons into the prison for an evaluation to detect whether an individual is a suitable candidate for probation. The evaluation may last from several weeks to several months and is often used as "shock incarceration" to deter felons from further crime. In the case of sex offenders, the mental health professional as well as others involved in the classification and evaluation process may, at this time, be called upon to make a determination of amenability for community treatment. The purpose of this chapter is to discuss the parameters of these evaluations, not the specifics.

The evaluators must realize that sex offenders are a specialized population and must not be overly influenced by the fact that many of these individuals have been law-abiding citizens in the past. Because his crime is so stigmatized, the sex offender may be in physical danger as he may be systematically targeted for violence by other inmates. There are severe problems inherent in evaluating the sex offender. Irvin Dreiblatt (1982) points out that there is no way, at this time, to identify sex offenders within the general population. One may or may not have an admission of guilt and the situation may be more or less incriminating. But before attempting to

predict amenability for community treatment, one must be fully cognizant of the limitation of this area. By carefully defining the factors associated with the crime—when, with whom, under what conditions—accuracy may be improved. It is quite helpful to know something about the base rates of different types of offenses. There is a strong feeling among clinicians that sadistic offenders and patterned same-sex offenders are the most dangerous. The sadistic offender may be diagnosed by the police report; the crime will be particularly brutal and degrading and marked with a certain ritualism. The scene of the crime may have been prepared in advance with confining devices and instruments of torture. Any pattern which suggests that sexual arousal was linked with inflicting pain on the victim should be carefully analyzed. The term "same-sex offense" is used rather than "homosexual," the latter term usually referring to a developed, adult sexual preference. The fixated same-sex pedophile is stuck at the immature stage of development prior to developing an interest in the opposite sex. He may have very little interest in male adults.

Dreiblatt (1982) points out that practitioners should bear in mind that:

- After the sex offender is apprehended, there is a suppression effect which should not be confused with a substantive change in behavior.
- Sex offenders are quite heterogenous and do not show one or even several consistent profiles.
- Many sex offenders have a highly habituated sexual preference, and their disorder may best be viewed as an addiction.
- Sexually deviant behavior is extremely complex, with multiple causes.
- Treatment selection must be matched specifically to the offender, and a multifaceted approach should be used. (p. 4)

Nicholas Groth (1979) has offered a variety of suggestions in evaluating dangerousness of pedophilic offenders. The potential dangerousness of the offender during treatment is a crucial factor in determining appropriateness of placement in community programs. His suggestions can easily be modified to assessing the rapist. He suggests that there are two basic questions that must be answered. First, to what extent is the offender's criminal behavior the result of external situational factors and to what extent is it due to psychological determinants? Second, under what circumstances did the assault occur and what are the chances and conditions of recurrence?

In order to evaluate these questions, one must determine:

- frequency from police records, family reports, hospital records, and perhaps the offender himself,
- appropriate sexual outlets,
- questionable sexual outlets, e.g., pornography or prostitution,
- history of misdemeanor sex crimes,
- access to victims,
- specificity of victims.

In evaluating the offender's life history, one should look for specific signs of stability and instability as a way of determining impulse control, stress management skills, and stress tolerance. Is there evidence of sadistic tendencies? Finally, does he assume responsibility for the offense? The technology is now available to evaluate deviant arousal by using plethysmography and this should be utilized if at all possible.

Pedophiles are often seen as passive individuals who use enticement and cajoling to lure their victims into cooperating. However, Abel and associates (1981) found that 58% of child molesters use excessive physical force and, even though the offender may not have used excessive force because the victim acquiesced, it is still advisable to evaluate whether he is aroused by violence. This information may be obtained through a physiological assessment. Another question which is important to evaluate with the incest offender is whether this individual is actually a pedophile with strong deviant arousal. This may also require physiological assessment. It is important to remember that these measures are not foolproof, as deviant arousal may be suppressed. In answering the latter question, one may look for a pattern of multiple marriages to women with children of similar ages which end in divorce a few years later. Also, sudden, unexplained moves may indicate a patterned offender who is constantly on the verge of being apprehended.

One should not overlook a careful evaluation of any drug or alcohol problems. If present, these problems provide an added challenge to treatment. The substance abuser is less predictable and this must be taken into account.

Family, friendships, and employment factors may be major factors in determining risk. Is the offender a transient, alcoholic derelict with no means of support, or does he have a stable job, family, and friends? The latter is a better risk and more likely to pursue treatment if treatment is offered as an alternative to incarceration. Treatment resources may substantially lower the risk of reoffending.

Evaluating for Treatment Amenability

There is considerable disagreement about whether sex offenders can be treated. Several early authors theorized that certain types of offenders are more responsive to treatment than others; however, none of these theories has been explored through research (Schrenck-Notzing, 1895; Pollens, 1938;

Shaskan, 1939; Brande, 1950; Ploscowe, 1951; Rosen, 1964). Allen (1940) stated that sexual deviations are as easily treated as neurosis if the individual is not obtaining some type of secondary gain. He felt that a younger age, shorter duration of symptoms, higher IQ, desire for a cure, and absence of alcoholism were factors which predicted success. Kozol, Cohen and Garofalo (1966) felt that successfully paroled sex offenders could be characterized as showing compassion for others, having few hostilities, and possessing a fairly positive self-image. Mathias (1972) stated that the unresponsive offender tends to be unreliable, manipulative, unmotivated, and inclined to handle anxiety with acts of sexual deviation which tranquilize him and thus reinforce the behavior.

Rosen (1964) listed 17 criteria for successful treatment:

- younger,
- first offense,
- no previous treatment failure,
- high IQ,
- ability to express self and good abstract thinking,
- socially well adjusted,
- depression, shame, disgust, and guilt related to deviant fantasy or action,
- healthy social environment,
- married, bisexual, or past heterosexuality,
- desire for cure,
- sincere effort to control behavior,
- acceptance of responsibility,
- socially discreet,
- absence of coexisting perversion,
- not neurotic, psychopathic, or psychotic,
- not homosexual or pedophilic,
- shy with women.

Again the reader is cautioned that "homosexual" in Rosen's content probably refers to males who assault boys. These individuals rarely are interested in adult homosexual relations and are often married.

Marcus (1971) suggested that the following criteria be used to identify those potentially dangerous and unamenable offenders who would be inappropriate for outpatient therapy:

- bedwetting,
- firesetting and cruelty to animals,
- delinquent acts between the ages of 8 and 13,
- escalation of sex offenses,
- interrelated criminality with sexual offenses,
- sustained excitement prior to and at time of offense,
- lack of concern for victim,
- bizarre fantasies with minor offenses,
- explosive outbursts,
- absence of psychosis,
- absence of alcoholism,
- high IQ,
- lack of human warmth or humanitarian depth,
- lack of social know-how.

It is readily apparent that there is disagreement among therapists on whether high intelligence is an asset or a liability. Basically, it is a factor that can be used or abused. Limited intelligence may prevent an individual from remembering, assimilating, or utilizing what he has learned in treatment. It may be difficult to rely on heavily verbal modalities or aim for the acquisition of insight. Some states, including Oregon, are developing specialized programs for low-functioning sex offenders.

On the other hand, an individual of high intelligence who lacks true motivation, abdicates responsibility, or lacks remorse may use his abilities to manipulate others. He may be able to learn all the appropriate jargon and theories. He can say exactly what therapists wish to hear. Individuals at both extremes of the intellectual spectrum present a special challenge for treatment programs.

There are several outpatient treatment programs that have established set criteria for admission. Pacific Professional Associates in Sherman Oaks, California insists that the therapy candidate recognize that he is a sexual deviant, that he is capable of being aroused by stimuli judged to be inappropriate by contemporary community standards, that he has trouble controlling his deviant urges, and that he is highly motivated to change his behavior. They prefer that their patients be between 18 and 40 years of age with an IQ above 80 and able to speak, read and write English; they should not be taking medicine that may interfere with thought processes or the autonomic nervous system. These criteria actually screen in many patterned offenders because deviant arousal is a criterion. Many situational offenders do not show deviant arousal.

The Multnomah County Community Corrections Sex Offender Treatment Program in Portland, Oregon accepts pedophiles and incest offenders who have no prior history of offending. They must not presently have a substance abuse problem, psychosis, or severe mental illness. There should not be a history of antisocial behavior or an escalation of this behavior. The candidate must accept his own responsibility and should not have a history of placing himself in a position where he can contact victims. Offenders should have stable family relations, friendships, and work histories. Preferably the offender has had only one victim and that victim was not inordinately young or physically or emotionally handicapped.

The Positive Approaches to Sex Offenders (PASO) Program in Albuquerque, New Mexico was one of the few programs to treat violent rapists successfully on an outpatient basis. A four-year follow-up study of 58 patients was conducted to differentiate between those who successfully completed the program and those who terminated or recidivated before its completion (Schwartz, 1977). Four offenders (7%) recidivated; another thirteen (21%) left the program for a variety of reasons but did not recidivate. The offenders were evaluated on 27 different factors. Five factors frequently associated with response to treatment did not differentiate responders from nonresponders. These were measures of emotional distress, motivation, denial, empathy, and frequency of crime. For child molesters, 74% of the group could be correctly categorized by using the variables of environmental stress, previous criminal convictions, alcoholism, and intact marriages. Using the Rorschach Genetic-Level Score, intact marriage, stable employment, and honorable discharge from the military, 93% of the rapists could be correctly categorized. Notably, 77% of the nonresponding pedophiles were alcoholics. Clinicians should be cautious in assuming that the same factors will predict amenability to treatment among all types of sex offenders. In general, responding pedophiles were individuals with normal heterosexual histories who committed the crime during a period of extreme stress, e.g., the loss of a job. Responding rapists were individuals who had a history of responsible behavior.

While the major emphasis for evaluating amenability may be focused on placement in the community-based program, the prison-based sex offender program may also have criteria for admission. The Vermont Treatment Program for Sexual Aggressors at Chittenden Correctional Facility in South Burlington, Vermont has established an admission policy which selects offenders with demonstrated histories of prosocial behaviors, and those who don't have a number of circumstances which threaten the individual's sense of self-control, e.g., alcoholism. Candidates must accept responsibility and acknowledge the harm done. Sadistic offenders are excluded.

Ideally, programs want individuals who are highly motivated, accept responsibility, and are not antisocial personalities, substance abusers, psychotic, mentally retarded, or sadistic. The community and the rest of the criminal justice system want the most dangerous offenders treated. The taxpayers have provided funds with the hope that sex offender treatment programs will alleviate some of their fears by rehabilitating individuals who are the greatest risks. However, the programs are painfully aware of the disastrous results which follow a reoffense commited by a "treated" sex offender. Consequently, programs are forced, out of fear for their own survival, to treat only the least dangerous. Society must recognize that some sex offenders will always reoffend, no matter how good the therapy. Treatment rarely if ever causes recidivism; it can lessen the extent. Education of the public and responsible media coverage will do much to alleviate the tendency to blame the program for the failure to "cure" what in some cases is an intractable condition. Then, programs will begin to accept and learn to treat those now considered untreatable. Much more research is needed in this area to establish amenability criteria for different groups in relation to treatment.

Evaluating for Classification

How well classification is handled may determine whether treatment can even be conducted. Many departments utilize classification systems which are based solely on past history and focus on issues such as prior escapes, detainers, and criminal record. However, it may be more helpful to have a system which focuses on current functioning. Sex offenders probably more than any other group are a heterogenous group, ranging from the highly predatory career criminal to the passive, deferent college professor.

Herbert Quay (1984) has devised a system based on both behavioral ratings and some social history data done by correctional officers and case managers. It divides offenders into five categories along a continuum—"heavies, con-artists, moderates, dependent, and neurotic/anxious." Table 4.1 identifies the major characteristics of these groups, and Table 4.2 offers some suggestions for programming. In some situations, this classification system may be best used to segregate individuals. In other cases, it may be best used to integrate weaker individuals with stronger, nonpredatory ones.

Whether sex offenders are treated in maximum, medium or minimum security institutions will have major implications for treatment. There may be more opportunities for therapeutic communities in maximum security prisons where mixing with the general population can be restricted. Therapeutic communities may make it somewhat easier for sex offenders to participate in group therapy. In an environment with other sex offenders, individuals are not stigmatized. There is less fear that the revelation of their crime or its details will place them in physical jeopardy. Not only can they begin to learn trust, but they have a much greater opportunity to practice the social skills many of them lack (see Chapter 11, Interpersonal Techniques). In a medium security prison, the safety of the site for a sex offender program depends primarily on the characteristics of that particular prison. In such a facility, there will be more contact with the general population even if the program is placed in special units, and there will also be less supervision. Many states have laws or policies forbidding the placement of sex offenders at minimum security facilities; if possible, however, a minimum security placement has many advantages. The rest of the population may feel that they have too much at stake to harass other inmates. There may also be the much needed opportunity

Table 4.1

CHARACTERISTIC BEHAVIORS BY GROUP

I — Heavy	— II	III — Moderate	IV — Light	— V
• Aggressive	• Sly	• Not excessively aggressive or dependent	• Dependent	• Constantly afraid
• Confrontational	• Not directly confrontational	• Reliable, cooperative	• Unreliable	• Anxious
• Easily bored	• Untrustworthy	• Industrious	• Passive	• Easily upset
• Hostile to authority	• Hostile to authority	• Do not see selves as criminals	• "Clinging"	• Seek protection
• High rate of disciplinary infractions	• Moderate-to-high rate of disciplinary infractions	• Low rate of disciplinary infractions	• Low-to-moderate rate of disciplinary infractions	• Moderate rate of disciplinary infractions
• Little concern for others	• "Con artists," manipulative	• Concern for others	• Self-absorbed	• Explosive under stress
• Victimizers	• Victimizers	• Avoid fights	• Easily victimized	• Easily victimized

Table 4.2

DIFFERENTIAL PROGRAMMING BY GROUP ASSIGNMENT

	Education	Work	Counseling	Staff Approach
Heavy (Groups I & II)	• Individualized • Programmed learning	• Non-repetitive • Short-term goals • Individual goals	• Individualized (behavorial contracts)	• By the book • No-nonsense
Moderate (Group III)	• Classroom lecture plus research assignments	• High level of supervised responsibility	• Group and individual (problem orientation)	• "Hands off" • Direct only as needed
Light (Groups IV & V)	• Classroom lecture plus individual tutoring	• Repetitive • Team-oriented goals	• Group and individual (personal orientation)	• Highly verbal • Supportive

The above tables are reprinted with permission of Herbert Quay and the American Correctional Association.

for transitional programs such as work or school release and/or furloughs, which are quite valuable in the therapeutic process.

Evaluating for Release

States with indeterminate sentencing may base parole on successful program completion. Some states with determinate sentences may release individuals regardless of progress in treatment. Oregon can transfer incarcerated sex offenders to a hospital-based program during their last two years and then request extension of their parole. Regardless of the parole issue, the therapist will want some measure of progress in therapy.

The treatment program in the Chittenden facility has set the following general objectives. The offender must be able to:

- Explicitly describe the situations that pose an increased risk of his acting-out in a sexually aggressive manner.
- Verbalize without hesitation the coping responses that he will enact in order to refrain from sexual aggression.
- Anticipate future risk situations and use problem-solving techniques to devise effective coping responses.
- Discern and modulate an adequate range of emotions.
- Express anger verbally and appropriately.
- Understand that every person in society has a right to define his or her own sex role as long as that role is not illegal.

- Show decreased arousal to deviant stimuli and increased arousal to appropriate stimuli.

Pacific Professional Associates, being a community-based program, can more easily measure response to treatment in real life situations. They are able to more readily evaluate where improved social coping skills are being put to use in the establishment of appropriate relationships. They also use measures of deviant arousal which must be below 20% on ten consecutive evaluations and for nondeviant arousal which must be above 80% for ten consecutive evaluations.

Systems which offer transitional programs have the advantage of being able to evaluate slowly the offender's response to real life challenges, e.g., socializing with females, responding to unexpected frustrations, being exposed to old temptations. However, these individuals do have the opportunity to reoffend while still actively participating in the program. More research is needed to help correctional professionals make decisions about who is ready for community-release programs. When treatment programs are tied to release, it may be best to have evaluations conducted by independent professionals.

In summary, there are a number of different decisions which must be made by correctional professionals. Different types of decisions may require a knowledge of different dynamics. Mental health professionals, classification officers, and security personnel can all become familiar with the research in this area. Treatment planning and programming must be based on a thorough evaluation of the offender population and the specific environment in which the treatment will be conducted. Education of all concerned segments of the community may make it easier to make decisions in an informed and professional manner, rather than based on fear and societal pressure.

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Chapter 5: A Systems Approach to Training and Education

by Roger C. Smith

Abstract

In this chapter, Dr. Smith writes from his experience in training all levels of professionals and concerned citizens in sex offender treatment. His programs in Oregon were noted for open attitudes toward the media and the public. Special training for chaplains and probation and parole officers is discussed, as is a special program which certifies behavioral technicians. A summary of how to train for special competencies includes a description of training materials developed by a variety of programs.

Ideally, administrators and managers who are responsible for implementing and maintaining correctional sex offender treatment programs would have access to fully trained clinicians who understand the dynamics of sexual deviance, are skilled in assessment of sexual pathology, and have knowledge of the range of treatment methodologies currently utilized. Programs would operate within an agency and governmental environment where the goals and methods of treatment were understood, supported, and even defended. Legislatures would provide adequate budgets for these controversial programs and support statutory change when existing law impeded treatment efforts. In this situation, legislators and agency administrators would provide the necessary political leadership to forge interagency cooperation.

Such programs would operate in a climate of widespread public acceptance. In this scenario, public expectations of sex offender treatment programs would be realistic, and specific treatment failures would be viewed from the perspective of overall program effectiveness.

However, the reality of managing a sex offender treatment program in a correctional setting is far from this ideal. Most current sex offender treatment programs operate under many constraints. In most correctional settings, trained clinicians are difficult to recruit, especially in institutions located in isolated rural areas, remote from academic and population centers. Most physicians, psychologists, social workers, activity therapists, and nurses have little or no formal academic or clinical training in the etiology of sexual deviancy, either in its assessment or treatment. Indeed, many clinicians have such biases regarding the efficacy of sex offender treatment that they actually undermine treatment efforts.

Despite the many pressures on correctional systems to manage sexually aggressive offenders more effectively, there often exists an antagonism toward specialized treatment programs for sex offenders. Sex offenders may be viewed as "unworthy" of specialized and expensive treatment. Administrators and staff often create procedural or environmental barriers which distract from the effectiveness of treatment within the institution.

In the real world, state legislatures choose from a competing array of human service programs. Specialized residential sex offender programs are expensive, and legislators often find it more expedient to enact highly emotional laws governing sexual conduct than to allocate resources needed to establish and maintain treatment programs (Brecher, 1978).

Both public and private agencies providing treatment services to sex offenders are intensely scrutinized by the media. Given the brevity of most media accounts of treatment strategies, it is predictable that public expectations of programs can initially be unrealistic. Subsequently, high profile escapes or reoffenses by offenders may result in public outcries to abolish these programs immediately.

Given the current reality of operating sex offender treatment programs, training efforts directed toward the public, governmental officials, and correctional staff can be as important as effective staff training. This chapter describes several areas of training and education which might be undertaken wholly or partially by the staffs of sex offender treatment programs. They include:

- educating the media and public;
- training key officials, including judges and prosecutors;
- training parole officers;
- educating and training institutional administrators and staff, particularly the institutional chaplain;
- training correctional officers in generic and specialized skills; and
- training professional staff in specialized techniques.

Program managers would be well served to include education and training as key elements of their implementation strategy. Training and education should be seen as ongoing tasks, both within the program and with the agencies and individuals in the community.

Public and Media Relationships

Good public and media relationships are important to sex offender programs as they seek to educate others about the role of treatment in the overall strategy to reduce sexual victimization. Professional efforts in this area may mean the difference between receiving adequate legislative support and budgetary authorization and failing to have the necessary resources. Handling a crisis situation poorly can lead to a

program's demise or to severe limitations in vital program components.

Effective media strategy requires a cadre of skilled spokespersons who understand basic communication principles. A media and public relations handbook, published by the National Institute of Corrections (1984), provides many examples of how correctional programs might develop effective strategies for informing the public about their mission and goals, thereby gaining broad community understanding and support. Agency administrators are encouraged to take a proactive approach to public and media relations. It is important to identify where informational deficits exist and then formulate an action plan for addressing these areas. Following are examples of areas which might be included in an overall action plan for developing good relationships with key public groups.

Public Service Organizations

Public service groups and clubs are often eager to become involved in local or regional programs that address pressing social issues such as sexual assault. Organizations such as the Rotary Club, Kiwanis International, Lions Club, or Jaycees frequently take an interest in such issues as a result of the involvement of their national organizations. Such organizations offer a forum for program representatives to explain the need for sex offender treatment, the methods employed, and the expected treatment outcomes. Addressing bar associations, law enforcement groups, professional organizations, and such politically active organizations as the League of Women Voters or the Junior League can also lead to very active and vocal community support.

Efforts in this area are usually the responsibility of program administrators and professional clinicians. However, line and other nonprofessional staff may also interact with community groups during tours of the program. Staff are also effective community educators in groups and organizations to which they belong. Participation of staff may also have the effect of improving their morale and commitment to program goals.

Citizen Advisory Groups

Citizen advisory groups exist in various forms in many state and local jurisdictions and have the potential to be of assistance to program administrators. The involvement of prominent citizens of varying backgrounds serves to legitimize the program with the public and the media, as well as with legislators and correctional or mental health administrators. Programs should consider forming groups which include representation from law enforcement, private clinicians, victim advocacy groups, religious organizations, and others who have an interest in the prevention of sexual abuse.

Technical Advisory Committees

Involving skilled professionals in the criminal justice and treatment field has been a common practice in corrections for many years. Such committees are potentially of great value to sex offender programs not only because of the range and scope of expertise but also because such groups often anticipate problem areas and assist programs in avoiding future difficulties.

Technical advisory committees are of value in dealing with specific problem areas for treatment programs. For example, correctional officials in Oregon were involved in a Behavior Modification Review Committee which had the responsibility of reviewing and approving behavioral treatment methods to be introduced in a sex offender program located within a state hospital setting. Without their participation and agreement, it would have been difficult to implement new and innovative treatment methods.

Concerned Citizens Groups

Establishing a sex offender program within a prison, a mental hospital, or in a community setting is not always greeted with unanimous public approval. In fact, the opposite is often the case. Opposition to sex offender programs may be variously motivated: fear of a program being located in one's own neighborhood, opposition to spending public funds for offenders and not victims, or a misunderstanding of the goals or methods the program wishes to employ. Public anxiety often grows into well organized opposition, including the circulation of petitions against the establishment or expansion of a program. Effectively countering public opposition with rational and informative campaigns requires a well planned and organized effort on the part of the sex offender program.

The California Probation, Parole and Correctional Association (1984) provided an excellent example of a strategy employed by the San Diego County Probation Department to counter a well organized campaign by local residents opposed to the establishment of an adult offender work camp at a county-owned site in a rural area. The strategy included the following:

- Identifying groups within the community whose support would be helpful, including political leadership.
- Providing in-depth briefings to community groups and leaders regarding the purpose of the facility and the ways in which it would benefit the entire community.
- Personally contacting residents in the area surrounding the proposed program site and explaining the reasons for locating the program there, the precautions and security measures which would be employed, and the overall community benefits of the program. In addition, they carefully listened to the residents' fears and objections.

- Demonstrating the department's responsiveness to the valid concerns of citizens by following up on commitments made to the residents.
- Holding public meetings with residents to give them an opportunity to express their concerns. The department clarified the issues which were of concern and sought citizen support and understanding.
- Providing media representatives with in-depth background information on the proposed program and the anticipated benefits to the community.

This successful public relations strategy involved a willingness to publicly discuss issues of concern to citizens, as well as a professional and proactive approach to utilization of the media.

Media Relations

It is often not possible to establish a sex offender treatment program within corrections or mental health without intense media scrutiny. A proactive and professional strategy for dealing with the media will enhance the program's image with the public and encourage balanced and informative reporting on issues of sex offender treatment. It is important that sex offender programs develop a well informed cadre of reporters if a program's goals and methods are to be reported accurately. The most effective way to do this is to offer background briefings to those newspaper or television and radio reporters who cover corrections or mental health issues. Such background briefings would include written information about the origins of the program, its goals and methods, staffing, budget, and the intended clients. The goals, as well as the limitations of treatment for sex offenders, should be explained. While some reporters will require only brief background information, others may wish to interview staff, clients, or actually to visit the program. Television reports will require visuals, such as footage involving the physical environment of the program, shots of activities within the program, or filmed interviews with staff and clients.

Interviews with clients may present special problems. Programs must formulate specific policies regarding client access to the media. Media release forms should be signed by program clients prior to contact with the media. Only volunteers should be permitted to be shown on television interviews. The presence of television cameras or other representatives of the media within a program may be beneficial to clients who sense how important the issue of sexual violence is to the public. Media exposure also brings with it the possibility of disruption within treatment groups or distortion of the program by individual clients. Prior to admitting media to a closed program, both staff and clients must understand the purpose of the news report and what is expected of each.

Programs may also participate in a host of other media activities which will enhance the program's image and educate the public regarding their purpose. They include involvement of staff and clients in special interest programs and documentaries on both radio and television, special interest stories in the printed media, or radio and television talk shows. Those representing the program must be knowledgeable and effective communicators.

The nightmare of many program administrators is having to respond to probing questions from reporters when something goes terribly wrong within the program, e.g., a client attacks another client or staff member, or a trusted client—about to be released—escapes and commits a heinous sexual crime. These are situations which are truly crisis times for programs and which demand that staff respond to the media in a straightforward and professional fashion. When such a crisis situation occurs, the media should be immediately notified and given all facts that are known at the time. The situation should be presented in a factual, direct fashion, without evasiveness, distortion, or attaching blame. If facts are not known, the program liaison to the media should attempt to get the facts and make them available. A "no comment" response can give the impression that a program is attempting to hide facts or cover up. During a crisis situation, all media should have equal access to a program spokesperson, and exclusive interviews should be avoided.

In all relationships with the media, it should be kept in mind that sex offender programs are publicly funded, and the public has the right to know what is happening within the programs. Good media relations involve professional communication, not manipulation. Skillfully handled, media relations will generate public support and understanding during good times and bad.

Media presentations can do much to train the public. However, special groups in the community need to be identified and recruited for intensive training.

Training Judges and Prosecutors

In most states, prosecutors and judges are faced with a flood of defendants charged with a range of sexual misconduct. Prosecutors and judges must have a basic understanding of the etiology of sexual deviancy in order to differentiate between highly predatory and dangerous offenders and those who might safely be sentenced to community-based programs.

Judges must understand numerous laws relating to the assessment, classification, diversion, and sentencing of sex offenders. They must have at least a rudimentary understanding of the way in which clinicians assess offenders for dangerousness, amenability to treatment, and prognosis for success. They must be aware of available treatment resources and the types of offenders who might be appropriately and safely placed in each setting.

A sophisticated judiciary is an important part of an efficient system for managing sex offenders. A unique sex offender program, operated under a joint agreement between the Departments of Mental Health and Corrections in the State of Oregon, offered a two-day sentencing institute at Oregon State Hospital for seventy circuit judges. Following a half-day plenary session in which the various statutes relating to sexual offenses were discussed, three groups were rotated for half-day visits to the sex offender program and two correctional institutions.

The training format utilized presentations by administrators, clinicians, and inmates in treatment. Judges were informed about all components of the system statewide, including assessment procedures available to courts, secure residential treatment programs for probationers, and programs within correctional institutions. Specific criteria for admission were spelled out, and the security level of each setting was described. The relationship between inpatient programs and aftercare supervision and treatment was described by program clinicians and the parole officers carrying specialized sex offender caseloads.

To promote a broader understanding of the offender and his unique characteristics, information was presented on offender typologies, assessment procedures, methods of determining future dangerousness, and treatment amenability, as well as the efficacy and limitations of specific treatment methodologies. Judges toured behavioral laboratories, viewed stimulus materials, and were shown slides depicting chart recordings of client arousal responses. With this basic background about treatment approaches, the judges' interaction with the program participants regarding their experiences in treatment was particularly meaningful.

In addition to improving the dispositions which courts make in sex offender cases, such interactions between clinicians and the judiciary can have other long-range positive outcomes. Judges who are well informed about sex offenders are realistic in their expectations of treatment. They become advocates for continued or improved treatment services and can be a powerful force in lobbying with legislators.

The training event for judges described above represents one approach to training judges, prosecutors, defense attorneys, and others involved in the decision-making process regarding sex offenders. A sophisticated and informed criminal justice system greatly enhances the effectiveness of treatment efforts within a correctional setting.

Training Parole Officers and Aftercare Providers

Most residential programs for inmates regard aftercare supervision and treatment as an important and integral part of the treatment process (Knopp, 1984). Programs should insure that parole officers and clinicians who provide treatment services during the aftercare period understand the treatment methods utilized during the residential phase of a program to enable both continuity and consistency.

It is important that parole officers supervising offenders in the community be familiar with the philosophy, goals, and expectations of institutional treatment programs. Program visits and both formal and informal training in treatment methods should be promoted. Opportunities to present information at meetings of parole officers should also be taken.

Parole officers must be familiar with certain key clinical issues. First is the offender's particular reoffense cycle or Relapse Prevention plan. Such plans spell out the behavior, cognition, and feelings which precede sexual acting-out. An intimate knowledge of the offender's cycle of behavior can result in an early intervention or interruption of a deviant cycle of behavior (see Chapter 14 on Relapse Prevention).

Second, treatment programs often impose special stipulations on offenders returning to the community. Most are designed to reduce the opportunity or temptation to reoffend. They may include forbidding child molesters from owning cameras which develop prints instantly, restricting living and working situations to areas with limited access to children or single women, or prohibiting working graveyard shifts or dating women with small children in the home. Parole officers must understand and consistently support these stipulations to minimize the potential for reoffense in the community.

Finally, parole officers must understand the important elements of sex offender treatment if they contract for services or refer parolees to community-based treatment providers. In particular, they must be cautious not to refer offenders to therapists who adopt an advocacy stance with clients, who minimize the seriousness of offense behavior, or who employ ineffective or unethical treatment methods. A familiarity with treatment strategies also assists the parole officer in identifying clinicians who are inadequately trained in this area.

There are several options which can enhance the knowledge and effectiveness of parole officers. On-site tours, jointly sponsored workshops and training events, "brown bag forums," and individual case conferences are particularly effective formats for training and mutual problem-solving.

Educating and Training Institutional Staff

While treatment program staff traditionally concentrate training efforts on the clinical staff, each employee should be familiar with the goals, philosophy, methods and limitations of an institutional sex offender treatment program. There are a variety of formal and informal approaches which are

effective in involving correctional staff in the development and operation of these programs. Correctional administrators can be involved in all aspects of planning, program design, and implementation. Workshops and training may be presented to groups of staff within institutional settings, including security personnel, educational and vocational staff, correctional counselors, mental health workers, chaplains, and institutional administrators.

Education of institutional staff also sensitizes them to the program participants' need for some degree of confidentiality, particularly in programs within a maximum security setting. Counselors or correctional officers who have daily contact with inmates should be aware of the criteria for admission in order to make appropriate referrals.

Programs housed within security institutions may be exposed to negative staff attitudes regarding sex offenders. Barriers may be erected which assure that inmates who have been publicly labeled as sex offenders will not volunteer for treatment services. If confidentiality is not honored, some offenders find that program participation can place them in danger of physical assault. The administration's willingness to be flexible in scheduling may also be a key to the success or failure of these programs. Education and training of institutional staff is an important, ongoing task for programs operating within a larger institutional setting.

The Special Case of Institutional Chaplains

One behavior often observed in sex offenders is a flight into religiosity following arrest or incarceration. The Reverend Charles Berger, Director of Clinical Pastoral Education at Oregon State Hospital, has worked closely with inmates in sex offender programs for over eight years. Berger also trains pastors who will work in institutional settings. In his view, the sex offender presents special problems for the chaplain (C. Berger, personal communication, 1986). Many sex offenders, particularly incest fathers and child molesters, have been raised in families which distort religious teachings to instill a fear of human sexuality in their offspring. Many others claim to have experienced a religious conversion experience directly following their arrest or incarceration and, as a result, they perceive no need for treatment. This sense of religiosity is distinctly concrete and appealing to antisocial personalities, who view life in terms of black or white, and allows them to reject those individuals whose views differ from their own.

Some offenders in treatment may resist particular aspects of treatment because of their religious beliefs. This is particularly the case with behavioral methods which require exposure to both deviant and appropriate sexual stimulus materials or to masturbatory reconditioning procedures. Offenders required to participate in these methods often drop out of treatment and seek support for their actions from sympathetic or uninformed chaplains. Typically, these offenders buttress their positions with scriptural references, particularly those cited with regard to conversion in which the offender's past is forgiven and only the future is relevant. Many offenders insist that prayer or reading the Bible will be sufficient to suppress deviant sexual thoughts and behaviors.

The understanding which a chaplain brings to this situation may be critical to the success or failure of the religious inmate. As Marie Fortune (1983) points out, pastors are rarely trained to deal with sexual violence in whatever setting. In the community, sex offenders often seek a pastor's immediate forgiveness and minimize or distort their actual involvement. Some seek to enlist the minister as a character witness on their behalf. In the institution, the offender may seek confirmation from the chaplain that his objection to treatment is justified or that he can alter sexual behavior through prayer or other religious means without treatment.

Training in the etiology of sexual deviance is necessary for all chaplains who deal with sex offenders. They are in a position to help the offender put religious beliefs in perspective and recognize the necessity of altering victim-creating sexual thoughts, feelings, and behaviors. Chaplains can confront religious behavior which is essentially an excuse to avoid treatment, while still supporting healthy religious beliefs and practices. The chaplain is in a unique position to present clinical information about an offender's religious concerns and needs to treatment staff. In doing so, the chaplain can become an important contributor to the interdisciplinary treatment planning process.

In order to be an effective spiritual counselor, chaplains should become familiar with the professional literature of this field. They should understand the nature and goals of the sex offender treatment program and be familiar with its methods. They should have a complete knowledge of scripture. Many offenders have memorized specific scriptural passages which support their narrow and concrete views and have disregarded other passages which might be more relevant. Finally, the chaplain should be comfortable with his/her own sexuality. Offenders quickly recognize a chaplain's personal discomfort in discussing sexual matters and may exploit it to their advantage.

The well trained chaplain makes an important contribution to programs by encouraging resistant offenders to participate fully in treatment, as well as contributing to an interdisciplinary treatment planning process for the offender. If the chaplain is not well grounded in the goals and methods of the treatment program, is unaware of the characteristics of the sex offender, and is not an integral part of treatment planning, he/she may actually undermine treatment efforts. Well trained, sensitive, and mature chaplains can often spell

the difference between success and failure for the religious client.

Training Strategies for Program Staff

The particular strategy employed by a treatment program for training program staff will be dependent upon several factors. The setting within which treatment takes place is a major determinant of the extent and type of training required. Outpatient models conducted primarily by professional staff require the least extensive staff training, while residential programs with extensive community linkages require comprehensive and specialized training strategies.

In planning an approach to staff training, the experience and expertise of clinical staff is the major variable to consider. Well trained clinical staff are a major asset in staff training both during program implementation and thereafter. Training strategies are also dependent upon resources available to the program, such as training budgets, clinical staff skills, and access to outside expertise. As this section will describe, there are currently many training resources available to sex offender treatment programs.

The training of staff may be divided into four categories:

1. Procedural or operational training;
2. Program philosophy, goals, and staff expectations;
3. Psychological dynamics of the sex offender; and
4. Specialized sex offender treatment techniques.

Procedural and Operational Training

Procedural and operational orientation is required of all new employees to acquaint them with the basic functional, procedural, and legal aspects of their jobs. Sex offender programs offer attractive career opportunities for many clinicians. Since sex offender treatment programs regularly employ highly qualified staff with no previous institutional experience, it is important that new staff be trained in institutional security policies and procedures. They should know self-protection methods, as well as how to manage aggressive behavior. Basic orientation to institutional operation should be completed before specialized training is undertaken.

Program Philosophy, Goals, and Staff Expectations

Staff should clearly understand the theoretical basis for the program, the approach which will be used to change sexually deviant behavior, and the types of clients that will be served. This is an important focus of training, particularly during the start-up phase of a new program.

Staff relationships with participants must be clearly defined. Guidelines and expectations for staff/client interactions should be spelled out in formal training sessions. This is a training issue of ongoing concern and an appropriate topic for periodic in-service training. Role playing and staff discussions regarding specific problems with clients is perhaps the most effective approach to refining and improving relationship skills with offenders.

Daily interaction with sex offenders may trigger a variety of intense feelings which interferes with the ability to remain objective. Some staff, both male and female, may have been victims of sexual abuse. Working with sex offenders may resurrect intense feelings which are later vented on clients. Many staff are personally angered or revolted by the violence and cruelty displayed by their clients. It is important that program managers anticipate staff needs in this area and provide an opportunity for staff collectively to discuss their feelings. In-service training sessions are ideal settings in which problems can be discussed. The emotional impact on staff in dealing with this population can be minimized as they learn appropriate and professional styles of interaction with clients.

Psychological Dynamics of Sex Offenders

Until recently, there have been few opportunities available for training staff to work in sex offender programs except in specialized areas such as behavioral assessment and treatment. Recognizing this need, several state programs have developed training manuals targeted at the caseworker or correctional officer staff. The North Florida Evaluation and Treatment Center (1985) developed a manual for staff training in which materials are largely self-taught and divided into separate modules of instruction. In some instances, readings are supplemented with videotapes. Experienced program staff assist students as they progress through the modules. Scheduled sessions provide students an opportunity to question trainers and gain a more in-depth understanding of each module. The course is competency based in that students must complete each module and achieve a passing score on a post-test.

Mastery of this course provides the student with a generic understanding of the program, the clients, and the change process. Key modules in this course include:

- a description of the sex offender program at North Florida Evaluation and Treatment Center,
- etiological factors in sexual deviance,
- behavioral manifestations exhibited by offenders,
- how to achieve and demonstrate a neutral stance in client interactions,
- skills needed for appropriate interactions with clients,
- crisis prevention and intervention,
- treatment modalities, and

• documentation of treatment progress.

This manual is a promising approach to training support and security staff. Depending on resources, programs may either use their own staff to conduct training or delegate it to outside experts. The Florida manual emphasizes the advantage of staff members presenting training because they will subsequently assume teaching and mentorship roles in the day-to-day work situations. The other distinct advantage of having staff trainers is that the practical impact of training may be observed and monitored on an ongoing basis.

In addition to the training format described above, there are other approaches which are effective in training staff. In-service meetings held on a regularly scheduled basis are excellent forums for a variety of management and treatment issues. Supervision meetings can be effectively utilized as a training tool. Mentorship by experienced and skilled staff members with new staff is also a productive supplement to formal training.

Training in Specialized Sex Offender Techniques

Many of the mental health staff have basic therapeutic skills which have application to the sex offender population. However, training in the specific therapeutic methods used with sex offenders is mandatory even with experienced clinicians. In this section, three areas of specialized competency are discussed with suggested approaches to staff training in each.

Group Process

Some form of group therapy is found in nearly every sex offender treatment program in the country, regardless of the specific model of treatment. Therapy groups have numerous goals and methods (see Chapter 11, Interpersonal Treatment Techniques). Examples include the following.

Core Treatment Groups

This type of group is the basis of any treatment program. It focuses on the discussion of specific sexual offenses, antecedents of sexually deviant behavior, emotional and cognitive problems characteristic of sex offenders, problem-solving, and other areas. These groups may be led by staff, facilitated by staff with leadership provided by participants, or led entirely by participants. Often the core treatment groups are highly confrontive and geared toward breaking down offender denial or minimization.

Empathy Groups

These groups are designed to sensitize offenders on the impact of their behavior on victims and others. They may incorporate group discussion of the offender's specific crime and its impact on the victim, tape or audio recording by victims, and/or role plays with offenders assuming victim roles. In some programs, offenders are confronted by women who have been actual victims of sexual assault. These confrontations tend to be highly emotional and require a skilled and sensitive therapist.

Cognitive Restructuring Groups

These groups assist offenders in identifying irrational or criminal thinking patterns which contribute to their sexual deviancy.

Victimization Groups

Many sex offenders have histories of prior sexual abuse themselves. These groups help offenders resolve feelings regarding their own sexual victimization.

Family Therapy Groups

Many programs involve the spouse or a significant other in family therapy. The goals for these groups include alerting the spouse to the offender's pattern of behavior, improving the couple's communication, and encouraging support from the partner for the goals of treatment.

Transitional Groups

Most programs conduct special groups for offenders transitioning from the institution to the community. These groups focus on fears and expectations of the offender, pragmatic community survival issues, and methods to minimize or prevent reoffense. They may include probation or parole officers who will ultimately assume responsibility for this supervision.

Developing skilled group therapists is not a quick or easy process. Therapists must be well grounded in the basic theory and practice of group therapy, possess good interpersonal skills, and build a repertoire of group interventions based on experience. Training of group therapists is a multifaceted process. In addition to formal academic training and familiarity with the professional literature, the most common training approach involves mentorship and supervision. Because of the lack of trained professional staff in most programs, the responsibility for facilitating groups with sex offenders often rests with paraprofessional staff. Thus, supervision becomes a critical training and monitoring tool.

Even professionally trained clinicians may find that they are unprepared for dealing with sex offenders. In traditional group therapy, an individual exhibiting distress or pain is the focus of attention. Sex offenders tend not to participate or disclose spontaneously, and a therapist must use other methods for promoting participation. Often, trained therapists will assign sex offenders a task such as reading an account by a

victim of a sexual attack and reporting their response to the assignment in group. This forces the individual to participate and opens up the area of empathy or lack of empathy for victims.

Because sex offenders are normally not eager to disclose feelings or to volunteer accounts of their sexual deviancy, many group therapists will establish specific standards for group participation. Offenders might be required to make a certain number of statements per group, have the quality of their group presentation evaluated, or have their affect judged by the therapist or other group members.

Given some of the differences which are inherent in working with this population, it is important that a therapist with little or no experience be paired with a more experienced clinician before assuming total responsibility for a group of sex offenders. Working with a co-therapist is a standard practice in sex offender programs. It is an excellent approach to training group therapists. It is also helpful, after a group meeting, to evaluate the session with a co-therapist. Often, one therapist can pick up cognitive distortions or manipulations by offenders which might be overlooked by the other. Many programs tape-record group sessions for review by therapist and supervisor. This is an excellent method to review and teach group skills.

Psycho-Educational Modules

Sex offenders have significant deficits in a variety of social and interpersonal areas, including basic communication skills, anger management, social and dating skills, sexuality, and assertiveness. Most programs present psycho-educational modules to offenders in a classroom or group setting, with the expectation that the skills learned will be practiced in everyday activities.

Psycho-educational training is currently offered in a variety of treatment settings. There are many self-help books widely available which cover clinical topics like anger management, stress management, and sexuality. Most can be easily adapted to sex offenders.

The Harborview Community Mental Health Center in Seattle (1984) published a three-volume *Life Skills Syllabi* containing course outlines for a variety of modules presented to their psychiatric patients. They range from classes designed to improve communication skills, manage anger, and promote social behavior change, to those teaching parenting skills, management of leisure time, and even the survival of holiday depression. These modules assume that lack of knowledge is related to problem behavior in the community and that these specific learning deficits can be identified and remedied.

Psycho-educational modules may be taught by either professional or paraprofessional staff. Of importance is the ability of the instructor to communicate with clients in a straightforward and nonjudgmental fashion. If classes are conducted by paraprofessionals, supervision by a trained professional is advisable.

Behavior Treatment Methods

Many comprehensive sex offender treatment programs employ a range of behavioral techniques designed to reduce deviant sexual arousal and strengthen appropriate arousal. Such programs normally use the penile plethysmograph for monitoring arousal and specific behavioral techniques for altering arousal, including covert sensitization, masturbatory reconditioning, behavioral contracting, and aversive conditioning. While aversive conditioning is commonly used, in some states it may be limited or forbidden by consent decrees.

Behavioral therapists include both professional and paraprofessional staff. Basic requirements for behavioral therapists include an understanding of behavioral theory and practice, good interpersonal skills, attention to detail, an analytic approach to problem-solving, and comfort with one's own sexuality.

There are several approaches to training behavioral therapists. There are currently many articles available which describe the specific behavioral methods used in the treatment of deviant sexual arousal (Laws & Osborn, 1983; Earls & Marshall, 1983). These articles provide guidelines for establishing behavioral laboratories and developing a repertoire of behavioral assessment and treatment methods. The literature may also be supplemented by on-site consultation with recognized experts in the field of behavioral assessment and treatment, or by visits to sex offender programs with operating behavioral laboratories. Some programs have established in-house behavioral training programs. The Sex Offender Program of the Correctional Treatment Program at Oregon State Hospital structured a formal training program for staff interested in becoming behavioral therapists. The course was designed and taught by clinical staff with expertise in behavioral methods. It included both classroom instruction and demonstration of competency in a clinical laboratory setting. The course involved weekly lectures and discussions with a variety of clinical staff. Students were assigned homework and periodically tested. The course lasted approximately twelve months. During the course, many students operated the penile plethysmograph under close supervision. Successful completion of the course led to hospital certification as a behavioral technician and established minimum competency standards for the agency.

To date, there have been few efforts to develop minimum standards of competency for behavioral therapists or technicians. The rapid proliferation of persons claiming expertise in administering and interpreting behavioral data will gener-

ate numerous professional and ethical issues. In the absence of standards, it is critical that paraprofessionals who function as behavioral therapists be supervised by clinicians with professional credentials.

Sex offender treatment programs represent a scarce and unique resource for training and education, not only for staff within the criminal justice system, but for the general public as well. This chapter advocates a proactive approach to training and education on a broad scale. Programs are encouraged to develop a strategy for training and education in the several areas discussed. Training and education are not one-time events, however. The field of sex offender treatment and prevention is complex and constantly changing. For program administrators, the training and education of judges, legislators, prosecutors, and others who impact on programs is crucial to survival. The media must be educated so that they may serve as an advocate or at least as an unbiased observer. The administrators themselves must constantly update their own knowledge so that the program remains on the cutting edge of therapeutic advances.

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Chapter 6: Sex Offender Treatment Program Evaluation

by Randy Green

Abstract

In the past few years, several of the nation's leading sex offender programs have been closed down. Dr. Green refers to this in urging that programs build a strong evaluation component into their treatment programs. Quantitative and qualitative components must be assessed, and techniques for doing this are recommended.

In the past 15 years our society has witnessed a massive increase in the incidence of reported sexual crimes. The criminal justice system and the mental health community have attempted to respond to this epidemic in a variety of ways. Responses have ranged from punishment and incarceration to the extensive use of probation. Treatment responses have encompassed a spectrum from small, intensive, secure residential programs to large community-based programs. Correctional and mental health program managers are under significant pressure to protect the community and "cure" the sex offenders before they return to society.

In an era of declining state economies, a pronounced shift appears to be occurring. Correctional divisions are finding treatment responsibilities shifting to them, as children's protective services and mental health divisions are, more and more, restricting their services to their primary client groups.

Consequently, treatment programs with a multitude of assessment procedures and innovative interventions are becoming more widespread in correctional settings. The wide array of multimodel treatment interventions includes group and family therapies, psycho-educational modules, behavioral treatment, cognitive behavioral paradigms, Relapse Prevention strategies, and drug therapies.

The convergence of these therapeutic advances with increased populations and limited resources creates a necessity for the incorporation of program evaluation components at each level of service delivery. From any vantage point, either pragmatic, ethical, or professional, it is incumbent upon managers of correctional mental health programs for sex offenders to establish and maintain program evaluation components within their treatment initiatives.

The necessity for such evaluation efforts is enhanced by additional considerations. Typically, people-changing programs within corrections divisions have been guided by trial and error and intuitive approaches, rather than by program efficacy data. In addition, Glaser (1973) has emphasized the need for differential offender typologies, which can be used as a basis for more appropriate classification, and treatment efforts that take into account the limited available resources. Such typologies can guide policy makers in decisions that pertain to those individuals entering limited-space treatment facilities or those returning to the community.

Another important reason for making program evaluation an integral part of sex offender treatment programs centers around the fact that there actually exists very little scientifically collected information regarding the efficacy of sex offender treatment, in terms of recidivism and behavior change. At this time, it has not been established which treatment works best with what type of offender, fundamental data which is potentially vital to program managers, agency policy makers, and legislators. Therefore, data collection and program evaluation integrated into treatment programs becomes advisable in anticipation of future scrutiny. This scrutiny, though sometimes threatening, helps foster an attitude of accountability and objectivity.

In this chapter, the concept of program evaluation will be developed and emphasized. Methodological obstacles in program evaluation and analysis will be discussed prior to a review of available sex offender program outcome data. Finally, different types of program evaluations will be examined in regard to the evaluation objectives. Program managers will be provided a number of evaluation options which can be pursued as thoroughly as their priorities and resources allow.

The Concept of Program Evaluation

Program evaluation is designed to be a systematic process for eliciting clear and objective feedback regarding the following primary issues:

- which type of treatment is most effective with what type of offender and at what cost, and
- to what degree is the program achieving success in accomplishing its established goals and objectives.

Evaluation components should be integrated into treatment programs at their beginning or as soon as possible for already-established operations. Fundamental questions for administrative and clinical staff during the establishment phase should center around the following foundational concerns:

1. What is the task or mission of this treatment program?
2. What is the profile of the offender to be treated?
3. What specific interventions will be employed?
4. What are the expected outcomes of these interventions?

a) To what degree will recidivism rates be a measure of program success?

b) Is the sex offender expected to be crime-free, or demonstrate reduced seriousness of new crimes?

c) What social/psychological changes are expected in the sex offender?

5. How can activities be defined and measured? As clients begin to participate in the program, additional questions should be asked periodically:

a) To what degree are clients meeting the program's expectations?

b) What types of clients are actually being treated? (For example, several pioneering sex offender programs have been receiving more chronic, refractory clients, as community-based alternatives have become increasingly available for incest offenders and other more amenable clientele.)

c) What programmatic changes would enhance the treatment process?

d) Is the program keeping abreast of the latest research?

Recent experiences of two states who have pioneered sex offender treatment program development will illustrate the need for these questions to be anticipated, rather than asked retrospectively. What happened in these states is instructive because the issues can be so readily generalized.

Western Washington State Hospital's Sex Offender Program, recognized nationwide as an innovative pioneer in this field, boasted an escape rate substantially less than comparable medium security institutions within the state. In 1985, however, a very dangerous rapist escaped from the unit. Following an enraged community and legislative reaction, an automatic program lockdown was effected for the nearly 225 residents. The lockdown lasted several months, during which time the Legislative Budget Analyst Office conducted an independent program evaluation. The program evaluation mandate was broad but did include an examination of the degree to which the sex offender programs were operating in a manner consistent with legislative intent, combined with an assessment of program effectiveness in accomplishing statutory objectives. Among other findings, authors of the report noted that earlier in-house program evaluation recommendations had been ignored. In addition, they concluded that the following action should be taken:

> Development of a comprehensive plan pertaining to the operations of the Sex Offender Programs . . . The plan should address, but not necessarily be limited to such issues as: the development of appropriate goals and objectives; treatment methods; organizational and supervisory issues; and staff training needs. In order to provide for future program evaluation, the plan should also emphasize data and statistical requirements as well as procedures for collecting and reporting same (Washington State Legislative Budget Committee Report, 1986, p. 74).

They incorporated several other recommendations which could be generally instructive to other programs. Specifically, they recommended that more realistic staffing and funding levels be established consistent with program responsibilities. They recommended that the programs should be authorized to consider amenability as a criterion for program involvement and that programs be able to control their own admissions.

Unfortunately, the sex offender programs at both Eastern and Western Washington State Hospitals were phased out. The Washington State Department of Corrections was mandated to develop a treatment program to fill the gap. An elaborate plan was developed which consisted of an assessment phase, a series of therapeutic communities to be housed at the Monroe compound, work release programs, and intensive community follow-up. The plan is currently being implemented by the editor of this volume.

In the mid-seventies, Ted Frank, who had been a model resident of the Atascadero State Hospital's Sex Offender Treatment Program, was released and shortly thereafter kidnapped, tortured, raped and murdered a two-year-old girl. The child's grandmother formed a citizens' lobbying group, Society's League Against Molesters (SLAM), which called for lengthy prison sentences for sex offenders.

The California State Legislature passed a bill in 1978, requiring the Department of Mental Health to evaluate the "adequacy and value of such counseling" of convicted sex offenders within the state prisons (California Senate Bill No. 1716, 1978). Following the results of this evaluation, a subsequent bill was passed which repealed the law requiring commitment of sex offenders to state hospitals (California Senate Bill No. 278, 1981). The new law required that sex offenders be delivered to the Department of Corrections after sentencing.

In conclusion, two state legislatures, prompted by public concern and demands for accountability, retrospectively assumed responsibility for sex offender program evaluation. They determined that the responsibility to collect and analyze data is an inherent function of such treatment programs. A small pilot research project on sex offender treatment is now being conducted at Atascadero. Such lessons should not be lightly dismissed by program managers in other states. Unless programs have kept careful records and established sound quality assurance programs, they will be in constant jeopardy.

Program Evaluation Implementation

As previously mentioned, program evaluation must be directed by the program objectives and specific purposes of

the research. Differential targets of evaluation can include reviews of program inputs, efforts (activities), results or project efficiency (Hudson & Galaway, 1979). Each of these aspects will be addressed at length in relationship to sex offender program evaluations.

Input Evaluations

These evaluations focus on an examination of all resources utilized within the treatment program itself. The concept of "inputs" pertains to every resource available for the program, including funding, staffing, and even client population demographics. Therefore, an input evaluation might legitimately review the following areas:

1. What funds are allocated for the individual program components of facility, security, staff?
2. What is the cost per client in capital outlay, treatment material, etc.?
3. What is the staff/client ratio?
4. What are the academic, experiential and attitudinal characteristics of the staff?
5. How is the staff organized to accomplish programmatic, statutory and clinical objectives?
6. What are the sources of referral of clients to the program?
7. How well do the referral sources understand the intent and capabilities of this program?
8. Is there a need to educate referral sources about those amenable to the type of treatment that this program provides?
9. Do the statutes and policies pertaining to the program need to be changed?
10. What are the demographics of the client population? Client demographics are very important for interpreting outcome and output studies, when comparing the results to those of nonprogram participants and for comparing data between treatment programs. At the minimum, it is recommended that the client demographic variables listed in Table 6.1 be collected on admission to the program.
11. What are the demographics of those sex offenders who, either by choice or refusal, do not participate in the program?

It is advisable to expend effort to obtain basic demographic data regarding these individuals in order to allow for possible comparisons in subsequent outcome studies intended by the agency or program.

Table 6.1

CLIENT DEMOGRAPHIC VARIABLES

Social Security Number
Age
Race
Educational Level
Marital Status
Prior Criminal Convictions, non-sex-related
Prior Criminal Convictions, sex-related
Prior Incarcerations
Prior Commitments, mental hospital
Current Offense
Weapons or Use of Physical Abuse
Number of Years, sexual acting out
History of Sexual or Physical Abuse (as victim)
Age Range of Victims (include options for more than one category)
Sex of Victim
Relationship of Victim to Offender
Chemical Abuse Patterns
Expressed Attitude toward Sexual Problems
Expressed Motivation toward Treatment
Sex Offender Typology (include options for more than one category)
Relevant Psychometric Findings

Effort Evaluations

These types of evaluations examine the process by which inputs are channeled into program output. The following questions can clarify process-oriented issues for a sex offender treatment program.

1. How is staff time allocated among administrative, security, public relations, documentation, training, assessment, and treatment tasks? How do these statistics reflect priorities and expectations?
2. How are decisions made regarding acceptance of an offender into treatment?
3. How are potential clients identified and offered treatment within an institution? How effective are these efforts?
4. How are decisions made regarding advancing, graduating, and terminating offenders?
5. How many groups, modules, behavior therapy sessions, activity groups, family or marital therapy sessions are being conducted on a monthly basis?
6. How is treatment planning conducted?
   a) How is input from staff solicited regarding an offender's treatment status?
   b) How is information communicated to other staff members regarding treatment plans?
   c) How is peer group input incorporated into the feedback process?
7. What measures are taken within an institution to insure privacy for sex offenders participating in treatment?
8. How are security issues considered in the program? If applicable, how does this apply to community access? How do risk assessments measure the changing levels of risk as a client responds to treatment in either direction?

Questionnaires can be tailored to specific programs in order to assess the manner, quality, and efficiency of a program's efforts or activities. In addition to questionnaires, quality assurance checklists can be designed that reflect key operational areas and gauge whether or not certain minimal standards are being met. Alternately, the *Correctional Institutions Environmental Scale* (Moos, 1974) could be used to determine the subjective perception of the environment from the viewpoint of the client/inmate. Any of these indices can be useful in providing program management with feedback regarding the process through which program input is transformed into program output.

Output Evaluations

These evaluations provide managers with data regarding the immediate accomplishments of the program. Examples of output data to which program managers need have regular access include the following:

1. Number of clients residing in the treatment unit (average daily population);
2. Number of clients being assessed or treated per month;
3. Number of clients being terminated, identified by type of termination:
   a) successful completion of the program,
   b) maximum benefit (a term used to designate clients who have been cooperative and motivated but about whom treatment staff continue to have serious reservations regarding prognosis. Persons being terminated from treatment as "maximum benefit" should have these concerns identified with risks and any recommendations for disposition clarified.),
   c) administrative termination (e.g., transferred because of overcrowding, because a more appropriate unit has been identified, or because an individual has "flat-timed" out of the program), or
   d) unsuccessful termination (i.e., failure to cooperate with treatment, major rule infraction, escape, etc.).
4. Number of clients entering aftercare programs (if applicable):
   a) specify type and intensity of correctional supervision and treatment follow-up,
   b) employment status,
   c) living arrangements,
   d) estimated degree of community support system,
   e) status with family.
5. Number of criminal justice system, legislative, or community members who may have been trained, toured, consulted, etc., during the relevant time period. This output can become particularly significant as a program becomes better known and recognized as a regional resource. The opportunity to influence public policy and opinion cannot be ignored by program managers of sex offender units. It is important to monitor continually how much time is being channeled into this endeavor. The value of output data, in part, comes from comparing output to specified program priorities and mandated tasks.

Results Evaluation

This level of program evaluation focuses on the longer term program goals for which the program has been established. For most correctional treatment programs, especially for sex offender treatment programs, recidivism rates are the central issue. For this reason, methodological issues pertaining to recidivism data will be incorporated into this discussion.

California Senate Bill 278 (1981) recognized that there was a great need for controlled experimental research studies to establish the efficacy of sex offender treatment. Therefore, it also required that a formal controlled program for 50 sex offenders be conducted by the Department of Mental Health in order that "the most effective, newest and promising methods of treatment of sex offenders be rigorously tested (Marques, Murrey, & O'Connor, 1985)." Consequently, a controlled design study was established at Atascadero State Hospital involving a volunteer treatment group, an untreated volunteer group, and an untreated control group. The program primarily utilized a Relapse Prevention model and assisted covert sensitization as the treatment intervention. A five-year follow-up on offenders who spent two years in residential treatment will conclude in January 1992.

The only other serious experimental controlled study in the field of sex offender treatment in this country is being conducted in Tampa, Florida by Richard Laws. Sponsored by the National Institute of Mental Health (NIMH), Laws began this outpatient study in August 1986, comparing effects of a combined regimen of Relapse Prevention and aversive conditioning, in contrast to a traditional therapeutic model. Once again, this study is currently in process, and results will not be available for some time.

With these exceptions, outcome evaluation of sex offender programs is in its infancy. A number of sex offender treatment programs have followed their patients over a period of time and reported the results (see Table 6.2). Other researchers have followed groups of untreated sex offenders and have reported their findings (see Table 6.3). This data was collected in a variety of different ways and represents widely divergent populations. It must be remembered that, when an outpatient program reports a success rate twice as high as a hospital or prison program, caution must be exercised in interpreting that statistic. Outpatient programs may have more treatable clients.

Table 6.2

RECIDIVISM RATES OF TREATED SEX OFFENDERS

Program	Number	Period in Months	Recidivism Rate: Sex Crime	Recidivism Rate: Other Crimes/ Technical Violations
Northwest Treatment Associates, Seattle (Outpatient)	900-1000	1–20	10%	
Wickramsera	23	22–108	5%	
Alpha House, Minneapolis (Outpatient)	65	0–132	0%	
Adult Diagnostic & Treatment Center, Avenel, NJ (Prison)	425	0–96	10–14%	
Western State Hospital, Ft. Steilacoom, WA (State Hospital)	511	0–204	28.7%	
Oregon State Hospital, Salem (State Hospital)	25	0–72		10–14% combined
Intensive Treatment Program for Sexual Aggressives, St. Peter, MN (State Hospital)	11	0–84	25%	
Massachusetts Treatment Center, Bridgewater (State Hospital)				
Treatment Program	120	—	28–30%	50%
Community Access Program	120	0–96	1%	4%
Sex Offender Program, Connecticut Correctional Institution, Somers (Prison)	79	0–36	8%	14%
New York Psychiatric Institute, New York City (Outpatient)	192	12	13% (self-report)	

Table 6.3

RECIDIVISM RATES OF UNTREATED SEX OFFENDERS

Author	Population	Number	Period in Years	Recidivism Rate: Sex Crime	Recidivism Rate: Other Crimes/ Technical Violations
Christiansen (1965)	Danish sex offenders	2934	12–24	10%	24.3%
Soothill & Gibbens (1978)	English child molesters and rapists	174	13–23	37%	48%
Bala & Donnelly (1979)	Released sex offenders, New York State	141	5	14.4%	23.4%
Groth (1984)	Released sex offenders, Connecticut	122	0–3	15.5%	36%

Direct, meaningful comparisons between groups of treated and untreated sex offenders are, however, very misleading. Outcome studies reported by sex offender programs have not employed classical experimental designs. The nonequivalence of samples makes it impossible to determine whether the various groups differ significantly in terms of other unspecified independent variables. For example, volunteers for treatment programs may differ significantly from those who do not volunteer. Conversely, staff might admit into treatment those who are most promising or amenable to treatment.

The classical controlled study is hindered in applied clinical settings by a variety of obstacles. Glaser (1978) noted that controlled experimental designs are complicated by several factors, including the following:

1. Legal and ethical problems with postponing treatment for motivated sex offenders who are randomly assigned to a control group;
2. Drop-out tendencies from volunteers who may be randomly assigned to a high-intensity, demanding treatment intervention;
3. A "Hawthorne effect" which threatens external validity by influencing those being evaluated to respond in a different manner from those in a nonevaluated treatment program which offers the same interventions;

4. Administrative pressures to keep bed spaces full, or to transfer unhappy, complaining clients, irrespective of research design considerations;
5. Insufficient numbers to provide a large enough sample for control and experimental groups;
6. Consent decrees which would forbid denial or postponement of treatment to a control group or limit some research design.

A recent study conducted by Perkins (1987) in England did utilize an experimental design contrasting a treatment group with a control group of individuals on a treatment waiting list but discharging before being treated. The experimental group was much more entrenched in their deviant patterns, having an average of 6.86 previous convictions for sex offenses vs. 2.17 for the control group. Nevertheless, at the conclusion of the follow-up period, the treated group had committed one reoffense, while the control group had committed at least twenty-eight new sex crimes. Although this compared only eighteen offenders, this type of research shows promise and should be followed up by much larger studies.

At this point, it is necessary to address another methodological issue encountered when conducting or interpreting outcome recidivism data: the definition of "recidivism" itself varies greatly. It must be defined any time it is reported. In the public's view, "recidivism" might subjectively be defined as one emotionally charged escape or reoffense, from which generalizations are made about the worth of the entire program. In other words, a recidivism rate of one could be entirely unacceptable to the public. This underscores the importance of having collected accurate follow-up outcome data to minimize the destructive impact of such subjective interpretations.

Many sex offender treatment outcome reports alternately define recidivism as either "criminal justice system contact," rearrests, reconvictions, or reincarcerations. Definitions can be further refined by specifying either all crimes or sex-related crimes only. Reports must also acknowledge that treated offenders may be continuing to commit sex crimes which are undetected.

Mark Weinrott (1982) has identified difficulties which he encountered when attempting to compare outcome studies. He cited comparability problems resulting both from different states' definitions of crimes and from vague or unstated definitions of recidivism within the report data. A recent experience by the New York Department of Corrections emphasized that changes in state statutes, over time, can also confound results. Statisticians noted the rate of convicted rapists skyrocketed when compared to data available five years earlier. On closer inspection, it was discovered that a less stringent standard for prosecution of rapists accounted for most of the increase in convictions (D. MacDonald, personal communication, September 1986).

What can be concluded from this brief review of methodological issues? Learning from the limitations and weaknesses of the current status of available outcome data, those involved in sex offender program management can redress some of the concerns identified here.

General recommendations for recidivism data collection by sex offender program managers include the following:

1. As a minimum contribution to advance the knowledge base and to examine their own program outcome, program managers should commit the allocation of staff time and funding for data collection.
2. When possible, programs manager should match treated volunteers with an equal number of untreated sex offenders who are in state institutions. Demographics from the treated sample will provide some guidelines regarding sample size, age range, or type of crime. Random samples, or stratified random samples, would enhance comparability considerations. In some states, random samplings may even be taken from a group of volunteers on a waiting list, who are subsequently released without treatment because their period of incarceration lapses prior to being accepted into treatment.
3. Follow-up should encompass at least a five-year time period. Longer or more frequent intervals of time are more desirable, but a five-year period is considered a minimum adequate standard for such follow-up.
4. At the minimum, FBI and state "rap sheets" should be used as a source for recidivism data collections. However, Weinrott notes that the use of such sources alone tends to underestimate reoffense rates. Weinrott, therefore, recommends use of independent evaluators who engage in field investigation, review police report data, and self-report forms from the sample group. The interested reader is referred to Weinrott's NIMH research proposal for further details. It is apparent that one can increase the confidence in reoffense data by going beyond the use of "rap sheets." Specific states may have additional follow-up possibilities already accessible to researchers.
5. The definitions of actual crime behaviors and "reoffense" or "recidivism" should be clearly stated. No single definition is problem-free. Conservatively, "reoffense" could be defined as reconviction for sex-related crimes. More liberally, tabulation of rearrests could compensate for the underidentification problem, recognizing that an arrest is, of course, not a conviction.
6. Because it is based upon the time in which the offender had an opportunity to recidivate, the time-at-risk (or life-table) method of figuring recidivism rates will provide a more realistic picture (Soothill & Gibbens, 1978; Weinrott, 1982). There are two such methods of calculation. The cumulative method divides the sample's total number of reoffenses by the total number of at-risk

months in the study. In contrast, the successive method identifies the number who were actually at risk during specific time periods and enables the tabulator to calculate an unbiased reoffense rate for each period (e.g., month or year).

A more extensive statistical analysis, developed by Maltz and McCleary (1977), is the failure rate analysis which examines the trend or pattern of reoffenses over the time period. It is possible that a major difference between treated and untreated sex offenders might be the length of time prior to reoffending. Follow-up data incorporating these recommendations would begin to provide a greater degree of standardization of sex offender outcome research.

Goal Attainment Scaling is a clinical outcome measure offering an individualized means of evaluating, as well as perhaps enhancing, the process of change in the sex offender. Goal Attainment Scaling is a process, originally developed by Kiresuk and Sherman (1968), which has been applied in more than 800 mental health centers in the United States and Canada. One application of this process has been made to sex offender treatment programs (Lang, Lloyd, & Fiqua, 1985). In their study of 46 sex offenders in a forensic hospital treatment setting, Lang et al. (1985) utilized this method of individualized outcome assessment to measure the achievement of specific treatment goals. From a total of 180 individual goal statements, 88% of the goals were either met or exceeded by 38 of the clients. The other eight individuals failed to achieve expected levels of success, defined as achieving two or more individual goals (see Chapter 7, Treatment Planning).

Rosenberg's Self-Esteem Scale (1965) can serve as a measure of change in self-concept. The Social Skills Checklist (Barlow, Abel, Blanchard, Bristow & Young, 1977; Becker, Abel, Blanchard, Murphy & Coleman, 1978) and the Interpersonal Behavior Checklist are measures which can reflect change in social skills, empathy or assertiveness.

One of the more neglected aspects in the field of sex offender treatment is program evaluation. Tremendous innovations and creative developments have taken place within the past two decades. Methods of determining effectiveness of treatment methodologies have lagged behind. It is clear that technology must be developed prior to its being rigorously tested. Also, field constraints, limited resources, and multiple jurisdictions have exacerbated problems in the adequate evaluation of sex offender treatment.

This chapter has reviewed general issues and components of program evaluation and suggested means by which program managers can assess their progress. The proposition has been advanced that sex offender program evaluation is not an option. Rather, the choice becomes when will the evaluation be conducted and what source will initiate it. The case has been advanced, furthermore, that program evaluation be coordinated with sex offender programs at the earliest juncture. Data gleaned from the evaluation efforts have the potential to enhance the efficacy of both the individual program and the field in general. The more emphasis that programs can provide for quality evaluation, the greater the potential for meaningful comparisons across programs and jurisdictions. Such a trend could contribute much to the longer term outcome to which every program subscribes, the reduction of future victims in our society.

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Part Three: Treatment

There are many misconceptions surrounding the treatment of sex offenders. The public may view this activity as ranging from the coddling of offenders, where therapists work to erase guilt and offer unqualified acceptance, to scenes from "The Clockwork Orange," where rapists receive near-lethal electrical shock. Many of the techniques utilized may sound somewhat bizarre to the general population. Thus, therapists and administrators must do everything possible to enlighten the community and dispel any misconceptions. Three areas of misunderstanding are repeatedly encountered—homosexuality, passive or misdemeanor sex crimes, and violent sex crimes.

In the early 1900's, treatment of sex offenders began with individual psychoanalysis for those few, privileged paraphiliacs whose conduct caused them or their families sufficient discomfort to expend considerable money and time on individual treatment. Rarely had these individuals been arrested. Prior to the publication of the *DSM-III*, homosexuals were commonly included among those labeled and treated as sexual deviants. Many of the earlier writings on the topic of deviancy included large numbers of homosexuals, along with pedophiles, exhibitionists, voyeurs, and rapists. Homosexuals who engage in sex between two consenting adults are not considered to be sexually deviant for the purposes of this work. Their behavior rarely results in imprisonment, although it may still be illegal in many states. This conduct is no longer considered to be a mental illness by the American Psychiatric Association except where it causes significant personal distress. It is a popular misconception that men who molest young boys are homosexuals. This is rarely the case. These individuals are frequently heterosexual in their sexual relations with adults. While homosexuals do molest children, they are the exception rather than the rule.

Another area which may cause confusion is the outdated distinction between passive and aggressive sex offenses. Almost all of the incarcerated sex offenders in treatment today are rapists or child molesters, either incest offenders or pedophiles. Exhibitionists, voyeurs, frotteurs, or those who make obscene phone calls may be jailed on misdemeanor charges and referred for counseling but are rarely imprisoned unless their behavior involves other criminal conduct. A decade ago, these individuals were considered to be essentially nuisances, passive individuals who presented little real threat. However, these offenses are now recognized as frequently comprising an escalating pattern of deviant behavior. The sexual addictions model emphasizes the increasing severity of crimes in the development of many sex offenders. Additionally, the actual intent of the individual arrested for a misdemeanor sex offense is frequently difficult to ascertain. The voyeur caught at someone's window may be on the verge of climbing in and committing a rape. Treatment personnel must examine the histories of all sex offenders for patterns of a variety of sex offenses. In those cases where the individual is incarcerated purely for exhibitionism, voyeurism, etc., these behaviors may be treated in the same way as the more serious types of sexual crimes.

A third issue which causes considerable misunderstanding among the public is the use of terms such as "violent rape" or "sadistic sexual assault." Any aggressive act falls along a continuum from those involving threats of violence to threats with weapons to various degrees of physical harm to death. Every sexual assault is a violent act. However, references in this work to "violent rape" or child molestation refer to situations where a considerable amount of unwarranted physical damage is done to the victim. Sadistic sex crimes are very specifically defined as sexual assaults which are usually elaborately planned with a distinctively ritualistic quality. Pain and degradation are systematically inflicted on the victim. Fortunately, sexual sadists represent a very small proportion of sex offenders.

Sex offender treatment is challenging enough without the massive misunderstandings which surround the field. Consequently, professionals in this area must be constantly updating their own knowledge and making this knowledge available to the public. Keeping abreast of the changes in this field is particularly crucial because in many areas the methods are still in their infancy. Because sex offenses have multiple causes even within a single individual, the problem must be addressed on a number of different levels.

Because sex offenders are such a diverse group, treatment must begin with an evaluation of individual assets and deficits. After this is completed, treatment planning can address specific areas of need. A lack of knowledge, particularly in the area of human sexuality, as well as a lack of coping skills can be addressed through psycho-educational modules. Where deviant arousal plays a part, behavioral techniques can be used to recondition sexual preferences. Group therapy can integrate a variety of approaches and address a number of issues simultaneously. Individuals confront their destructive values and thought patterns, work through their own victimization,

examine their deviant cycle, and learn empathy while improving their social skills.

Different types of treatment can be offered during different phases of incarceration. While many offenders are in denial when first incarcerated, a significant proportion have admitted their guilt and are highly motivated. Some type of treatment should be offered to these men before they retreat back into denial. At this initial stage, the principal question is "Why?" "Why would I do such a thing?" Didactic presentations on the origins of sexual deviation, as well as classes in stress management, anger management, and communications skills, can provide only the basic information for the individual to begin his personal exploration, but can give him skills which he can use to adjust to prison. For those individuals in denial, sometimes all that is needed to break this down is the permission given the individual by the group to admit the deed. Even discussing sexual assault in the abstract can open one up to personal admission.

The middle stage of incarceration can continue with the psycho-educational modules while beginning the group process. The final stage, which should probably be started no sooner than two years prior to release, should focus on intensive treatment. Behavioral techniques can be initiated. Offenders may be moved into therapeutic communities and group work intensified. The transitional phase leading to aftercare is crucial in assisting the individual through this difficult period of readjustment.

Administrators are frequently concerned about who should provide sex offender treatment. A psychiatrist in a consulting role should be involved if medication, either specific to sex offenders or utilized to treat accompanying mental illness, will be needed. Since there is very little specific training in sex offender treatment available through any mental health degree program, no discipline is recognized as particularly proficient in this area. The leaders in this field include psychologists, social workers, rehabilitation counselors, criminologists, and educators. Both professionals and paraprofessionals make a valuable contribution. Correctional officers can be trained to facilitate groups and teach modules. Correctional counselors or caseworkers can do this as well. The inmates themselves can also be trained to assist in providing certain treatment techniques under supervision.

The personality of the staff member is probably more important than his/her degree. Even their gender is important. Where at all possible, male-female teams should be used for a variety of reasons.

- The offender needs an appropriate male role model to demonstrate correct social skills and attitudes towards females.
- The offender needs an appropriate female figure with whom he can practice social skills, as well as work through anger, power, or other issues.
- The offender needs a male-female dyad to model appropriate interactions, conflict resolution, and nonsexual relationships.

Each therapist should be able to be confrontive but caring. If the treatment staff do not communicate to the offender their commitment to him as an individual, then when heavy confrontation begins, the offender will usually drop out of therapy outright or withdraw into himself. Substance abuse counselors often do quite well in this work, as many of the dynamics of the two conditions are similar. Staff should be screened for individuals who have unresolved conflicts relating to sexual assault.

A final issue in dealing with this type of treatment is not to oversell it. This is a new, challenging but controversial area. Many people do not accept its efficacy and are just waiting to discredit any program which overstates its effectiveness. Every program will have its failures, and the failures are the ones that will make the front page of the newspaper. The program should be sold, but cautiously.

Chapter 7: Comprehensive Treatment Planning for Sex Offenders

by Randy Green

Abstract

Dr. Green discusses the necessity of good treatment planning, not only for plotting the course of treatment but also as a method of quality control documentation. The use of Goal Attainment Scaling as a quantitative tool for objectively measuring progress is presented.

The delivery of treatment services to sex offenders is a complex and specialized field. Those involved in therapeutic interventions with sex offenders should have not only a general therapeutic background but also specialized training and understanding of the unique dynamics of the sex offender. Inadequate treatment planning or a lack of understanding about sex offenders can result in the mistaken judgment by therapists that an offender has successfully completed treatment and is safe to live in the community. Reinforcement of offenders' denial or minimization problems is often the result of such misunderstanding. While issues of planning, documentation, and evaluation are too frequently perceived as luxuries or scourges by therapists, they are necessary to the establishment and continuation of quality treatment.

Advantages of Comprehensive Treatment Planning

Contemporary treatment programs for sex offenders use a multimodal intervention model which is based on the premise that the causes of sexually deviant behavior are complex and multidetermined (Groth, 1983). A responsible treatment plan might best be defined as a remediation plan which, based on the sex offender's identified resources, problems, needs, and/or deficiencies, uses the most effective, appropriate, and available treatment methods to achieve the offender's treatment goals.

In addition to simplifying the flow of complex interactions and issues, such a plan offers a number of other advantages.

- Individuals who are involved with the sex offender are informed as to what treatment has been offered the client and can see documentation regarding response to that treatment. A comprehensive treatment plan allows one to identify those issues which are yet to be addressed or resolved. Such a plan provides a logical and standardized basis of providing feedback on the offender's treatment status to the offender himself, treatment personnel, and concerned agencies.
- Accountability and professional quality assurance standards can be enhanced by an established treatment planning and documentation process. Such a system invites the clinician to think continuously of needs and objective goals.
- An established treatment plan guides the clinical staff and the client toward a series of treatment objectives. Given the varied clinical issues and staff with diverse training, an effective clinical treatment plan reduces the likelihood of legal liability for clerical errors. Without a treatment plan which continually refocuses everyone to central concerns, staff and client efforts may get sidetracked from core issues onto more peripheral ones. Resources are inevitably limited, so it is important that staff be able to differentiate those issues which are necessary from those which are desirable but not critical. Goal setting and periodic review help to keep staff focused on realistic goals for clients.
- A good treatment plan provides an opportunity to trace the progress of the offender on each goal throughout the treatment record. Periodically, summaries of treatment interventions, coupled with the offender's responses to treatment, can be written in the file. This facilitates a ready reference for anyone desiring a general overview of the offender's treatment.

A Comprehensive Treatment Planning Process

A treatment planning process for a sex offender treatment program includes four steps, which are described below.

Assessment of Treatment Needs

Any type of sex offender treatment flows from a thorough assessment of a sex offender's resources, needs, and deficiencies. It is imperative that a treatment provider has either performed or has access to a thorough assessment (see Chapter 8, Clinical Assessment).

Synthesis of Data

The synthesis of data obtained during the evaluation is a process which helps staff develop a comprehensive plan for treatment intervention. The staff should develop preliminary conclusions regarding the dynamics of the offender, problems and needs which should be addressed in treatment, and those strengths and assets which the offender brings into treatment. Risk management issues, motivation for treatment, intellectual or psychiatric impairment which might influence

response to treatment (such as borderline or mild mental retardation, mood, personality or thought disorders) should be considered in developing a comprehensive perspective on the offender.

From this synthesis, target goals should be established for treatment. The goals should be prioritized and sequenced. For example, the emotional involvement of the offender in treatment is sometimes enhanced by a victim-empathy focus early in the treatment process. Also, information regarding sex offender dynamics and cognitive distortions is frequently placed early to provide the offender with general awareness of concepts and vocabulary used in the program. Goals should be stated in clear, specific, observable terms which can be understood by the staff and the client. They should be realistic, time-limited, and developed in active coordination with the client.

Determination of Clinical Interventions

Following the identification of specific goals, methods are selected which are likely to accomplish them. The range of approaches used in a comprehensive treatment program include, but are not limited to, the following components:

- Psycho-Educational Modules: A series of didactic-experiential educational modules focused on clinically related topics, such as sex offender dynamics, anger management, Relapse Prevention, etc. (see Chapter 10, Psycho-Educational Modules).
- Interpersonal Techniques: Either group, family, marital or individual (see Chapter 11, Interpersonal Techniques).
- Psychological and Behavioral Diaries: Written logs and journals, autobiographies.
- Bibliotherapy Assignments: The use of reading assignments on any number of books and articles which have been written addressing topics of incest, rape, anger management, assertiveness training, irrational beliefs, etc. These can be very constructive treatment adjuncts for those offenders who are able to read. For those who cannot, many of these materials can be put on audiotapes.
- Arousal Reconditioning: Overt or covert methods of counterconditioning, behavioral rehearsal, and/or masturbatory reconditioning (see Chapter 12, Behavioral Techniques).
- Cognitive-Behavioral Techniques: Relapse Prevention methods, identification of deviant cycle, and evaluation of basic incorrect assumptions and perceptions (see Chapter 14, Relapse Prevention).
- Pharmacological Treatments: The employment of neuroleptic or antiandrogenous medication. Typically, these methods are deemed highly intrusive and are prescribed only when other methods appear to be ineffective in remediating the relevant symptom behavior. Clinical use of this method is now being questioned by many professionals in the field (see Chapter 12 on behavioral techniques, including chemical therapies).
- Aftercare Needs: Job search, preparation of a Relapse Prevention plan, and establishment of an ongoing support system to reduce the likelihood of reoffending (see Chapter 13, Aftercare).

Review and Evaluation of Treatment Progress

Every two or three months or as the need dictates, the progress of the offender should be reviewed considering the established goals and assigned treatment. In preparation for the review, it may be helpful to request a relevant assessment. In addition, the offender should be prepared to discuss progress toward each goal. Treatment staff, the offender, and peers involved in the treatment group(s) can all be helpful and desirable participants in such a review. If an offender is not responding to treatment, a revision of treatment goals is advisable. If limited space is available in the program, those clients who are most cooperative and motivated must be given priority.

The clinical treatment planning process is most effective when used regularly and when modified as the need arises. In the process, it keeps treatment relevant and targeted toward the needs of each offender.

Major Treatment Goals for Sex Offenders

Of course, the major goal of sex offender treatment is to reduce victimization, with the hope of reducing victimization for any given offender to zero. There are usually a number of steps between getting an offender into treatment and discharging him into the community with some confidence. Most treatment programs will take on only those offenders who admit their guilt. However, some states mandate that all sex offenders go through treatment. One way to handle this requirement is to place all clients into psycho-educational classes where information on sexual assault, effects on victims, and the dynamics of sexual deviation are discussed. As the clients see that these topics can be discussed in a rational, open manner and hear other clients begin to admit their guilt, still others can begin to open up. However, even for those who refuse to admit their guilt, the classes may expose them to information which they can process on their own.

The goals of treatment progress from owning one's deviant behavior to exploring its origins to identifying its precursors

and substituting alternative coping mechanisms. These goals can be specified on a treatment plan using the Goal Attainment Scaling format (Kiresuk & Sherman, 1968). The goals are weighted for importance and scored according to objective criteria. Of course, the plan must be individualized and may include extended work on substance abuse, family relations, or other special problems. A number of broad goals will be outlined.

Goal I **Admitting guilt.** The offender should be able to openly acknowledge guilt. This admission is a basic requirement for meaningful participation. Offenders proclaiming their innocence make other participants uncomfortable and suspicious. Their participation has a voyeuristic quality to it. They may be viewed as a threat to the confidentiality of the group as they may remain closed and aloof. However, sophisticated therapy groups may welcome the challenge of breaking down denial. This goal can be outlined for Goal Attainment Scaling as follows:

–2 Insists upon innocence. States that it is a case of mistaken identity or revenge on the part of the victim.

–1 Admits that some sort of act may have occurred but insists that either the motivation was not sexual (e.g., hygiene rituals, etc.) or that an adult victim was fully consenting.

0 Admits guilt.

+1 Admits guilt and exonerates victim from any type of complicity.

+2 Admits guilt for current offense as well as other offenses, exonerates victims and recognizes deviant motivations.

Goal II **Accepting responsibility.** Not only must an offender admit his guilt but he must accept full responsibility for it. Offenders frequently acknowledge the deed but blame alcohol, drugs, provocative victim behavior, or other outside factors. The offender must be able to distinguish between understanding the dynamics of his behavior and blaming the behavior on some contributing factor, e.g., his own victimization. Levels of attaining these goals include:

–2 Admits that he performed deed but blames seduction or claims that it is not deviant behavior (e.g., a teacher who molests postpubescent students).

–1 Admits that he performed deed but attributes it to alcohol or drugs or claims that it was a one-time occurrence that will never happen again.

0 Accepts responsibility.

+1 Accepts responsibility and recognizes need for help. Shows some victim empathy.

+2 Accepts responsibility, recognizes need for help, understands dynamics without placing blame. Demonstrates high degree of victim empathy.

Goal III **Understanding dynamics.** Once the offender acknowledges his guilt and assumes responsibility for his behavior, he may feel extremely guilty. He may spend a good deal of time ruminating over his crimes and castigating himself. This energy can be put to much better use investigating the dynamics behind the behavior. Often a major part of dealing with dynamics is dealing with the offender's own victimization. The levels of this goal include:

–2 Minimizes dynamics, claims that since crime was only a situational quirk and will never happen again, there are no underlying dynamics.

–1 Identifies a few superficial dynamics but shows little clear understanding of relationship between dynamics of acts or blames his crime on dynamics.

0 Understands dynamics.

+1 Independently recognizes how dynamics are involved in crime.

+2 Independently identifies dynamics and works actively to resolve these dynamics.

Goal IV **Identifying deviant cycle.** It is often tempting for any mental health client to focus on dynamics, going over and over traumas of the past and assuming a victim stance. The client must be encouraged to deal with and lay aside past traumas, victimizations, and injustices, and identify the chain of immediate precursors to his acting-out. Deviant sexual arousal may be a crucial part of the cycle and will need to be addressed with behavioral techniques (see Chapter 12, Behavioral Techniques). Other deficits related to precursors must be remedied. The levels of this goal include:

–2 Denies that crime was anything but a purely impulsive deed with no recognizable precursors.

–1 Unable to identify cycle through cognitive deficits or claims that alcohol has fogged hismemory of the event.

0 Identifies deviant cycle.

+1 Immediately identifies deviant cycle and is in process of identifying techniques for averting it.

+2 Readily identifies deviant cycle and can readily substitute alternative coping strategies.

Goal V **Making restitution.** The final goal of any victimizing behavior should be to make amends to the victim, either concretely or symbolically. It is not always possible to make actual restitution to the victim. However, clients should be encouraged to do so whenever the victim is available and amenable. Restitution can be in the form of money. Where this is not possible, the offender might apologize through a letter and through the victim's therapist or another third person. If the victim is a family member and the family plans to reunite, much work needs to be devoted to mending the relationship while maintaining the safety of the victim. If the victim is unavailable, offenders may make restitution by supporting victims' assistance groups financially or through in-kind sup-

port (e.g., building dollhouses to be used in play therapy), by participating in media presentations on sexual assault, or by helping other offenders. The levels of this goal include:

- –2 Refuses to make restitution, even through helping peers in group therapy.
- –1 Minimizes ability to make restitution by offering various excuses.
- 0 Makes some type of restitution.
- +1 Makes restitution based on understanding of victim's pain.
- +2 Makes restitution based on empathy for victim in a variety of different ways.

Many other goals may be included over the course of treatment. The individual may need substance abuse treatment, social skills training, vocational training, or family therapy. The Goal Attainment Scaling technique has the advantage of being readily translated into numerical scores which can then be compared (see Table 7.1). A score based on a ceiling of 100 can be calculated using the following formula:

$$GAS = \frac{50 + 10\Sigma_{i=1}^{n} w_i x_i}{\sqrt{(1-p)\Sigma_{i=1}^{n} + p(\Sigma_{i=1}^{n} w_i)^2}}$$

- x_i = raw score or outcome level on the ith scale
- w_i = relative weight attached to ith scale
- p = weighted average intercorrelation of scales (usually set at .30)
- n = number of scales

This system can provide evidence of progress or lack of it to the patient and a method of quality assurance to the program. It is invaluable in research and in improving sex offender treatment.

In summary, comprehensive treatment planning for sex offenders is a complex process which requires trained staff who understand the key components of such treatment and who have an organized process to systematically deliver the core treatment methodologies. While these components are often viewed as fixed integral parts of a sex offender treatment program, they essentially represent state-of-the-art concepts of a still developing specialty field. The field could look very different in the near future and will only be improved by continuous self-examination and program evaluation. Extensive program evaluation must yet take place to determine which methodologies work best with which individuals. Chapter 6 on program evaluation reviews this issue in greater detail.

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Table 7.1

SAMPLE GOAL ATTAINMENT SCALING

	GOAL WEIGHTS				
OUTCOME VARIABLES	I. Admitting Guilt	II. Accepting Responsibility	III. Understanding dynamics	IV. Identifying deviant cycle	V. Making restitution
Most unfavorable treatment outcome thought likely (-2)	Insists on innocence.	Admits crime but blames it on seduction or claims behavior was not deviant.	Minimizes dynamics, denies importance.	Denies that crime had precursors.	Refuses to make restitution.
Less than expected success with treatment (-1)	Admits some part of crime but attributes to victim or rationalizes nature of deed.	Admits guilt but attributes to alcohol, drugs or claims it was one-time occurrence.	Superficially identifies dynamics but shows little understanding.	Unable to identify cycle.	Minimizes ability to make restitution.
Expected success (0)	Admits guilt.	Accepts responsibility.	Understands dynamics.	Identifies cycle.	Makes some type of restitution.
More than expected success with treatment (+1)	Admits guilt and exonerates victim.	Accepts responsibility, recognizes need for help and shows victim empathy.	Recognizes and understands dynamics.	Identifies cycle and begins to develop coping skills.	Makes restitution; empathizes.
Best anticipated treatment (+2)	Admits guilt for current offense & other offenses. Exonerates victim, recognizes deviant motivation.	Accepts responsibility, recognizes need for help, understands dynamics without placing blame, demonstrates empathy.	Independently identifies dynamics and works to resolve them.	Readily identifies cycle and uses coping strategies.	Makes restitution in variety of ways.

Chapter 8: Clinical Assessment of Sex Offenders

by Michael J. Dougher

Abstract

In this chapter, Dr. Dougher outlines the process of assessing the sex offender. He discusses the use of the social history, as well as a variety of different psychological tests. The use of the penile plethysmograph in conducting a physiological assessment is presented.

There are three assumptions which serve as the basis for much of what is discussed in this chapter. First, sex offenders comprise an extremely heterogeneous population which cannot be characterized by single motivational or etiological factors. Recent attempts to develop classification schemes and explanatory theories of sex offenders have cogently argued that sexually offensive behavior is varied, complex, and multiply determined (Finklehor, 1984; Prentky, Cohen, & Seghorn, 1985; Carter & Baird, 1986). Accordingly, any attempt to explain or treat sexually offensive behavior must consider the specific factors pertinent to an individual's offense and the psychological characteristics of the individual offender.

Second, with current techniques, some but not all sex offenders can be effectively treated. Recent reviews by Kelly (1982) and Lanyon (1986) show that treatment with many types of child molesters enjoys an encouraging success rate. Previous work by Abel, Blanchard and Becker (1978) also reports success with some types of rapists. However, other research suggests that excessively violent or sadistic offenders, sociopathic offenders, and offenders not motivated for treatment are almost impossible to treat (Hobson, Boland, & Jamieson, 1985). The task then for those faced with treating sex offenders is to determine who is amenable to treatment and who is not.

Third, adequate treatment involves a comprehensive and individually tailored treatment program. As stated earlier, there is considerable variation in the kind of acts offenders commit, their motivations and their psychological characteristics. Thus, treatment should be tailored to the needs of individual clients. Moreover, a variety of issues or areas of concern need to be addressed in treatment. Deviant sexual arousal, social skills deficits, irrational beliefs and attitudes, anger and stress management, and self-esteem problems are all areas that may demand therapeutic intervention (Barlow, 1974; Abel, Blanchard, & Becker, 1978; Dreiblatt, 1982). It would appear evident that treatment does indeed need to be comprehensive.

If taken to be valid, all three of the assumptions listed above point to the importance of an in-depth and comprehensive assessment of the offender as a prelude to effective treatment planning and implementation. Decisions about treatment amenability, target areas for intervention, and selection of treatment procedures require an adequate information base which can only be acquired through thorough assessment procedures. Moreover, given the fact that many, if not most, sex offenders tend to lie about their offenses and are unreliable and deceptive in their verbal reports, the importance of a thorough assessment cannot be overemphasized.

While comprehensive and thorough assessment procedures are costly and time consuming, it is still essential that they be conducted. With already limited resources, many correctional mental health workers might be tempted to cut corners in the assessment process or feel that comprehensive assessment is beyond available means. However, there are ways to gain a great deal of information at relatively low cost and many of these will be discussed. The point is to get as much information as possible from as many sources as possible.

Generally, assessment in the area of sexual diversity has been concerned with five issues:

1. The assessment of sexual diversity in society (Kinsey, Pomeroy, & Martin, 1948; Kinsey, Pomeroy, Martin, & Gebhard, 1953; Hite, 1981);
2. The identification or diagnosis of sex offenders, usually subsequent to arrest for an alleged offense (Laws, 1984);
3. The identification of sex offender characteristics or a sex offender profile (Marsh, Hilliard, & Liechiti, 1955; Toobert, Bartelme, & Jones, 1959);
4. The determination of treatment amenability and identification of target areas for therapeutic intervention (Laws & Osborn, 1983);
5. The evaluation of treatment outcome (Tracy, Donnelly, Morgenbesser, & MacDonald, 1983).

Assessment Issues

Information regarding the specific offense(s) committed by a sex offender is extremely important to the determination of treatment amenability and the formulation of a treatment program. Factors to be evaluated and their clinical significance determined, as well as suggested interventions, follow.

Nature of Specific Offense

Did the crime involve fondling, masturbation, exhibitionism, rape, beating, sadism, or murder? Generally, any crimes involving extreme violence and sadism should serve as a warning sign and the offender should be more thoroughly assessed.

Victim Characteristics

What are the demographic factors such as age, sex and physical characteristics of the victim(s)? Pedophiles who exclusively assault boys tend to be more resistant to treatment, as are offenders who choose very young victims. Victim characteristics should be used when constructing offense cycle analyses or when using behavior therapy techniques to alter sexual arousal patterns (see Chapter 14, Relapse Prevention, and Chapter 12, Behavioral Techniques).

Antecedents of the Offender's Crimes

Were alcohol or drugs involved? Was the crime committed under conditions of stress or in a particular psychological state such as depression? Was the crime premeditated or spontaneous/ impulsive? The antecedents of an offense are useful in helping the client identify the offense cycle, to target related behavioral or psychological problems, and to gain some information about the type of offender. For example, if stress is a reliable antecedent such as with regressed or situational pedophiles, then stress management procedures may be indicated. Likewise, if drugs or alcohol are typically used before a crime, then drug or alcohol treatment may be warranted. Premeditated offenses tend to be associated more with fixated-preference pedophiles than regressed-situational pedophiles. Offenses with impulsive features may suggest that the offender needs training in impulse control.

Previous Offenses

In general the best predictor of future offenses is the number of previous offenses (Dreiblatt, 1982; Tracy et al., 1983). Obviously then the number of previous offenses, especially those resulting in arrest, is a good predictor of treatment outcome. If there are previous offenses, it is useful to determine whether the modus operandi and antecedent conditions are similar. Compulsive and ritualistic offenders may require different intervention strategies than first-time offenders or those with no particular offense pattern.

Level of Psychopathology

The presence of psychopathology, apart from the offender's actual crime, has important relevance for treatment. If a psychosis is present, medication may be required and treatment techniques will be limited. Some behavioral methods cannot be utilized if the client's physiological functioning is affected by medication. Career criminals and others with entrenched antisocial personalities rarely respond positively to treatment.

Developmental History

Such factors as the offender's relationship to his parents and siblings and the nature of the offender's family relations are important to assess. In particular, information should be gathered about any abuse, neglect or trauma suffered, parental death or abandonment, methods of discipline, use of ridicule, family sexual behavior, and the adequacy of parental role models. These areas have obvious implications in the development of the offender's characteristics. Insight-oriented therapy, flooding or desensitization techniques may be warranted to deal with the emotional remnants of the offender's abuse.

Educational History

This characteristic varies tremendously among offenders. Specifically targeted areas should be school performance and level of education, classroom behavior, intelligence level, and the presence of any learning disabilities. School performance gives some information about the offender's ability to persist at long-term goals and his self-discipline and self-esteem. These characteristics correlate with positive treatment outcome. Continued education may become a treatment goal. A lack of intellectual ability might preclude certain verbal therapies or imagery-based behavior therapy.

Social History

There is likely to be considerable variation among offenders concerning their social histories. Of particular importance are the nature of the offender's relations with peers, the nature and duration of his friendships, the relative age of his friends, the nature and extent of social isolation, his stability in relationships, and whether the offender was active or passive in his social relations. Obviously, interpersonal relations are of central concern when dealing with the sex offender. If the offender is lacking in social skills, then social skills training may be in order. If debilitating social anxiety is present, especially in social settings with women, desensitization may be warranted. Passivity or, alternatively, dominance may characterize the offender's social relations and may thus serve as targets of intervention through group therapy. Extreme social isolation may also indicate a more severe psychopathology or personality disorder.

Sexual History, Experience, and Knowledge

Limited sexual experience and knowledge among sex offenders is not unusual despite the nature of their crimes. Also common is an excessively rigid and puritanical attitude about sexuality. Assessment should focus on the nature, quality and quantity of previous sexual experiences. Age and type of first sexual encounter should be determined as well as the nature of masturbatory fantasies and the use of pornography. Additionally, assessment should be made of any sexual trauma or victimization. Any history of sexual dysfunction should be

ascertained. Information on the history, severity, and frequency of sexually deviant and offensive acts should be gathered. Sex education or sex therapy may be appropriate therapeutic interventions. Information about sexual fantasies and deviations should be included in the development of specific behavioral interventions aimed at sexual arousal patterns.

Religious Beliefs

Religious beliefs should be thoroughly evaluated with this population. These individuals frequently come from religious backgrounds which instill repressive sexual attitudes, fear of adult sexuality, and a lack of accurate sexual knowledge. Other individuals escape from the guilt and responsibility of their crimes by suddenly becoming extremely religious. They often state that they no longer need treatment because they have been forgiven for their sins. Individuals of certain denominations may express religious objections to certain types of assessment or treatment procedures including the viewing of sexually explicit materials or techniques using masturbation.

Occupational History

It is useful to obtain a record of the offender's work history, including types of jobs, job performance, level of responsibility, and employment stability. As with educational history, an occupational history can reflect a person's ability to persist at a task or pursue long-term goals. Job stability may also indicate good frustration tolerance, as well as the ability to cooperate with others, especially authority figures. Occupational training may be warranted as part of treatment.

Level of Anger

It is a common observation that many sex offenders harbor substantial anger which is frequently directed toward women. While this is most prevalent in rapists and exhibitionists, it is also present in many pedophiles. Since anger may serve as a primary source of motivation for many sex crimes, it is an important target area for assessment and treatment. Insight-oriented therapy or anger management training may be used (Novaco, 1975).

Level of Responsibility and Ability to Empathize

All too often sex offenders are unwilling to take responsibility for their offenses or fail to understand the traumatic impact on their victims. Pedophiles tend to blame children for being too seductive or interested in sex while claiming that their own sexual activities with children are educational and in the best interest of the child. Rapists can also be heard to blame their attacks on the sexually provocative style of their victims or on the worn-out and offensive assertion that women secretly wish to be raped. Moreover, it is not unusual to find rapists surprised by the traumatic effects of their crimes. Failure to take responsibility for their actions or to empathize with their victim's plight is a primary target for assessment and treatment. Group therapy and cognitive-behavioral techniques are useful methods of confronting the irrational beliefs held by sex offenders regarding their own psychopathology. Empathy training or victim confrontation techniques can be useful in enhancing the offender's awareness of the often devastating effects of his crime.

Awareness of Emotions

A common problem with sex offenders, especially with regressed-situational pedophiles, is their lack of awareness and the inability to cope with their emotions. Feelings of anger, tension, sexual arousal, inferiority, etc., are often denied by offenders until it is too late. Consequently, effective means of coping with these emotions are not employed. Verbal insight therapy, group therapy, and stress inoculation (Meichenbaum & Novaco, 1978) or stress management procedures can all be useful in helping offenders identify the source and presence of emotional reactions and effectively respond to them.

Cognitive Distortions about Men, Women, and Children

Sex offenders often have irrational beliefs about who is responsible for their sexual offenses and the impact the crimes have on their victims. These irrational beliefs are frequently concerned with what it means to be a man, the psychology of women, and the inherent vulnerability of children. A desire to project a "macho" image or, conversely, low self-confidence regarding one's masculinity is common among offenders. Ridiculous beliefs, such as all women are rejecting, domineering, and calculating are also typical. Finally, the idea that children benefit from and enjoy sexual encounters with adults is a very common belief, particularly among fixated-preference pedophiles. Sex education, group therapy, and cognitive-behavioral techniques may be useful procedures in dealing with these problematic beliefs.

Sexual Arousal

It is now widely accepted that deviant arousal plays an important role in the commission of sex crimes. Barlow (1974), Abel and his colleagues (1976, 1978) and Laws (1984) have all argued cogently that sexual arousal must be a primary target of intervention in the comprehensive treatment of sex offenders. Moreover, as early as 1965, McGuire, Carlisle and Young argued that deviant sexual fantasies, coupled with masturbation, play an important etiological role in sexually deviant behavior. Finally, Quinsey (1981) argues that the best

available predictor of long-term therapy success is the reduction of deviant sexual arousal coupled with an adequately high level of appropriate sexual arousal. Deviant sexual arousal is a primary target area for assessment and treatment. Behavior therapy techniques are particularly useful in modifying deviant arousal patterns (Quinsey & Marshall, 1983). (Also see Chapter 12, Behavioral Techniques.)

Assessment Procedures

A variety of techniques have been used to assess and evaluate sex offenders. These techniques include clinical interviews, self-reporting, psychological tests, questionnaires, rating scales, and physiological measures. Each of these techniques will be discussed. It should be mentioned, however, that whenever possible a medical and/or neuropsychological exam should be conducted in addition to a psychological assessment. Some medical and neurological disorders manifest as sexually deviant behaviors (Berlin, 1983).

The Clinical Interview

The clinical interview is by far the most commonly used and may be the most important assessment procedure with sex offenders. It must be kept in mind, however, that sex offenders are notoriously unreliable and deceptive in their verbal reports, and all information so obtained must be viewed with skepticism. In this regard it is useful to obtain as much collateral information as possible when conducting an interview. Such information includes police reports, arrest records, any previous psychological and medical reports, previous statements made by the offender, and any information that can be obtained from others who know the offender. The information obtained can then be used to corroborate the offender's statements in an attempt to assess his veracity and reliability or to confront him when discrepant information is uncovered.

The goal of the clinical interview is to obtain as much information as possible with as much detail as possible. As this can be a time consuming process, alternatives and supplements to the interview process can be very helpful. These include having the offender create a detailed autobiography or completing specific questionnaires. Nevertheless, these should never substitute completely for the interview because so much additional and useful information can be obtained through the personal interaction of an interviewer. For example, behavioral observations, follow-up detail questions, and exploration of discrepancies between what the offender has reported and what is included in official records can best be obtained in this setting.

The clinical interview should be comprehensive. Beginning with the offender's earliest recollection of his childhood and family situation, the interview should progress through his educational, social, sexual and occupational history. (See appended evaluation, Appendix A.) It should also include detailed probing into the nature of the offender's sex crimes with an emphasis on their antecedents. An excellent model for the clinical interview is the autobiographical outline used in the Transitional Sex Offender Program at Lino Lakes, Minnesota. (A copy of the outline may be found in Appendix B.)

Psychological Tests

The use of psychological tests with sex offenders has a long history although their use has primarily been to identify personality characteristics of offenders or to create a psychological profile of the sex offender. Unfortunately, these attempts have not been very successful. One reason for the lack of success in accomplishing their intended goals is that the tests were not constructed for use with sex offenders. Another reason is that they require a high degree of inference which reduces their reliability. Nevertheless, psychological tests can be useful in combination with other assessment procedures to create a clinical picture of an offender and to identify target areas for clinical interventions. Those tests which are most frequently used with offenders will be discussed here. However, mental health workers who deal with sex offenders are encouraged to use whatever assessment procedures are considered helpful, as long as those procedures are used appropriately. No test should be the sole source for identifying, diagnosing or classifying sex offenders; rather, it should be used as part of a more comprehensive assessment procedure and as an aid in identifying target areas for clinical intervention.

Projective Tests

Early work with sex offenders focused heavily on the use of the Rorschach to identify the underlying dynamics of the population and to determine whether there were signs or responses that differentiated sex offenders from other populations (Pascal & Herzberg, 1952; Hammer, 1954; Hammer & Jacks, 1955). As mentioned earlier, not much came of this work. The reliability and validity of these procedures never held up (Laws, 1984).

While not strongly recommended, projective techniques with sex offenders should only be used as part of a more comprehensive assessment procedure to aid in obtaining general clinical information.

Objective Tests

The psychological test most frequently used with sex offenders has been the Minnesota Multiphasic Personality Inventory (MMPI). Early efforts with this test attempted to identify a profile characteristic of sex offenders (McCreary, 1975) and to develop scales comprised of selected items which seemed to discriminate sex offenders from other populations (Marsh

et al., 1955; Toobert et al., 1959). Although these profiles and scales are often generated through sophisticated statistical procedures, they have not been shown to differentiate sex offenders from other populations reliably (Rada, 1978). Consequently, as is the case with projective tests, the MMPI should not be used as a means for identifying, diagnosing, or classifying sex offenders. This does not mean that the MMPI cannot be valuable as an assessment tool, provided it is used to identify personality characteristics and relevant clinical issues for individual offenders.

Obvious uses of the MMPI with sex offenders include identifying those who have psychotic processes or personality disorders. However, the usefulness of the MMPI is not restricted to offenders with severe pathology. Even when all scale scores are within normal limits, interpretation can be useful. Graham (1977) and Greene (1980) provide useful interpretations of profiles and high-point pairs even when all scores are within the normal range. For example, if an offender produces a profile with high-point pairs on Scales Four (psychopathic deviance) and Three (hysteria), or on Scales Four and Ten (social isolation), this information has clinical implications. With the former pairing, one might be more concerned with the offender's level of repressed hostility or unrecognized stress; with the latter, issues around social withdrawal and social anxiety might be more prevalent.

The validity scales can also be of value. The extent to which an offender is dishonest, defensive or malingering has obvious implications for treatment amenability and prognosis.

There are some objective tests which have been specifically constructed to gather information about sexual knowledge, experiences, attitudes, interests, and behaviors. One example is the Sex Knowledge and Attitude Test (Lief & Reed, 1972). While not particularly useful in identifying or classifying offenders, this test can help determine an offender's knowledge and attitudes about sexuality.

The Sex Inventory (Thorne, 1966) and the Clarke Sexual History Questionnaire (SHQ) (Paitich, Langevin, Freeman, Mann, & Handy, 1977; Langevin, 1983) are inventories that tap specific sexual interests and activities. The Thorne Inventory also measures sexual conflicts, fixations, repressions, control, confidence, and promiscuity, while the Clarke SHQ measures the frequency of various sexual behaviors as well as disgust for any sexual behaviors. The clinical utility of the tests is obvious when trying to assess offenders' sexual histories, proclivities and attitudes or designing a specific treatment plan. Moreover, both tests have been shown to be able to differentiate offenders from nonoffenders, although only the Clarke SHQ has been able to differentiate among offenders.

A particularly promising test for measuring sexual interests and behaviors is the Multiphasic Sex Inventory (MSI) developed by Nichols and Molinder (1984). The MSI is a 300-item, true-false test with 14 clinical and validity scales. Three of the clinical scales measure sexually offensive behavior (rape, child molestation, exhibitionism), five measure sexual deviations, four measure sexual dysfunction, one measures sexual knowledge and attitudes, and one scale is a measure of the offender's treatment attitudes. One positive aspect of the MSI is that it has been normed on populations of sex offenders. In addition, the test enjoys good psychometric properties and comes with an elaborate interpretive guide. Although more research with the MSI is needed, especially regarding cross-validation, it holds particular promise for clinicians working with incarcerated sex offenders.

In addition to the use of psychological tests, sexual interests and behaviors can be assessed in a less formal way. For example, Laws (1984) describes a card-sort procedure in which offenders are requested to sort a set of cards, each of which describes some sexual activity, into piles corresponding to the level of sexual arousal. The activities described include homosexuality, heterosexuality, rape, masochism, sadism, male pedophilia, female pedophilia, voyeurism, and exhibitionism. In addition, several treatment facilities have developed extensive questionnaires which ask for specific details of various sexual experiences.

Assessment of Social Skills

Most clinical descriptions of sex offenders refer to a deficiency in the area of social skills (Cohen, Seghorn, & Calmas, 1969). Specific aspects of social skills, such as assertiveness, can be tapped by relevant inventories such as the Rathus Assertiveness Scale (1973). However, more global social skills assessment generally involves role playing (Bellack, 1983), where clients are typically instructed to act out some contrived scenario in the presence of others. These scenarios are then either videotaped or observed by raters who judge the level of specific skills. Often clients view the videotapes themselves and generate corrective solutions to their observed deficiencies. There is a considerable body of literature concerned with social skills assessment and training which may prove useful to clinicians working with sex offenders (Turner & Hersen, 1981).

Psychophysiological Procedures

The discussion thus far has been restricted to psychological assessment techniques. While these techniques are certainly useful and should be used, they are not sufficient in themselves. The literature has become increasingly clear that deviant sexual arousal is an essential aspect of a comprehensive assessment procedure and may even be the single most important measure (Wincze, 1982; Earls & Marshall, 1983; Laws & Osborn, 1983; Laws, 1984). Direct measures of penile erection appear to be the only reliable and valid measure (Zuckerman, 1971) (see Chapter 9 on the penile plethysmo-

graph). Currently measures of penile circumference are most commonly used (Geer, 1980; Earls & Marshall, 1983; Laws & Osborn, 1983).

The most common approach to the measurement of sexual arousal involves having offenders attach a gauge around their penises. Deviant and nondeviant sexual stimuli are then presented to the offender, and changes in the circumference of the penis are recorded on a strip chart recorder. The strip chart produces a record of changes in the offender's erection to each of the stimuli presented. In this way, differential sexual arousal can easily be observed.

There are a few private companies that manufacture and sell complete systems for assessing sexual arousal (sometimes called a penile plethysmograph). With some knowledge of electronics, however, virtually any strip chart recorder can be adapted to measure and record penile responses.

Sexual stimuli can be presented to offenders through three modalities: slides, audiotapes and videotapes. Some researchers argue that slides are typically more arousing than audiotapes (Laws & Osborn, 1983). There tends to be considerable variation among researchers as to which modality elicits the strongest responses. It is a good idea to try different methods with an offender in order to determine which one is maximally arousing for that particular person. Regardless of the method, offenders should be presented with a variety of deviant and nondeviant stimuli in order to be sure of the presence and extent of their arousal pattern. It is often the case that many offenders are unwilling or even unable to reveal their arousal to deviant stimuli or activities. For this reason, it is useful to expose the offender to as wide a range of stimuli as is practical.

Deviant and appropriate slides can be obtained from commercial sources or from various treatment programs around the country. Explicit child pornography can often be difficult to obtain, but local law enforcement agencies—or even the offenders in treatment—may be good sources for this type of material. It is advisable to inform local legal authorities that one has such materials and why. Most state statutes against the possession of obscene materials have provisions which allow the possession of such materials for research and treatment.

Audiotapes are the easiest source of stimuli to produce. Both appropriate and deviant sexual activities can simply be described and recorded. Offenders' deviant and appropriate experiences and fantasies can serve as an excellent source for these tapes. These tapes can be continuously refined to produce maximum levels of arousal and to minimize boredom with repeated presentations.

Except for child pornography, videotapes of virtually any kind of sexual activity can be easily obtained. Rape, sadism, bestiality, bondage and discipline, and a variety of other deviant as well as mutually consenting and nondeviant sexual activity are readily available. Gene Abel (Abel & Blanchard, 1976) has produced a series of videotapes depicting mutually consenting sex, rape and assault which may be particularly useful for assessment purposes. These tapes attempt to minimize extraneous sexual stimuli by eliminating sound and scenes of exposed genitalia which might in themselves elicit sexual arousal.

Regardless of the modality, deviant stimuli are typically presented for two and three minutes. Several stimuli can be presented within a given assessment session although care must be taken not to satiate offenders with sexual stimuli which may diminish their responsiveness. Unfortunately there is little research on the physiological assessment of sexual arousal. Therefore, it is not possible to give specific guidelines for the number of stimulus presentations per session or even the length of an assessment session. One study (Julien & Over, 1984) suggests that habituation was not a problem when normal males were presented with eight 12-minute depictions of sexual activity, even over a five-day period. Nevertheless, caution is urged when presenting large numbers of stimuli. It is best to schedule repeated assessment sessions over several days.

Sexual arousal is typically reported in terms of the percentage of maximal erection. Clients are generally instructed to masturbate to 100% erection and measurement of maximum penile circumference is then taken. Subsequent arousal levels are then calculated as a percentage of the maximum erection. Laws and Osborn (1983) offer a guide to interpreting arousal levels. They have subdivided arousal levels as follows: 0-20%, no arousal; 20-40%, low arousal; 40-60%, moderate arousal; 60-80%, high arousal; and 80-100%, very high arousal. They argue that at least a moderate level of arousal is necessary for clear judgment and evaluation of treatment possibilities.

It is important to note that simply the presence of deviant arousal is not an indication of sexual preferences or deviant tendencies. It is important to consider deviant arousal in relation to the magnitude of nondeviant arousal. If appropriate arousal is low, then moderate levels of deviant arousal may warrant treatment. Conversely, if appropriate arousal is high, then moderate deviant arousal may not be of any clinical concern. Abel (1976) has developed a rape index which is used to differentiate rapists from other offenders and normals. The index is a ratio of the percentage of an offender's arousal to rape stimuli, compared to his percentage of arousal to mutually consenting sex.

Although direct physiological monitoring of sexual arousal is probably the best available measure, it is certainly not infallible. To some extent, offenders can exert control over their arousal and thus create an appropriate-looking record. While all faking cannot be eliminated, some steps can be taken to minimize the offender's tendency to fake. It is advisable to observe offenders periodically while they are undergoing

assessment in order to be sure they are not manipulating themselves or the gauges. It is necessary to determine whether the offenders are attending to the stimulus materials being presented and not to some fantasy of their own. One technique to evaluate this is to have them describe the slides or videotapes or to answer factual questions about the stimuli after the presentation. Offenders should also be asked to give subjective ratings of their arousal, which can then be compared to the objective rating and assist in detecting any obvious discrepancies. Offenders who show strong arousal to deviant stimuli but give low subjective ratings may be trying to deceive the examiner, and their records should be viewed as suspect.

Finally, stimuli should be presented under two different instructional conditions. For certain stimuli, offenders should be told to try to enhance their arousal; for others, they should be instructed to suppress their arousal. Difference in arousal levels between the two instructional conditions can then be used as an indicator of the degree to which cognitive suppression of arousal is possible for that particular client.

While the data obtained from physiological procedures is objective and useful, caution is urged in interpreting it. It should be remembered that the setting in which this data is obtained is quite different from the real world. There will be some inherent variation within subjects over time and this data is susceptible to cognitive influence. As discussed earlier, this data should never be used exclusively to identify, diagnose or classify offenders but must be interpreted cautiously and within the context of the offender's history, available records and psychological characteristics.

The assessment procedures for sex offenders described above should provide a comprehensive base of information that can be useful in generating effective treatment programs for individuals. While no assessment procedures are capable of identifying offenders apart from their criminal history, these procedures can be used to create a clinical picture of the offender and to identify specific target areas for clinical intervention and treatment.

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Chapter 9: The Penile Plethysmograph

by William D. Pithers and D. R. Laws

Abstract

This chapter dispels many of the myths regarding the use of the penile plethysmograph. Its use as an assessment and treatment device is clarified.

Traditionally, a client's self-report of symptoms has been the primary method through which a therapist has evaluated treatment needs and outcomes. Although many clients are able to accurately perceive and report their current functioning, some individuals suffer from disorders that affect their thought processes to such an extent that self-reported information is invalid. Sometimes an evaluation occurs under circumstances in which the clients have a vested interest in the outcome (e.g., competence to stand trial) that might affect their symptom presentation.

Regardless of the circumstances, some response bias in self-reported information is always to be expected. To minimize inaccuracies of self-report, many psychometric devices include specialized validity scales, designed to detect overly self-protective or self-disclosing response tendencies.

Assessment of the sexual aggressor poses difficulties beyond those encountered with traditional mental health clients. In many instances, the sexual aggressor has not entered therapy on his own accord. More typically, sex offenders reluctantly seek therapy after their abuses have been discovered by authority figures or significant others. Often, the offender views his disorder as problematic solely because it led to his arrest, conviction, and imprisonment. For such individuals, leaving prison and treatment as soon as possible, rather than achieving attitudinal and behavioral change, represents the goals of therapy. Due to these circumstances, the sexual aggressor's self-report may be particularly suspect.

Since many sexual aggressors prefer to describe their deviant sexual interests inaccurately, therapists must have access to an evaluative procedure that objectively and reliably measures an individual's sexual arousal pattern. The penile plethysmograph is regarded by experts in the treatment of sexual aggressors as the only ethical, reliable, and valid means of assessing a male's pattern of sexual arousal.

Penile plethysmography is an essential technology in the assessment and treatment of the sexual aggressor. Dr. James Breiling of the Antisocial and Violent Behavior Branch of the National Institute of Mental Health (personal communication, July 11, 1983) has stated that any restrictions imposed on a specially trained clinician's ability to employ the plethysmograph in assessing and treating sexual offenders "would be analogous to depriving a physician the right to obtain x-rays in cases of bone injuries." This technology offers information about an individual's specific treatment needs and provides a clear criterion of his response to treatment.

Information contained in this chapter represents an introduction to the basic concepts of penile plethysmography. The rationale for employing the plethysmograph will be summarized, as will the types of information that may be derived from this technology. The importance of integrating this type of information with data from other evaluative procedures is emphasized. The chapter discusses current uses and potential abuses of the plethysmograph. The need for mental health professionals to obtain specialized training before employing the plethysmograph is strongly emphasized. Factors that may affect the validity of evaluations are also presented.

This chapter is not intended to prepare clinicians to conduct plethysmographic evaluations. Only supervised experience will provide professionals with the necessary skill to conduct this type of assessment.

Penile Plethysmography as a Technology

Measurement of sexual arousal patterns is recognized as a necessary component of sex offender treatment programs. A national survey identified 297 treatment programs for adult sex offenders (Knopp, Rosenberg, & Stevenson, 1986). Of these, 215 (72%) provided outpatient services and 82 (28%) were institutional programs in corrections or mental health facilities. Behavioral methods were used by 64% of all programs, while counterconditioning occurred in 32%. Penile plethysmography to measure sexual arousal in clients was used in 27% of the programs. On the basis of this survey, behavioral assessment and treatment techniques appear to represent a major component of therapeutic interventions used with sex offenders.

Plethysmography is defined as the use of an instrument for "determining and registering variations in the size of an organ or limb" (Webster's Unabridged Dictionary, 1971, p. 1740). The application to measurement of male sexual arousal is obvious. An electronic device, called a penile transducer, is attached to the penis by the client. It detects changes in the size of the organ from a state of no sexual arousal (flaccidity) to a state of complete arousal (full erection). If one presents sexual stimuli of both deviant and nondeviant content to a client while measuring his sexual response, the associated degrees of erection provide an indication of his sexual interests, preferences, and inhibitions.

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Information contained in this chapter represents an introduction to the basic concepts of penile plethysmography. The rationale for employing the plethysmograph will be summarized, as will the types of information that may be derived from this technology. The importance of integrating this type of information with data from other evaluative procedures is emphasized. The chapter discusses current uses and potential abuses of the plethysmograph. The need for mental health professionals to obtain specialized training before employing the plethysmograph is strongly emphasized. Factors that may affect the validity of evaluations are also presented.

This chapter is not intended to prepare clinicians to conduct plethysmographic evaluations. Only supervised experience will provide professionals with the necessary skill to conduct this type of assessment.

Penile Plethysmography as a Technology

Measurement of sexual arousal patterns is recognized as a necessary component of sex offender treatment programs. A national survey identified 297 treatment programs for adult sex offenders (Knopp, Rosenberg, & Stevenson, 1986). Of these, 215 (72%) provided outpatient services and 82 (28%) were institutional programs in corrections or mental health facilities. Behavioral methods were used by 64% of all programs, while counterconditioning occurred in 32%. Penile plethysmography to measure sexual arousal in clients was used in 27% of the programs. On the basis of this survey, behavioral assessment and treatment techniques appear to represent a major component of therapeutic interventions used with sex offenders.

Plethysmography is defined as the use of an instrument for "determining and registering variations in the size of an organ or limb" (Webster's Unabridged Dictionary, 1971, p. 1740). The application to measurement of male sexual arousal is obvious. An electronic device, called a penile transducer, is attached to the penis by the client. It detects changes in the size of the organ from a state of no sexual arousal (flaccidity) to a state of complete arousal (full erection). If one presents sexual stimuli of both deviant and nondeviant content to a client while measuring his sexual response, the associated degrees of erection provide an indication of his sexual interests, preferences, and inhibitions.

This technology is used in two ways. First, it may be used as an assessment technique to evaluate the client's interest in or preference for abusive versus nonabusive sexual activities. Second, the plethysmograph is used as one of a variety of measures to indicate a client's success or failure in treatment. In effective treatment, one expects to see a progressive decline in deviant sexual arousal and/or an incremental increase in sexual arousal to depictions of consenting sexual acts.

The work of Masters and Johnson (1966) showed that a variety of physiological responses occurred concurrently during sexual behavior. However, responses such as increased heart rate, increased respiration, flushing, sweating, and changes in galvanic skin response all occur in the same form in other states of heightened physiological arousal. For purposes of assessment and treatment of sex offenders, penile erection response serves as the best single dependent variable. For maximum effectiveness, plethysmographic measures should be supplemented by other data, such as subjective estimates of levels of sexual arousal, self-reports of the percentage of deviant and nondeviant sexual fantasies, frequency of masturbation and content of the accompanying fantasies, card sorts, and other indicators of sexual interest and performance.

Inclusion of the penile plethysmograph in comprehensive treatment programs for sex offenders offers numerous advantages. Among these advantages are: 1) identification of individuals who manifest excessive arousal in response to stimuli depicting sexual abuse, 2) discernment of lack of arousal to stimuli of consenting sex, 3) identification of offenders whose arousal disorder necessitates specialized behavioral therapies, 4) minimization of distortions evident in self-reported levels of arousal, 5) evaluation of therapeutic efficacy, and 6) enhancement of certain forms of behavioral therapy.

Identification of Deviant Sexual Arousal

Many accounts have been proposed to explain the etiology of deviant sexual behavior (Laws, in press). Certainly, sexual offenses typically are caused by the interplay of numerous factors (e.g., emotional mismanagement, self-hatred, cognitive distortions, inadequate social skills, etc.). In most cases, no single factor represents the causal agent. Therefore, assessment of sexual aggressors must be wide-ranging, including measures of the offender's emotions, knowledge, behaviors, and beliefs. In this fashion, the specific factors predisposing each offender's abusive sexual acts may be determined and ameliorated by prescriptive therapies.

A major factor predisposing sexually abusive acts of some offenders is a disordered sexual arousal pattern. While one may reasonably speculate that most adult males prefer adult females as consenting sexual partners, research demonstrates that a significant subset of offenders harbors preference for sexual acts with children or acts that stress sexual violence.

In a review of assessment data from a random selection of 200 sex offenders, Pithers, Kashima, Cumming, Beal, and Buell (1987) found that 69% of the rapists and 57% of the pedophiles exhibited deviant sexual preferences during plethysmographic evaluation. In this sample, more pedophiles manifested greater sexual arousal in response to depictions of children than to images of adults. Similarly, a greater percentage of rapists found visual representations of rape to be more sexually arousing than stimuli of consenting sexual acts.

Thus, some rapists experience greater sexual excitement in response to situations containing a fusion of violence and sexual activity than to depictions of sexualized affection. Attempts to victimize children may be driven by a sexual preference for those who have not yet developed secondary sexual characteristics. Although such men may periodically engage in consenting sex with peers or reveal a history of occasional attempts to do so, their predilection is toward sexual abuse. Once excessive arousal to deviant fantasies has been discerned through plethysmographic evaluation, highly specialized treatments may be implemented to decrease arousal to abusive acts.

Identification of Lack of Normal Sexual Arousal

Stimuli depicting consenting sexual acts with peers may evoke little arousal from some offenders. Rather than expressing the pleasures of intimacy and an ultimate acceptance of another person, sex may represent a frightening exposure of personal inadequacy to individuals afflicted by diminished self-esteem. For men whose lives are imbued with hatred, the notion of sexually expressing affection and respect for another may seem acutely alien. Regardless of its etiology, lack of arousal to consenting sex with peers may be problematic. Minimally, such a dysfunction may be frustrating. Maximally, offenders may rationalize their abusive behaviors as being attributable to their inability to participate in consenting sex with peers.

In a study examining precursors to sexual offenses, sexual dysfunctions were noted in 11% of both the rapist and pedophile samples (Pithers, Kashima, Cumming, Beal, & Buell, 1987). Since most sexually dysfunctional males do not victimize others, dysfunction obviously cannot be considered a causal factor of sexual abuse. However, in conjunction with other factors, inability to engage in affectionate sexual relationships with peers appears related to some offenders' crimes.

Increasing sexual arousal to consenting relationships with peers may provide offenders with an opportunity to communicate sexually in an effective manner, rather than attempting to meet their emotional needs through behaviors damaging to others. A combination of specialized behavioral treatment (e.g., orgasmic reconditioning) and group therapy may enable

sex offenders to develop increased levels of arousal to depictions of consensual sex.

Determination of Need for Specialized Behavioral Therapies

Identifying offenders who have disordered sexual preferences is essential to establishing effective treatment. Existence of a disordered arousal pattern does not signify an offender is untreatable but is an indication that specific forms of behavioral therapy must be undertaken to assist the offender to alter his preference pattern. Several of these behavioral interventions are described elsewhere in this monograph (see Chapter 12, Behavioral Techniques).

Neglecting to evaluate an offender's arousal pattern may result in failure to treat a central etiological factor of that offender's abusive behaviors. In such a situation, the offender may accomplish changes in many aspects of his therapy but continue to have a preference for sexual abuse. For example, if pedophiles harboring sexual preference for children participate only in group therapy to enhance communication skills, treatment will likely yield a pedophile with social skills. In the absence of specialized intervention, deviant arousal patterns are unlikely to change and the offender may be at high risk of relapse.

Minimization of Client Misrepresentation

Sex offenders are notorious for misrepresenting their favorite fantasies and behaviors. Minimization of one's sexual offense is not an unusual event, particularly during the early stages of therapy. Since the plethysmograph does not rely entirely on honesty of self-report for accuracy, the assessment procedure may yield information that the offender has been reluctant to disclose. The penile plethysmograph represents the only objective, valid method of assessing an offender's sexual arousal pattern.

Once an accurate representation of the offender's sexual preferences has been gained through plethysmographic evaluation, confronting the offender with this information encourages increased honesty and fosters additional self-disclosure. In one study, 55.5% of a sample of 90 offenders acknowledged additional paraphilias when confronted by a variety of assessment data, with the penile plethysmograph being the source of 62.2% of the added admissions (Abel, Cunningham-Rathner, Becker, & McHugh, 1983). In clinical application, the results of a plethysmographic evaluation often enable denying offenders to accept responsibility for their crimes.

Although the penile plethysmograph is critical to assessment and treatment of sexual aggressors, it seldom should be the only procedure employed in evaluation of such clients. While the plethysmograph may be used alone to examine changes in arousal pattern as a result of behavioral therapy, integration of data derived from personality assessment, behavioral observation, self-report, evaluation of functional skills, and assessment of the client's attitudes and values remains the only method of obtaining a comprehensive representation of an individual's functioning. However, assessment of a sexual aggressor cannot be considered complete until information about his sexual arousal pattern can be acquired.

Objective Evaluation of Change

In some instances, offenders acknowledge deviant sexual preferences during an initial interview, without need of plethysmographic evaluation. Although such an admission may be viewed by some as a favorable prognosticator for change, clinicians are advised to avoid the pitfall of assuming that, since the offender forthrightly attested to his deviant interests at the onset of therapy, he will be equally honest later on.

If attaining a normal arousal pattern is a criterion for completing treatment and if completing treatment is necessary for parole, even well intended offenders will be tempted to deny the existence of any interest in abusive acts. Dependent clients may deny experiencing deviant fantasies, in a misguided effort to please an admired therapist. Individuals paying for outpatient therapy may report an absence of abusive fantasies in order to avoid further expense. Thus, even offenders who honestly disclose deviant fantasies at the onset of treatment have powerful incentives to report dishonestly later on.

Even when offenders openly acknowledge deviant fantasies at the beginning of treatment, completing a plethysmographic evaluation is necessary to gain a baseline against which the results of later assessments may be contrasted. In this fashion, the effects of treatment may be documented objectively.

Monitoring of Behavioral Therapies

While the penile plethysmograph is used primarily as an assessment technique, some forms of behavioral therapy may be performed most effectively when using a plethysmograph to monitor treatment sessions. Olfactory aversive conditioning represents one behavioral intervention that may be facilitated by use of the plethysmograph.

In olfactory aversive conditioning, arousal to stimuli depicting sexual abuse is paired with a noxious odor. Typically, presenting the unpleasant odor leads to rapid loss of erection. After repeated pairings of the aversive odor and deviant stimulus, deviant stimuli no longer elicit arousal.

Research on aversive conditioning has demonstrated that the effects of treatment vary depending on when the noxious stimulus is presented. When the stimulus is repeatedly presented after the client has developed a relatively high level of sexual arousal, the offender simply becomes less responsive to the deviant stimulus. However, if the aversive stimulus occurs when response to the deviant sexual scenario is at

a low level, sexual response to stimuli depicting consenting sexual acts is paradoxically heightened. Thus, the impact of some forms of behavioral therapy may be increased through utilization of the penile plethysmograph.

Setting Up a Laboratory

Most traditionally trained mental health professionals have never seen a behavioral laboratory and have little idea of its essential components. The basic requirements are quite simple. A relatively secluded area, where one can work with one to three clients at a time (depending on the size of the program), is needed. A variety of electronic equipment is necessary so one can talk and listen to the client, present slide, audiotape, and videotape stimuli to him, and record his erection response data. The following paragraphs detail each of these requirements.

Space Considerations

Small areas can be effectively used as laboratory space. A clinic area with small examination rooms along a hallway represents an ideal area since no building modification would be required. One room could be used for equipment and two or three others as testing rooms. In areas with more limited space, as in the Vermont Treatment Program for Sexual Aggressors, equipment may be stored on a multishelved rolling cart and simply brought out into a secluded area of the infirmary corridor before an evaluation in the examining room. In such circumstances, electronic equipment may need to be connected through wall-mounted interfaces.

Alternately, a room in an office suite could be subdivided, as was done in the laboratory for the Florida Mental Health Institute program. In this laboratory, there are four 4 ft. X 6 ft. X 8 ft. rooms along one wall. An 11 ft. X 12 ft. control room occupies the remainder of the space. Two levels of shelving run around three sides of the control room, on which computers, printers, audio and video cassette players, and video monitors are stored. There is also a sink where penile transducers may be cleaned and disinfected. With a centralized control room, service capability can be increased by operating two or three rooms simultaneously. Although this might seem to be a complex task, it can be accomplished easily by one operator.

Client Rooms

Ideally, the client space should be sufficient to house a reclining chair with disposable examination paper on the seat, a video monitor on a cart, a headset with a boom microphone, and a wall-mounted interface panel containing an operator call button and two female jacks into which the headset and transducer leads are plugged. Outside the room, above the door, should be a shelf supporting a slide projector with its lens inserted through the wall. The overhead light can be turned off inside the room. The area is temperature controlled and each client room has a strong ventilation fan. Adequate ventilation is critical, particularly if the room will be used as a site for olfactory aversive conditioning.

The preceding description may seem lavish to some readers, but all of these components are not absolutely necessary. Creativity may be exercised. For example, the slide projector may be placed inside the room and remote-controlled. Audiotapes can be played through a speaker rather than a headset. Inexpensive two-station intercoms are available.

Control Room

In the Florida Mental Health Institute Laboratory, one or two operators are seated on secretary's chairs as they use the control equipment. There is a control station for each client room equipped with the following equipment:

- one dual floppy disk drive personal computer with monitor,
- one printer,
- one audio cassette player,
- one video cassette player and monitor, and
- a computer interface for the erection response sensor.

There is a master switching panel which permits the operator to independently send slides, audio, video, or voice to each room, and receive vocal responses from the client.

Again, this is quite elaborate. Very few laboratories are currently computer-operated. A master switching unit for stimulus modalities is a convenience, not a necessity. Alternately, one room could be employed for slide presentations, one for auditory, and one for videotape. The greatest expense is the erection response recorder.

Recording Devices

Laws and Osborn (1983) specified the basic requirements for measurement devices:

> The basic measurement system requires a sensing device called a penile transducer, to detect the behavior and send an electronic signal to some type of recorder that can read out the minimum, maximum, and all intermediate values of the response. Preferably, to reduce operator error, the recording device should produce a hard copy record whether that be a pen tracing of the response or a digital readout in percentages. . . . Transducers are relatively cheap while recording devices are expensive (pp. 300-301).

There are basically two types of recorders used in these laboratories: strip chart physiological recorders and computer-driven systems.

Strip Chart Recorders

Strip chart recorders have the longest history of use in this type of work. These are basically multichannel recorders which

trace an analogue of a physiological response on a moving strip of paper. The resistance change from the penile transducer is sent through a special coupler to the amplification system of the recorder, which converts the signal and produces a tracing of the response on a graduated chart.

Computer-Controlled Devices

A less affordable but more sophisticated unit is also available. In this system, all programming, stimulus presentation, recording, and data analysis are controlled by software. The system runs itself but must be monitored by an operator who can intervene at any point. This type of unit permits simultaneous monitoring of the erection response and three additional physiological responses such as heart rate, galvanic skin response, and respiration.

Sensing Devices

Two types of penile transducers are most frequently employed: the metal band strain gauge and the mercury-in-rubber strain gauge. Both operate on the same electrical principle of variable resistance.

Metal Band Transducer

The metal band, looked at from the side, resembles a man's ring, flat on the top, open at the bottom (Barlow, Becker, Leitenberg, & Agras, 1970). An electronic strain gauge is glued to the flat portion and its electrical leads run directly to the recorder. The client fits the ring to his penis with the flat section on top. As he becomes sexually aroused, the two side pieces gradually spread apart, straining the gauge on the flat section and producing a change in electrical resistance. This change in resistance is amplified, and then converted by the recorder to a printed hard copy. The metal band transducer is reliable and durable but expensive. If carefully handled, the life of the gauge is indefinite. For that reason, the metal band gauge may be the choice of laboratories that assess clients infrequently.

Mercury-in-Rubber Transducer

The mercury-in-rubber strain gauge is the most widely used device, as it is the least expensive (Bancroft, Jones, & Pullan, 1966). The mercury gauge is a loop of flexible silicone tubing, filled with mercury and plugged at both ends by electrodes. The electrical leads run directly to the recorder. Its operation is the same as with the metal band gauge. When the client becomes sexually aroused, the mercury column is thinned out, creating heightened resistance. These gauges have a realistic life of only one to two months.

A variation of the mercury-in-rubber transducer, the indium-gallium gauge, is apparently not yet in wide use. Its construction is the same as the mercury unit, but the tubing is filled with indium-gallium. Reliability tests in the Florida laboratory have shown that its operating characteristics are identical to the mercury gauge (Murrin & Laws, 1986).

Stimulus Presentation Equipment

As indicated in the preceding description of the basic laboratory arrangement, three basic stimulus presentation modalities are in current use: photographic slides, audiotapes, and videotapes.

Slide Projectors

A good quality machine, preferably one with automatic focus, should be employed to display photographic slides. A long remote cord to advance the slide tray is essential since using automatically timed display and interstimulus times is not advisable.

Audio Cassette Players

Since audio cassette players are used only to transmit the spoken word, an expensive, high fidelity recorder is not required. However, a lot of fast-forwarding and rewinding is typically done and these functions fail very quickly in the cheaper machines. An external speaker jack is necessary in order to avoid having the tape deck in the same room as the client.

Video Cassette Players

The quality of video cassette recorders (VCRs) has increased markedly in the past few years. An inexpensive VHS High Quality (HQ) machine can be employed to attain reasonable image sharpness. High grade videotapes should be purchased since they create less wear on the video and audio heads during regular play.

Erotic Stimulus Materials

An effective stimulus is required to elicit sexual arousal. Our experience has been that the more graphic and detailed the erotic stimulus and the closer it comes to capturing the interests of a specified group of sex offenders such as pedophiles or rapists, the more likely it is to elicit sexual arousal that is indicative of a particular client's interests. Three stimulus modalities are commonly used in behavioral laboratories: slides, audiotapes, and videotapes.

Slides

Photographic slides are the weakest stimulus modality for eliciting high levels of sexual arousal (Abel, Barlow, Blanchard, & Mavissakalian, 1975). They are used mostly to determine age and gender preferences (Freund, 1963, 1967a, 1967b, Quinsey, Steinman, Bergerson, & Holmes, 1975). A very wide variety of stimulus materials can be collected on slides and they have the advantage of being easy to make, store, and handle. Laws and Osborn (1983) reported that they

found slides useful with about two-thirds of their clients, particularly pedophiles.

There is a problem in using slide stimuli. In recent years, Federal and state statutes have been enacted that broadly define and severely restrict ownership and use of material deemed pornographic. Before employing any such materials, opinions should be sought from legal counsel and an institutional review board to make certain that the program is in compliance with Federal and state laws (see Chapter 23 on the legal use of sexually explicit material). In some states, exemption from child pornography statutes for medical or scientific purposes may be gained from the Attorney General. The importance of staying strictly within the limits placed on the use of this material cannot be underestimated.

Videotapes

Videotaped stimuli for assessment of rapists (Abel, Blanchard, Barlow, & Guild, 1977) were initially used with great effectiveness for a number of years. These were the only videotaped stimuli that were ever found useful with sex offenders. This was a tailor-made assessment which showed simulated sequences of consenting sexual intercourse, rape, and physical assault without sexual activity. A controversy remains whether this is an effective technique, and its original authors have abandoned its use (Abel, Blanchard, Becker, & Djenderedjian, 1978). A revision was made by Crawford and Bonham (1981), but it received limited use in the United States.

In order to measure sexual response with any existing system, it is first necessary to make a determination of the 0-100% levels of arousal for each client. It is only in this preassessment calibration procedure that videotaped depictions of sexual activity have been useful.

Audiotapes

Audiotaped descriptions of sexual activity are the modality of choice for most applications. Pioneered by Abel and his colleagues (Abel, Levis, & Clancy, 1970; Abel et al., 1975; Abel et al., 1977), this method is very flexible in that stimuli may be prepared that are applicable to a particular offender group (Abel et al., 1977; Avery-Clark & Laws, 1984; Laws, 1986) or may be tailored to the unique interest of a single offender (Laws & O'Neil, 1981). The flexibility lies in that one may vary any parameter of the stimulus (e.g., age of the victim, characteristics of the victim, nature of the sexual activity, modus operandi of the offender, use or nonuse of violence, etc.) in order to relate different levels of arousal to different components of the stimulus (Abel et al., 1975; Laws, 1984).

The Florida Laboratory has attempted to standardize these stimuli. They have developed sets to evaluate female and male pedophilia, female and male incest, rape, and exhibitionism. Each script consists of three paragraphs of fifteen lines each. Each script is exactly three minutes long, a time Avery-Clark and Laws (1984) demonstrated to be the probable optimal stimulus duration. Initial data from nearly 100 clients suggest that these are powerful stimuli.

The use of audiotaped descriptions also may minimize the legal issues mentioned previously. There is no question about the source of the materials. They are prepared by adults specifically to be used with adults. No one is exploited in their production; no one earns illicit profit from the effort.

Protecting the Client and Issues of Informed Consent

Many sex offenders repeatedly perform behaviors most persons find reprehensible. However, this does not mean they are undeserving of concern or should expect less than the best standard of professional treatment.

While penile plethysmography is a highly specialized behavioral assessment procedure, its use occurs in a more general therapeutic context. Therefore, one must specify to the client the purpose of the plethysmographic evaluation and how the assessment data may be used. Among the issues that must be addressed include: clients' fears, confidentiality, and informed consent.

Clients' Fears

Sex offenders do not ordinarily see themselves as psychologically troubled people. Most enter treatment under coercive circumstances and, upon initial interview, vehemently deny any involvement in deviant sexual activity.

When these offenders discover that they will be subjected to testing by penile plethysmography, they may become anxious and frightened. Frequently the offender may view the plethysmograph as a sexual lie detector which will reveal things that he would prefer that no one know. The best way to handle concerns about the nature of the plethysmograph and treatment in general is to be quite frank about it.

Offenders have a right to know the nature of the assessment procedures and what they may expect to gain from it. They should be made aware of exactly what their participation will entail. They should be informed that they will be asked for detailed information about their past and present sexual experiences. They should also be instructed that they cannot be forced to respond sexually, and that they are participating in the procedure consciously and freely.

Confidentiality

Issues of confidentiality are controversial in sex offender treatment programs. Some treatment providers insist on total confidentiality to increase the chances of an offender detailing all his criminal sexual acts. Other providers advocate no

confidentiality, requiring offenders to sign full and irrevocable waivers before entering treatment, in the belief that reporting sexual offenses to authorities might enable intervention for victims.

Regardless of programmatic philosophy regarding confidentiality of information, plethysmographic evaluation data should be treated in a confidential manner. Such information would have little meaning to other agencies. However, providing the offender feedback about his sexual arousal pattern may motivate him to accept responsibility for the current offense, and hopefully to disclose additional victimizations. In such cases, confidentiality may be protected only if enough detail to identify the victim is not provided. However, where such details are disclosed, treatment providers are required by law to report this information to legal authorities.

Informed Consent

As with confidentiality, various approaches exist regarding the necessitity of obtaining specific informed consent before plethysmographic evaluations. Some providers consider the plethysmograph to be only one of many psychometric techniques employed during a psychosexual evaluation, none of which requires a special informed consent document. Other professionals regard signature of a special informed consent document to be essential.

In order to decide the optimal procedure in a particular setting, the therapist should request information about basic elements of an informed consent document from the National Institute of Mental Health (Parklawn Building, 5600 Fishers Lane, Rockville, MD 29857). With this information, administrators, attorneys, and the ethics committee of the particular state professional group may be asked to consult on this issue. If informed consent appears essential, the drafted document should be submitted to an institutional review board or correctional administrator for approval.

Limitations of the Plethysmograph

Validity of information derived from the plethysmograph may be compromised by both avoidable and unavoidable influences. Detrimental but avoidable factors include examiner incompetence, overinterpretation of data, and failure to adhere to administrative standards. Efforts by offenders to suppress arousal to preferred but deviant sexual stimuli and restrictions imposed by laboratory measurement of real world behaviors represent the principal unavoidable pitfalls.

Avoidable Pitfalls

Examiner Incompetence

The penile plethysmograph should be employed only by mental health professionals who have received thorough training in the procedure. Unfortunately, no regulation currently exists regarding qualifications necessary to purchase a plethysmograph and conduct evaluations. Since plethysmography is a relatively esoteric assessment procedure not covered in graduate training programs for mental health practitioners, opportunities to gain experience are limited to internships in treatment programs using the procedure.

As a result of these factors, some practitioners may be tempted to purchase the necessary equipment and pursue on-the-job training. Attempting to conduct plethysmographic evaluations without the needed training is not only unwise but also violates professional ethics. Incompetent evaluations may lead to erroneous conclusions about an offender's arousal pattern. This might prolong an individual's treatment needlessly, or enable an offender to gain access to situations in which he may create yet another victim.

Overinterpretation of Data

Because of the high face validity of the data, it is easy to overinterpret the significance of the information and make unwarranted conclusions. Laws and Osborn (1983) summarized the problem:

> Does the presence of high levels of arousal to rape, pedophilic, or other deviant stimuli in a laboratory mean that surely the person will rape, molest children, or otherwise disport himself in a deviant fashion? Of course, it does not. Undeniably, sexual arousal is considerably more than just penile erection. The erection response is not even present during the commission of some deviant sexual acts and, when present, the offender may or may not use his genitals in the act itself. Nonetheless, if in an assessment . . . a male shows a very large erection response to a deviant sexual stimulus, and very little or no response to a nondeviant stimulus, this is more than presumptive evidence that he is more sexually attracted to the former than the latter. This would be a particularly reasonable conclusion if the man had a known history of sexual deviance. Such data, however, do not mean that he will necessarily act upon his arousal; they do mean that he may be at risk to do so, and in the case of a known sex offender, that is reason enough to justify therapeutic intervention. . . . Deviant sexual arousal is deviant sexual behavior. That is what the data show (p. 373).

Thus, the way to use and not abuse plethysmographic data is simply to report what was done and what was found. If this can be unequivocally related to known behaviors of the client, and particularly if the client admits to the accuracy of the measured pattern of sexual response, it is permissible to report that. It is not legitimate, given the current state of the science, to make any prediction whatever concerning future behavior or to comment about questions of guilt or innocence. It is suggested that all reports summarizing plethysmographic evaluations contain such disclaimers.

Failure to Adhere to Administrative Standards

Several research studies have failed to differentiate sex offender and nonsex offender populations. Analysis of these studies generally reveals methodological shortcomings. Errors identified in these studies are summarized in Table 9.1.

Several studies comparing arousal patterns of incarcerated sex offenders and nonsex offenders have neglected to evaluate the extent of overlap between the two groups (i.e., sex offenders who have a history of frequent nonsexual crimes and nonsex offenders who have engaged in sexual aggression in the past). Recently, it was discovered that some studies failing to differentiate rapists from normal subjects had employed stimuli that showed the victim initially resisting the assault but later deriving pleasure from it. When more realistic depictions of the victim's constant abhorrence of the assault were used, rapists appear more aroused than normals.

When appropriate procedures are employed, information derived from the penile plethysmograph is usually reliable and valid. The test-retest reliability coefficient for baseline measurement of penile circumference has been reported to be 0.94 (Farkas, Evans, Sine, Eifert, Wittlieb, & Vogelmann-Sine, 1979). On the basis of this reliability estimate, the plethysmograph appears to match or surpass the reliability of the most highly regarded psychometric techniques: the Wechsler Adult Intelligence Scale-Revised and the Minnesota Multiphasic Personality Inventory. Rates of diagnostic accuracy have been estimated to be as high as 90% (Knopp, 1984).

As with any assessment procedure, failure to follow administrative and interpretive standards lessens the adequacy of the resulting information. Before beginning the evaluation, examiners must provide clients with detailed information about the procedure in order to allay anxiety that could inhibit arousal. Instructions to the offender should be standardized.

Table 9.1

ERRORS/SOLUTIONS IN RESEARCH METHODS COMPARING SEX OFFENDERS WITH NONSEX OFFENDERS

Error	Solution
Presentation of only one stimulus from each category of sexual partner/victim or activity.	Several stimuli from each category should be used to increase reliability and validity of data.
Stimulus exposure durations which are too brief.	Two- to four-minute exposures are recommended.
Use of "weak" stimuli.	Descriptive audiotapes should be used.

Equipment must be calibrated for each client before and after the session. Clients must be given adequate time to become flaccid before presentation of another stimulus. The client should be instructed to self-report his estimated level of arousal after each stimulus so his subjective estimate can be compared to the objective measurement. Opportunity should be provided for debriefing upon conclusion of the session. If one follows accepted procedures, information from the plethysmographic assessment is usually accurate.

Unavoidable Pitfalls

Suppression of Deviant Arousal

The major unavoidable pitfall of the penile plethysmograph is that tumescence may be subjectively controlled. To some extent, males can control their sexual arousal. A male's ability to suppress arousal to a preferred stimulus is usually greater than his ability to generate arousal to a nonpreferred one (Laws & Rubin, 1969; Henson & Rubin, 1971; Laws & Holmen, 1978; Alford, Wedding, & Jones, 1983). An individual who is predisposed to sexually abuse children may be able to inhibit his arousal. An inexperienced clinician may misdiagnose this individual as normal. Thus, failing to identify pathology when it exists is essentially the only error in classification resulting from plethysmographic assessment.

Concern about response suppression is particularly great when the plethysmograph is employed with incarcerated offenders. Imprisoned offenders have extensive opportunities to exchange information about specific stimuli and suppression strategies.

The instructional set may be varied to estimate the extent to which a client has tried to suppress his arousal. Clients may be directed to allow themselves to become aroused to the initial set of stimuli, but to attempt to suppress arousal to a second stimulus set. If little difference in arousal exists under the two instructional sets, one may hypothesize that the client attempted to suppress arousal throughout the evaluation, regardless of instructional set. Preparing several sets of stimuli may also alleviate this problem.

Precautions may be taken to minimize response suppression during plethysmographic evaluations. If, in spite of these measures, suppression should occur, the examiner is often able to discern suppression through the presence of certain artifacts in the recording of the arousal response. For example, attempts to influence the outcome by covert masturbation, or by mechanically attempting to manipulate the transducer, are readily apparent on the record (Laws & Holmen, 1978). Although no foolproof method for detecting faking yet exists, the phenomenon continues to be investigated (Quinsey & Chaplin, 1987).

False positive errors (i.e., identification of a disordered arousal pattern in a normal individual) are extremely rare and have been found only under experimental conditions when

subjects, in a laboratory setting, have been instructed to attempt to respond physiologically to deviant stimuli. Even though experimental subjects can generate sexual arousal to a nonpreferred gender or age group, irregularities in the response recording are typically apparent. Since strong incentives against faking a deviant arousal pattern exist for sex offenders (i.e., incarceration or prolongation of probation), not a single instance of an offender feigning abusive preferences has been reported in the clinical literature.

Limitations of Laboratory Analogue Approaches

People responding in a laboratory situation, and particularly those who are already in confinement, are not exposed to the real temptations of society. It is important to remember that, however extensive the data collected, no more than an approximate picture of the offender's deviant and nondeviant sexual interests will be obtained.

What the physiological recording indicates is a precise measurement of what is happening within a specific individual, in a given laboratory, on a certain day, under a set of controlled circumstances. But what may be present one day may be absent the next, then reappear a week or a month later, then disappear again. However, it is reasonable to expect that, over time, evidence of fixed behavioral patterns will appear. What one must look for is consistency over time. In this manner, the plethysmograph can assist the clinician's ability to accurately assess treatment needs and progress.

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Chapter 10: Psycho-Educational Modules

by Randy Green

Abstract

Dr. Green discusses the psycho-educational technique as applied to the treatment of sex offenders. This didactic approach can be utilized in a wide variety of settings to achieve a number of different goals. Modules may be used to introduce offenders to information about sexual deviation, as well as to help individuals learn to operate within a group. A number of coping skills can be taught using this procedure.

Many sex offender treatment programs use cognitive-behavioral theory as a foundation for a major component of their treatment methodology. This treatment component is an educational intervention strategy designed to provide information to the offender on pro-social beliefs and attitudes as well as knowledge, skills, and abilities which the offender lacks. Typically, this intervention takes place through the use of psycho-educational modules.

The theory behind psycho-educational programs is that individuals may be prevented from achieving optimal adjustment due to certain deficits or maladaptive behavioral patterns. In most communities, one can find programs which teach parenting skills, communication techniques, assertiveness, etc. These courses feature a didactic presentation by a trainer who is not necessarily a therapist and often use workbooks and homework assignments. The format is nonthreatening as it takes place in a class setting rather than a group therapy session. This technique is readily adaptable to sex offender treatment programs and can be tailored to address a number of different areas, ranging from cognitive distortions to the enhancement of social skills.

Each offender has acquired a set of beliefs, attitudes and expectancies which have contributed to the victimization of others. For example, a child molester may operate under the assumption that female children enjoy having their genitals stimulated by adult males. Similarly, a rapist may maintain a belief that women enjoy having rough sex. An exhibitionist may assume that he is impressing women with his physical display of masculinity and virility. These examples serve to illustrate that there are certain cognitive distortions which can directly contribute to the victimization of others.

Offenders may also maintain other stylized, well rehearsed "thinking errors" or irrational beliefs which reinforce their victim-creating and/or irresponsible behavior patterns. These beliefs can be very powerful in undermining constructive changes in the offender's repertoire of responses. Yochelson and Samenow (1976) have identified these thinking disturbances in their work *The Criminal Personality*. An example of a criminal error in thinking is the concept of "instancy," in which the individual "wants what he wants when he wants it," without regard to the impact on anyone else. An example of an irrational belief or misconception might be an offender's belief: "I must be loved and approved by everyone in my sphere of acquaintances. If I am not, I'm worth nothing. I'll be rejected, and that would be catastrophic." This thinking process creates a context within which the individual continuously perpetuates a sense of frustration and rejection. The offender may then turn to more accepting, less threatening, and more vulnerable children for acceptance. Albert Ellis (1956), among others, has identified other misconceptions or irrational beliefs which can exist in the cognitive belief systems of offenders.

Additionally, each individual who sexually victimizes another frequently has certain deficiencies or distortions which impair his ability to manage his life responsibly or constructively. For example, child molesters may have poor social skills and shyness, leading to avoidance of female or male peers. Feeling alone and perceiving himself to be isolated from socially appropriate partners, the pedophile may seek primary social gratification and acceptance from children. He resorts to children for intimacy and to gain a sense of competency and/or adequacy.

As noted in the chapter addressing treatment planning issues, current sex offender treatment approaches attempt to target these problem areas in a variety of ways. Psycho-educational modules can teach a variety of skills which the sex offender lacks. Besides the clinical benefit derived from the use of psycho-educational modules, this mode of intervention has additional advantages. The format for such modules can be useful in establishing the authority and credibility of those who teach them. The psycho-educational module can also be useful in providing the instructor with data regarding the offender who lacks motivation. Thus, the modules may serve as a preliminary screening tool to convey initial information about sex offender dynamics and need for treatment and to determine whether an offender is interested in and amenable to more intensive and costly intervention.

The psycho-educational module can be an unobtrusive recruiting tool for encouraging offenders to participate in further, more intensive treatment. For those states required to provide treatment, such a module becomes a means of following legislatively mandated treatment requirements. It also provides an initial test of motivation. Consequently, an orientation module on "Dynamics of Sexual Offenders" provides staff with a way to document those who profess a desire for treatment but whose behavior/performance shows the opposite. It also allows the participants to learn how to com-

municate in a group and to begin discussing the sensitive topic of sex. Another benefit derived from this method is that such modules can provide common language and therapeutic concepts which can be useful in all other aspects of the treatment program.

Finally, psycho-educational modules are a cost-effective means of first-line therapeutic intervention. Such modules allow for ratios of one staff member per twelve to fifteen offenders. Communicating substantial amounts of information, the offenders are prepared for more intimate and intense group experiences which focus on personal application, self-disclosure, and confrontation. These latter treatment components require higher levels of commitment from the offender. The modules may be taught by anyone trained in that particular area, including the offenders themselves.

The content for a psycho-educational module can be varied. Modules lend themselves to a broad range of topics which can be developed and utilized to address the diverse needs of sex offenders. The types of psycho-educational modules frequently used in treatment follow.

Types of Modules

Sex Offender Characteristics

This module focuses on the general typologies of sex offenders, elaborating on their psychodynamics and behavioral patterns. Various classifications such as those discussed by Groth (1979) and Finkelhor (1984) are introduced. The causes of sexually deviant behavior are addressed. Issues including compulsivity, escalation of offense behavior, and principles of addictive behavior patterns are presented. Issues relating to victim empathy are discussed. An explanation of various treatment concepts and interventions is reviewed. Goals for such a course include the following.

- Provide an opportunity for the offenders to see themselves as individuals who are in serious need of help in order for behavioral change to occur.
- Give hope to those troubled by sexually deviant behavior and/or its consequences.
- Confront cognitive distortions and misperceptions.
- Make a convincing statement to sex offenders regarding their need for treatment which is necessary to the prevention of future victims.
- Learn about the variety of cognitive and behavioral treatment methods available (including masturbatory reconditioning, satiation, covert sensitization, other aversive conditioning methods, and fantasy logs), and the rationale for their use.

Victim Awareness/Empathy

This course is designed to provide the offender with an awareness of the impact of his criminal behavior on others—emotionally, physically, relationally, and sexually. This focus on the victim is an attempt to confront the offender with myths such as, "if the child doesn't resist, she/he doesn't mind it," etc. Information will be provided to the offenders regarding victim dynamics, such as why children, for example, tend to respond the way they do to certain engagement strategies and eventual victimization. Goals should include:

- Identification of the long- and short-term impact of sexual assault on the victim.
- Recognition of the myths which society reinforces which perpetuate sexual assault.
- Identification, where possible, of the specific impact on the offender's victim.
- Involvement in some type of restorative activity, e.g., the payment of restitution, donating to a rape crisis center, participation in a media presentation or public information campaign, etc.

An initial attempt is frequently made in this module to assist those offenders who were themselves victims of physical and/or sexual abuse. A substantial percentage of offenders have, in fact, been victimized and sexualized at early developmental ages. The primary point in identifying this phenomenon as an issue is to assist the offenders in the development of empathy for their own victims, to shift their focus from self-centeredness to other-centeredness. The context in which this powerful and sensitive area is handled should never excuse the offender's behavior. At a later time, the offender's own victimization should be dealt with more thoroughly to assist him in gaining some insight into this area. However, the primary rationale for its inclusion here is to assist the perpetrator in using his own pain as a bridge to empathy and concern for others. At this point, the staff should always be aware of the possibility of depression or suicidal ideation.

Another topic dealt with in a victim awareness class is the victim clarification process. Whether or not victims ever actually receive a clarification letter routed through their own therapists, the process of multiple rewrites of the clarification letter can have the effect of generating a sense of ownership, remorse and guilt in the offender. This is a constructive goal which serves to provide a potential inhibitory effect (see Chapter 11, Interpersonal Techniques, for further discussion).

Cognitive Restructuring

This course focuses on the beliefs, values, and thought patterns which allow the offender to initiate and then rationalize a sexual assault. The goals are to:

- Assist the sex offender in identifying irresponsible beliefs or thinking errors.
- Recognize those errors which each offender utilizes most frequently.
- Learn alternative thought patterns to dispute or replace the distorted ones.
- Provide all offenders with a language of accountability and change within the treatment program.

In addition to the above, keeping a journal to record daily thinking errors can augment the scope of the course and provide the offenders with practice in identifying those errors and then intervening. This technique also provides an opportunity for staff to assess an offender's motivation and degree of self-awareness.

Since many sex offenders are rather concrete in their thought structures, they often find models such as these very helpful in effecting change and for holding themselves and others accountable.

Deviant Sexual Acting-Out (Pre-Assault) Cycle

Presuming that each offender has one or more identifiable pre-assault cycles, this psycho-educational module emphasizes the recognition of those patterns. The instructor will assist an offender in gaining insight regarding his motives, emotions, fantasies, thoughts, and actions by recording the antecedents for each separate type of crime or victim category. Sharing this information with the class and receiving feedback from staff and peers can facilitate honest disclosure. By observing class members manifesting their deviant cycle, appropriate confrontation methods and interventions can be learned. It is hoped that offenders can later identify, intervene, and halt their cycle prior to the commission of another offense.

Relapse Prevention must be addressed prior to an offender's release. Relapse Prevention is defined as a "therapeutic approach specifically designed for the maintenance phase of behavior change programs . . . toward helping the client maintain control of the behavior over time and across situations (Pithers, Marques, Gibat & Marlatt, 1983, pp. 215-216)." (Also see Chapter 14, Relapse Prevention.) These authors cite a study which found that 75% of the relapses were preceded by situations which evoked a negative emotional state, and 20% of the sample relapsed following interpersonal conflicts. A Relapse Prevention module attempts to accomplish the following goals for the offender:

- Dispel any misconception that treatment will eliminate all problems with future sexually deviant behavior.
- Identify situations which create a high risk for relapse and the subsequent chain of responses culminating in reoffense.
- Identify cognitive and behavioral skills which will enable the offender to control his behavior and reduce the likelihood of relapse.
- Demonstrate the use of these Relapse Prevention strategies.

Anger Management

Many offenders have serious difficulties with the appropriate expression of anger. Their failure to manage anger in a responsible manner increases the likelihood of displacement through aggression toward others. The goals of such a module include:

- Assisting the offender in becoming aware of both the dimensions and determinants of the anger problem. (Novaco, 1976).
- Assisting the offender in learning the role that anger plays in the acting-out pattern.
- Assisting the offender in learning and implementing a stress inoculation approach to anger management.

Assertiveness Training

Subassertive or passive communication patterns are frequently found among sex offenders who perceive themselves to be inadequate or inferior both to their peers and to those in authority. Fearful of expressing their thoughts or feelings and risking rejection, they often suppress their emotions, which then manifest themselves through passive-aggressive, aggressive, or direct victim-creating behavior. Goals of a module of this type are similar to those of anger management and include:

- Assisting the offender in identifying passive, aggressive, and/or passive-aggressive patterns of behavior.
- Assisting the offender in relating these maladapted communication patterns to the acting-out cycle.
- Assisting the offender in learning and demonstrating assertiveness skills, with an end to being able to practice these skills with those who appear to be most threatening or intimidating.

Substantial material is available for assertiveness training module preparation. In 1960, Stevenson and Wolpe taught clients that assertive expression of one's feelings is incompatible with social anxiety; they taught these individuals how to be more disclosing and transparent through the technique of behavioral shaping.

Social Skill Training

Another psycho-educational module which focuses on communication styles is related to social skill development. While

some sex offenders are quite socially adept, others cannot sustain appropriate social interactions with peers and cannot respond to the disclosures of others. Inaccurate perceptions of women and misinterpretation of their responses are additional social skill problems manifested by offenders. Although this relationship is not yet proven, such deficiencies may alienate them from others and may tend to reinforce victim-creating patterns of behavior (Becker, Abel, Blanchard, Murphy, & Coleman, 1978). Goals for social skills training modules frequently include:

- Identification of verbal and nonverbal social skill deficiencies through the use of interview techniques, observation, collateral contacts, and the Social Skill Assessment Scale (Barlow, Abel, Blanchard, Bristow, & Young, 1977; Becker et al., 1978) and the Empathy Assessment Scale (Truax & Carkhuff, 1967; Becker et al., 1978).
- Identification of the relationship of social skill deficiencies to the pre-assault cycle of the offender.
- Development of appropriate cue discrimination.
- Development of pro-social skills, characterized by appropriate voice, conversation, affect, and motor behavior responses, for those situations in which the offender has the most difficulties (Becker et al., 1978).

Surveys of heterosocial skill training (Abel, Blanchard, & Becker, 1976, 1978) found that many programs utilize female staff or volunteers during semistructured sessions. "Minimal dating" or "heterosexual shyness" research has used such specific techniques as a dating manual, group discussions of dating practice behaviors, heterosocial behavior practice, contact with female volunteers, semistructured social programs involving an "in vivo" contact with community women, arranged simulated dates with both positive and negative feedback, role modeling, videotaping, and social reinforcement shaping (Becker et al., 1978).

Social skill training with developmentally retarded sex offenders is even more critical since their level of social functioning is often very low (Murphy, Coleman, & Haynes, 1983). Similar techniques to those described above can be used with this population. However, the staff must begin at more basic skill levels and use more learning trials (Matson, 1980; Matson, Kazdin, & Esveldt-Dawson, 1978).

Psychological Models for Behavior Change

A psycho-educational module in this category would include presentation of certain personality or psychological models which offenders can use in describing their own personalities, their relationships, their learned maladaptive responses, and their goals for more adaptive behavior. Examples of such helpful models include but are not limited to Transactional Analysis, Rational Emotive Therapy, and Cognitive Behavioral Theories. The goals of this component would assist the offender in the following ways:

- Understanding specific models of intrapersonal and interpersonal dynamics/behavior which would be of assistance in understanding oneself and others more realistically.
- Demonstrating insight into oneself and others by relating current life experiences in terms of these models.

Autobiographical Awareness

Assigned autobiographies provide a method through which a participant can present a summary of key issues, patterns or themes in his life which may have influenced his current lifestyle, assumptions, and coping patterns. (See Appendix B.) The facilitator must avoid reinforcing "poor me" or "victim stance" responses from the offender, assisting the offender in distinguishing insight from excuse-making. Some goals of a module of this type would include:

- Understanding oneself and others more clearly in terms of maladaptive, victim-creating behavior symptoms.
- Understanding which nonsexual needs may have been met through inappropriate sexual behavior.
- Reexamining and updating past history by replacing erroneous assumptions with current reality-based, pro-social beliefs.

Sexual Education

Many sex offenders are poorly informed regarding human sexuality. They hold attitudes and myths which frequently reflect their lack of information. This, in turn, reinforces their avoidance of intimate mutually consenting sexual relationships and their treatment of victims as objects rather than as persons. Groth (1979) cites an example of one offender who claimed that raping a woman was better than consenting sex between two males because it was normal. Goals of a human sexuality psycho-educational module attempt to assist the offender in the following ways:

- Identifying myths, inaccurate unhealthy values, and/or role stereotypes which have obstructed healthy psychosexual and sex role development.
- Identifying how these beliefs/attitudes have related to deviant sexual acting-out.
- Replacing unhealthy beliefs or attitudes with constructive, nonvictim-creating beliefs or attitudes.

The content of human sexuality modules includes information on myths and misunderstandings regarding human sexuality, anatomy and physiology of sex, values and attitudes, reproduction, methods of contraception, sex roles and gen-

der identity issues, masturbation, variations of sexual behavior involving mutuality and consent, and the relationship of fantasy to sexual behavior.

The Sex Knowledge Inventory (McHugh, 1979) can be used as a pre- and post-intervention measure for this module. For the retarded sex offender, the Sexual Knowledge Inventory (Edmondson, McCombs, & Wish, 1979) is available in addition to the Essential Adult Sex Education Curriculum (Zelman & Tyster, 1979), which was designed for the developmentally disabled (Murphy et al., 1983).

Stress Reduction/Relaxation Management

Many sex offenders lack healthy, adaptive coping responses when they experience stress, anxiety or frustration. For some offenders, the entry into their pre-assault pattern is their primary method of stress reduction. Others use some form of chemical abuse which, in turn, may be part of the pre-assault pattern. Consequently, goals of this module include the following objectives for the offender:

- Identifying the dimensions in which stress manifests itself in all aspects.
- Identifying the primary determinants of stress.
- Identifying the maladaptive methods used to cope with stress.
- Identifying how stress is involved in the pre-assault pattern.
- Identifying constructive alternatives to reduce external stress.
- Identifying and developing constructive methods of stress reduction and relaxation.
- Demonstrating competency in using those particular methods in terms of actual stress.

Chemical Abuse

Alcohol abuse has been found to be prevalent among sex offenders; however, its influence is best understood as a contributing factor which varies in importance according to the different types of sex offenders (Tracy, Donnelly, Mergenbesser, & MacDonald, 1983). In addition, the use of other chemicals can be involved as part of a sex offender's pre-assault pattern. Researchers agree, however, that while drugs may act as general disinhibitors of behavior, they do not account for the fact that an offender acts out in a sexually deviant manner. Given the contributory relationship of chemical abuse with many sexual offenses, many treatment programs provide a module on chemical abuse for those who have an identified problem in this area. Goals for the offender to accomplish in such a module include:

- Accepting the reality of one's chemical abuse pattern.
- Identifying one's own dynamics/patterns of chemical abuse, especially as they relate to sexually deviant behavior.
- Developing a commitment to abstain from chemical use of any type.
- Developing interventions for Relapse Prevention.
- Establishing a support system in the community to augment strategies for Relapse Prevention.

Sexuality and Religious Belief Systems

Therapists who work with sex offenders are likely to encounter religious beliefs which may initially appear to complicate or even obstruct treatment efforts. In the development of their attitudes towards sexual expression, many offenders have struggled with the integration of their religious beliefs with their sexuality. They may have grown up with highly rigid and suppressive proscriptions against experiencing any sexual thoughts, emotions, or arousal. Others have distorted healthy religious precepts, using them improperly to instill exaggerated and unrelenting guilt, self-deprecation, depression, diminished self-esteem, and diffuse anger into their daily experience. Others, upon a conviction for sexually deviant behavior, profess instant healing and new life and a total lack of need for treatment since they have been cured spiritually. Finally, many offenders express in religious terminology a strong resistance toward homosexuality or masturbation as viable alternatives to their established patterns of sexual deviancy. They state that their beliefs allow for only the adult heterosexual expression of sexuality in the context of marriage.

These are some of the major issues which therapists for sex offenders are likely to encounter. It can be useful, in a module or group, to enlist one or more clergy or pastoral counselors sympathetic with program goals to join with the primary therapist in treatment. In that content, certain goals can be established which will assist the offender in the following ways:

- Identifying conflicts which may have developed over sexual identity and practice with spiritual beliefs.
- Resolving in a constructive manner religious concerns regarding behavioral treatment modalities.
- Reconciling and integrating a healthy concept of sexuality within one's spiritual belief system.
- Using spiritual beliefs and resources to establish a healthy foundation for victim-free behavior.

The use of psycho-educational modules as a topically focused, time-limited, and cost-effective intervention has been reviewed. This structured group method is widely used in many current sex offender treatment programs. These modules can be readily adapted to the needs of each specific pop-

ulation. Psycho-educational modules can be utilized as an appropriate and efficient introduction to a comprehensive treatment program.

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Chapter 11: Interpersonal Techniques in Treating Sex Offenders

by Barbara Schwartz

Abstract

Dr. Schwartz discusses techniques for dealing with the sex offender in both individual and group therapy. Major steps in treatment are outlined, as are specialized group techniques such as victim empathy training.

Interpersonal techniques of treatment, which include individual and group psychotherapy, were the first approaches used in treating sexual deviants. For many years, psychoanalysis was the only approach available and that was available only to the wealthiest. Around the turn of the century, Schrenk-Notzing, a German physician, established an institute to treat paraphiliacs with techniques such as hypnosis and various programs similar to the Outward Bound wilderness experiences currently used with offenders. Group experiences, both formal and informal, played an important part in that program. Many advances have been made using behavioral techniques to enhance the treatment of sex offenders, but interpersonal techniques—particularly group therapy—remain the core of almost all programs.

Individual vs. Group Therapy

Sexual deviation, even when not conceptualized as an addiction, certainly has much in common with the traditional addictions—particularly as regards denial, guilt, and secrecy. It is these characteristics which make sex offenders particularly difficult to treat in individual therapy. The offender will lie, minimize, and rationalize his behavior, and it is quite a task for a lone therapist to muster the strength or the evidence to confront these defenses. Just as the use of groups in treating addictive disorders is viewed as particularly useful in breaking down barriers, so it is with the sex offender. The group members are able to recognize their own patterns and may provide confrontation and support far more effectively than could the individual therapist.

Unfortunately, group therapy cannot always be conducted in a prison system. Offenders may doubt whether confidentiality is possible in such a setting. They may realize that in certain institutions, being stigmatized as a sex offender is tantamount to being given the death sentence. Other offenders are so socially isolated and inept that group participation is simply beyond their ability. Individuals who may have committed extremely bizarre crimes may need much individual work before they are ready for a group. There are also situations in institutions which may limit group therapy. Physical barriers such as lack of privacy or the lack of enough appropriate participants may preclude this form of treatment. In such cases, individual therapy may be the only choice, but this should only be utilized as a method of involving offenders until systematic changes can be made to facilitate group participation or to overcome the initial reticence and anxiety of the offender. It should also be noted that individual therapy perpetuates the "sexual secret" and may provide an opportunity for the offender to play at a seduction game, either in fantasy or reality. Individual therapy can be useful as an adjunct; however, it should be recognized that individual therapy may undermine group participation. The offender may be able to resist group pressure to open up if he can instead form an alliance with an individual therapist. The therapist, therefore, should constantly emphasize the importance and even preeminence of the group as the primary interpersonal treatment tool. (See Table 11.1.)

When individual therapy is the only tool that can be used, the therapy often replicates the issues that are dealt with in

Table 11.1

PROS AND CONS OF INDIVIDUAL THERAPY

Pros	Cons
1. Provides more individual attention.	1. Therapist more easily manipulated.
2. May provide more confidentiality.	2. Denial may be more easily maintained.
3. May be used to develop trust and basic social skills for extremely withdrawn or alienated clients.	3. Therapeutic dyad perpetuates the "sexual secret."
4. May be provided in variety of physical settings.	4. More opportunity for attempts at seduction on the part of the client.
5. May be used on short term basis to overcome initial reticence and anxiety.	5. Less opportunity to practice and develop social skills.
6. May be used where crime is extreme, unusual or stigmatized, e.g., sadism, coprophilia, necrophilia.	6. Less opportunity to learn empathy or help others.
7. May be used where offender is mentally retarded or mentally ill and has trouble cognitively functioning in a group or is disruptive.	7. Less therapeutic confrontation by peers.

groups. The course of sex offender treatment seems to be fairly predictable. Most of these individuals respond to accusations with denial. If they were not caught actually committing the act, then they plead innocence because either they were simply not the offender, or because the act involved mutual consent and the victim is playing a vindictive game, or they were too drunk to know what happened but they are sure that they never could have done such a thing, or they were "set-up" by another adult who had some motive for hurting them. If the offender was caught in the act, it was all a terrible misunderstanding. The therapist or the treatment program staff must carefully evaluate how much of their resources can be expended on breaking down denial. Rarely is one able to successfully confront individuals who claim that the situation was one of mistaken identity. Often programs or therapists choose to treat only those making a full confession. However, often defenses are paper-thin and will crumble once the individual understands that the therapist will not reject him and brand him as a sex-crazed pervert.

Once denial is broken down, there may or may not be empathy for the victim. It is helpful here to utilize the many victim accounts, written or available as audiotapes or movies, to educate the offender as to the effects of sexual assault. At this point, it is the therapist's job to induce guilt. This is the most dangerous point in the therapy. The offender may re-erect his defenses. He may become seriously depressed, even suicidal. He may unleash vast quantities of anger and frustration onto the therapist.

While the feelings of shame and self-recrimination experienced at this point may be a healthy sign of empathy, offenders cannot be permitted to wallow in interminable guilt. At times offenders turn this process into a type of self-pity which stultifies progress. This person may claim that he cannot deal with the issue because he feels so sorry, so remorseful that he wants to kill himself. The therapist must attempt to discriminate between true emotional responsiveness and sentimentality, which is one of Samenow's criminal thought patterns (Yochelson & Samenow, 1976).

Guilt can serve as the motivating force behind the inquiry into the dynamics of the crime. Referring to an earlier theory which outlined this author's theory of sexual deviation, the process now becomes one of exploring the reservoir (see Chapter 2, Characteristics and Typologies). This may include family dynamics, childhood victimization, developmental difficulties, traumas in later sexual experiences, as well as attitudes, values, and beliefs. Having the offender write an extensive autobiography is often helpful. At this point, exploration of deviant fantasies can begin. It is usually best to wait until the offender has a realization of how devastating and deep-rooted his behavior is before starting on the behavioral techniques. Even without the use of physiological assessment techniques, one can do some behavioral reconditioning. Covert sensitization, masturbatory satiation, and thought stoppage can be utilized if the individual is highly motivated. Whenever possible, physiological measurements should be used to assess progress in modifying deviant arousal.

The last stage of individual therapy should focus on strengthening the floodgates. By this time, the individual should have begun to have an awareness of his deviant cycle, and Relapse Prevention techniques can be taught. He may have to learn assertiveness training, anger management, or social skills. He may have to confront the criminal thought patterns which have enabled him to rationalize his abuse of others or begin to deal with other addictive behaviors. Most importantly, he must understand that as a person he will always be at risk regarding this type of behavior and must be forever vigilant.

History of the Use of Group Therapy

One of the earliest uses of group therapy was at Atascadero State Hospital in California, where a program known as the "Emotional Security Program" was instituted during the mid-50's. Patients in the program participated in group therapy. Self-governing committees made important therapeutic decisions regarding the program participants (Schultz, 1965). Several prisons with inmates committed under Sexual Psychopathy Laws have offered group therapy, although this often has been simply a method to provide token treatment to large groups of inmates. Costell and Yalom (cited in Resnik & Wolfgang, 1972) stated, "Group psychotherapy provides an arena in which their symptoms or offenses may be translated into the interpersonal context and in which disturbed interpersonal relationships may be appreciated, understood and altered (p. 119)." The group is able to provide the participants with motivation, hope, and the realization that their individual problems are not unique, as well as an opportunity to help others. The members can develop socializing techniques, utilize positive role models, and experience emotional release (Resnik & Wolfgang, 1972). Costell and Yalom reported that homogeneous groups work best with pedophiles, while heterogeneous groups were most successful with rapists. In a Canadian treatment program for incarcerated offenders, Marcus (1971) played videotaped sessions back to the group and noted that this technique "produced a crisis in which the person attempts to bring two aspects into harmony thus increasing self-knowledge (p. 33)." Anderson (1969) exchanged videotapes of sessions between offenders and a group of college students.

The first reported use of outpatient group therapy with sex offenders was conducted at Philadelphia General Hospital. The program treated primarily exhibitionists who were on probation or parole. It was assumed initially that the sex offender has both a low tolerance for anxiety and a fear of authority. Therefore, in one-to-one treatment, the therapist

would be viewed as an anxiety-arousing authority figure. Consequently, the patients would fail to show up or would withdraw into passive resistance (Peters & Roether, 1972). The program assumed that many trained therapists would have communication difficulties with individuals who have poor educations and limited verbal skills (Peters & Sadoff, 1971). Individuals convicted of sex offenses often show both of these characteristics, as the more intellectually and economically stable offender in general is less frequently convicted if caught. The use of the group was viewed by the Philadelphia project as a means of helping to bridge the verbal, educational cultural gap between patient and therapist (Peters & Roether, 1972).

The groups acted to counteract the social isolation of the members. Communicating with others of his status tended to build up the member's self-esteem and subsequently his respect for others. The groups also acted to exert pressure in the direction of social conformity and to reinforce control of impulses (Peters & Sadoff, 1971).

Follow-up of the Philadelphia General Hospital project, comparing 92 offenders in group therapy with 75 under general supervision, found a recidivism rate of 1% for the patients treated in groups versus a 5% rate for the others. Of the general supervision group, 27% committed crimes other than sex offenses, as opposed to 3% of the group therapy patients (Peters, Pedigo, Steg, & McKenna, 1968).

Establishing Therapy Groups

In a recent survey of sex offender programs conducted by this author, group therapy was the one universal feature of every treatment program; in many instances, it was the only treatment provided. In establishing sex offender groups within a prison, there are a number of issues to be considered. In this author's program at the Central New Mexico Correctional Facility, entering sex offenders went into a psycho-educational class. Didactic issues regarding sexuality and deviancy were presented to the students. Individuals were screened as to their amenability for treatment and then moved into the advanced groups. In the prison environment, it is less threatening to begin with a class format. Often the participants abandon the class format and begin to interact in a therapeutic manner.

One must decide whether to mix individuals convicted of various sex offenses. Those new to the group therapy process may feel most comfortable with individuals who have committed similar crimes. Thus, many programs divide rapists from child molesters or pedophiles from incest offenders. This is referred to as homogeneous grouping. However, a group of child molesters might include a situational incest father and a sadistic child murderer. Other factors might be used to homogeneously group offenders. Length of time in treatment, degree of denial, age, history of substance abuse, history of sexual victimization, etc. may form the basis of a group identity. However, the mixing of individuals who have committed different types of crimes may enliven the groups considerably. While, in general, pedophiles tend to be passive and dependent, rapists tend to be more assertive. They can provide a beneficial balance to each other if the more talkative ones can be prevented from monopolizing the sessions. They can also share more diverse experiences.

Another question facing the program planner is whether the groups should be structured or unstructured. It has been this author's experience that, because the entire concept of group therapy is so threatening to incarcerated individuals, the intentional structuring of groups tends to be a good introductory technique. Utilizing lectures, audiovisual aids, guest speakers, and workbook materials can allow the participants to begin processing highly threatening and emotionally arousing materials without being preoccupied with issues of trust and confidentiality. As the materials are discussed, emotionally charged issues tend to be resolved until the group may naturally need less structure or individuals may be transferred to more advanced groups. The psycho-educational materials presented earlier in this monograph lend themselves to structured group formats.

Specialized Types of Group Therapy

A variety of types of groups have emerged from the various sex offender treatment programs throughout the country. One type of specialized group, which initially evolved at Western State Hospital, Fort Steilacoom, Washington, was the guided self-help group. Because the groups are led by the participants and may or may not have a therapist present at all times, an extensive amount of therapy can be provided. Participants may spend up to 25 hours a week in the group. While one participant leads the group, another serves as scribe, making it possible for the therapist to review several groups conducted simultaneously. Sessions may also be recorded on videotape. Every aspect of one's life is dealt with in the group.

At the Oregon State Hospital program, the group is highly involved in helping each member recognize and record his individual deviant cycle. The cycle is divided into recognition of his deviant arousal pattern coupled with his observable behaviors and his thought processes while in the cycle. This information is recorded on large charts which are posted around the group room, and all members are expected to recognize and confront an individual when he slips into that cycle. Because these individuals can earn community passes, it is important that each group member closely monitor his peers. These individuals are well aware that one individual's deviant behavior can destroy a program, as it did at Atascadero and Fort Steilacoom.

An interesting approach to dealing with the traumas found so frequently in the childhoods of sex offenders was developed at the Adult Diagnostic and Treatment Center at Avenel, New Jersey. Developed by Dr. William Pendergast, the technique is known as Reeducation of Attitudes and Repressed Emotions (ROARE). Of the rapists treated at this program, 90% had been sexually abused during childhood (Pendergast, 1978). The method uses a marathon format and is conducted in the facility's fully equipped television studio where a tape is made of the session. The group begins to confront the selected member, badgering him until he flies into a rage, at which point other members make physical contact with him. According to Dr. Pendergast, the individual then regresses to a reenactment of the memory of his own sexual trauma and undergoes a cathartic experience. Later, the tape of the session is reviewed with the therapist and the patient. This technique is currently utilized to a lesser degree but remains an interesting alternative approach.

Patrick Carnes' (1983) work on sexual addiction has led to the founding of Sexaholics/Sex Addicts Anonymous groups throughout the country. Utilizing AA's 12-step approach, the technique is easily adapted to the new or existing program. A variety of curriculum packets geared to this approach are available, and volunteers who are active in the community may be recruited to establish self-help groups within programs. These groups can also provide a natural transitional program for offenders being released to larger communities.

Empathy for others is one of the basic mechanisms which helps control negative impulses. Offenders as a group lack empathy for a variety of reasons. There is little opportunity to develop empathy for his victim once the offender is arrested. He may or may not ever see his victim again. If he undergoes a trial, he may be entirely focused on renouncing everything the victim says, as well as attempting to impugn her character. Different programs have taken a variety of approaches in helping the offender experience the impact of his behavior on the lives of others.

It is suggested that groups focusing on empathy begin slowly, in the least threatening way, in order to avoid the retreat into defense mechanisms caused when offenders are flooded with guilt. A number of both professional and personal victim account books are currently available. Offenders may start out with materials often available through local rape crisis centers, dealing with the rape trauma syndrome and child sexual assault. They then may move on to personal accounts, such as K. Brady's *Father's Days* (1981) or M. Morris' *If I Should Die Before I Wake* (1982). Movies further personalize the trauma of the victim. Films such as "Something about Amelia" and the Canadian Film Board's "A Scream from Silence" and "A Matter of Consent" are excellent dramatic presentations. If the group is working up to direct victim confrontation, "Rape! Face-to-Face" is another excellent documentary. The therapist may prepare an audiotape based on police reports or on victim impact statements which retell the event from the victim's perspective. This can be expanded into role playing with the offender playing the role of victim.

Cooperation of local victim groups should be actively sought. If counselors of victims can present the offending behavior from the victim's viewpoint, it can have an impressive emotional and intellectual impact.

The final stage is the actual confrontation between victims and offenders. This is usually done with victims from other cases. It is important that the victims are fully oriented to the entire experience—everything from procedures for entering the prison to the goals and techniques of the sex offender program. If at all possible, they should come in as a group, accompanied by their counselor so that they may later have the maximum opportunity to process the experience. The offenders should be fully prepared for the amount of rage which will probably be directed at them. It is cautioned that this technique should only be used with advanced groups where the members have abandoned their denial and are able to cope with their anger and the anger of others.

Whenever possible, group energies should be directed towards assisting community efforts in combating sexual assault. The group may make video presentations aimed at the general public or at potential offenders. They might raise money to contribute to an agency working with victims or, as individuals, voluntarily agree to pay or increase restitution to their victims. They might put their talents to work to construct dollhouses and/or dolls to be used by other agencies in play therapy with child victims. Such projects help enhance the participant's self-esteem and make them feel a part of a larger community effort.

Family Therapy

Family therapy can be utilized with sex offenders in two ways. In the more general context, it is a modality which should be made available to every sex offender involved in a comprehensive program. The anger and resentment towards women characteristic of the rapist and the fear and immaturity associated with many pedophiles are often associated with dysfunctional family interactions which may still be occurring or are being compulsively replicated in other relationships. The work now being done with adult children of alcoholics and expanded to individuals raised in a variety of disturbed familial environments may be directly applicable to many sex offenders. Working on issues of grief, anger, and forgiveness may assist in freeing the offender from his pattern of displacing his rage onto innocent victims. Learning new communication techniques is vital, not only in improving existing relationships but in building a support system which can be utilized to interrupt the deviant cycle. Improv-

ing marital relationships, both sexual and nonsexual, will assist in reinforcing appropriate outlets. Conjugal visits, where allowed, can be utilized as part of the therapeutic process. In situations where this is not an option, traditional marital, conjoint or family therapy can be employed as well as couples or family groups, which can be either educational, therapeutic or a combination of both. Nancy Steele's program at Lino Lakes, Minnesota features at least one family session where all members of the extended family participate in an attempt to help them understand the offender's situation and to provide additional information about his background.

Another way to provide treatment to the family member is to focus more specifically on their needs. Who could possibly be more shunned and emotionally isolated than the wife of an incarcerated rapist or child molester? Not only does she find herself lonely, bereft of emotional and possibly financial support, and angry not only at a violation of the law and the marital contract, but she is subtly blamed by society and possibly herself. After all, it is a common misconception that sex crimes are perpetuated by sex-starved individuals who are deprived of suitable gratification. Therefore, who else is to blame but the partner who failed in some way to provide suitable sexual satisfaction? This unfounded guilt may be compounded by real sexual trauma related to her own victimization. There are no studies at present on the incidence of marital rape in families of rapists, but it may be quite high. In this author's experience, wives of sex offenders had a phenomenally high rate of childhood sexual abuse, with up to 80% being victims of incest. These individuals may also be entangled in co-dependent relations with their spouse's acting-out. Patrick Carnes' (1983) work on the addiction model of sexual deviancy provides valuable insights into working with co-dependency in these situations.

The other, more specific way of dealing with families is in the area of incest. Perhaps the best known work in the field has been done by Henry Giarretto, Ph.D., of the Institute for the Community as Extended Family, Child Sexual Abuse Treatment Program (CSATP) in San Jose, California (Mayer, 1985). This program is community-based, providing group treatment to the offender, wife and victim(s). Self-help is provided through Parents United, Daughters and Sons United, and Adults Molested as Children United. Dr. Giarretto (personal communication, 1984) reports:

- About 90% of the children avoid foster or institutional placement and are reunited with their families.
- The recidivism rate among father-offenders has remained at less than one percent.
- Child victims treated by CSATP do not persist in the self-abusive behavior . . . reported by adults who were molested as children who did not receive individual and family therapy.

While one advantage of this program is that it is largely community-based, the fathers often serve an initial period in jail, being released on furloughs to attend treatment. Sex offender programs in jails or in minimum security facilities may be able to take advantage of similar programs throughout the country. Where community participation of this sort is not possible, programs may still be provided for families. Marital and family therapy can be arranged in most settings, and marital and family groups meeting at least once a month are incorporated into many programs. It should be remembered that in states without sex offender treatment programs, incest offenders with supportive family systems amenable to treatment may end up in prison. In states with programs which interact with the courts and social service departments to provide alternatives to incarceration, offenders serving sentences for incest may primarily be antisocial individuals with prior criminal records or fixated pedophiles who have long histories within and outside the family patterns of child molestations. Neither of these types is particularly suited to family-centered therapy.

Therapeutic Communities

The therapeutic community is a residential program whose aim focuses on rehabilitation rather than mere incarceration. All staff involved with these residents become part of the treatment team, and every aspect of daily interaction becomes the focus of therapeutic intervention.

Fenton, Reimer, and Wilmer (1967) describe "correctional communities," which is more precisely what is being discussed, as "a method of social therapy in which staff and inmates make a conscious effort to utilize all experiences in all areas of their lives in a therapeutic manner (p. 1)." These authors point out that the staff in a typical institution influences the residents in only one specialized area, e.g., security, mental health, education. This creates an environment that is ripe for manipulation and for playing staff members against each other. In the "correctional community," all staff play a therapeutic role with individual disciplines uniting in common goals. The residents form a community that holds its members accountable.

Incarcerated individuals usually deal with their imprisonment with suppression, rationalization, anger at society, withdrawal, and/or manipulation (Fenton, Reimer, & Wilmer, 1967). Institutions filled with these individuals may adapt many of these same characteristics. The staff may be isolated from each other, deviant behaviors may become the norm, and antisocial values may become predominant.

The therapeutic community can combat many of these trends. For the first time in their lives, residents may be exposed to a group of people who utilize cooperation and

communication. An expression and acceptance of emotions are valued, and an atmosphere is created where the expression of emotion is reinforced, resulting in an atmosphere of mutual help. This is particularly important for the sex offender who may be unable to find other residents to confide in due to the nature of his crime.

Staff must learn to function in ways alien to the traditional correctional model, with the role becoming one primarily of adviser rather than enforcer. Even when in an authority role, the staff member needs to be able to explain the meaning behind the rules and enlist the cooperation rather than the coercion of the community.

The community must begin to assume responsibility for the conduct of its members. Initially this may fly in the face of the most basic prison code—the dictate against "snitching." The members must come to appreciate how the conduct of one reflects upon all the others. The very existence of the community relies on the degree to which its members are willing to confront one another. This becomes increasingly the case if community release is part of the program. For this reason, therapeutic communities such as that at Oregon State Hospital force members to learn everyone's deviant cycle and to confront each other when that cycle surfaces.

Therapeutic communities for sex offenders exist today in a few states, including Oregon, Minnesota, Massachusetts, Utah, Montana, and Vermont. Other states house sex offenders together but not in therapeutic communities. There are a number of factors which determine whether a therapeutic community could or should be established in a prison setting.

The first duty of any institution is to make sure that its residents are physically safe. Because the existence of a therapeutic community for sex offenders would stigmatize the residents, each state's corrections department must determine whether this is a wise undertaking. Can the residents be segregated from the rest of the prison population without depriving them of other services, e.g., educational opportunities and recreational facilities? Depending on the individual personality of each prison, this may or may not be possible. Personalities of institutions may change drastically due to factors such as overcrowding. Any situation which increases tension among residents will be reflected in the treatment of sex offenders by the rest of the population. Sensational sex crimes will increase the pressure.

Therapeutic communities cannot operate in every prison. Where they are possible, however, they are cost-effective and provide a facilitative environment in which psychological and

Definition: Therapeutic Community

The primary goal of a Therapeutic Community is to foster personal growth. This is accomplished by changing an individual's life style through a community of concerned people working together to help themselves and each other.

The Therapeutic Community represents a highly structured environment with defined boundaries, both moral and ethical. It employs community imposed sanctions and penalities as well as earned advancement of status and privileges as part of the recovery and growth process. Being part of something greater than oneself is an especially important factor in facilitating positive growth.

People in a Therapeutic Community (T.C.) are members, as in any family setting, not patients, as in an institution. These members play a significant role in managing the T.C. and acting as positive role models for others to emulate.

Members and staff act as facilitators, emphasizing personal responsibility for one's own life and for self-improvement. The members are supported by staff as well as being serviced by staff, and there is a sharing of meaningful labor so that there is a true investment in the community, sometimes for the purpose of survival.

Peer pressure is often the catalyst that converts criticism and personal insight into positive change. High expectations and high commitment from both members and staff support this positive change. Insight into one's problems is gained through group and individual interaction, but learning through experience, failing and succeeding and experiencing the consequences, is considered to be the most potent influence toward achieving lasting change.

The T.C. emphasizes the integration of an individual within this community, and the progress is measured within the context of that community against that community's expectations. It is this community, along with the individual, that accomplishes the process of positive change in the member. The tension created between the individual and this community eventually resolves in favor of the individual, and this transition is taken as an important measure of readiness to move toward integration into the larger society.

Authority is both horizontal and vertical, encouraging the concept of sharing responsibility, and supporting the process of participating in decision making when this is feasible and consistent with the philosophy and objectives of the Therapeutic Community.

—from the TCA credentialing packet

social growth may occur. However, they must be constantly monitored and revitalized or they become just another cellblock with a fancy name.

Sexual offenses are violations of interpersonal relations. They represent a violation of trust, betrayal of intimacy, and dissolution of boundaries. Treatment must involve establishing an awareness of what appropriate relations represent. Often sex offenders have little, if any, awareness of normalcy in this area. Violated as children, abused or neglected, many have little opportunity to observe and learn anything other than exploitive interactions. Relearning involves confrontation, acknowledging one's own pain, and generalizing this recognition to the pain of others. It then involves relearning how to change one's thought patterns, appropriately channel one's emotions, and control one's behavior.

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Chapter 12: Behavioral Techniques to Alter Sexual Arousal

by Michael J. Dougher

Abstract

Dr. Dougher presents a variety of behavioral approaches utilized in modifying deviant arousal. While most of these techniques involve the use of the plethysmograph, some may be used without this device. Covert sensitization, satiation techniques, counterconditioning, and behavioral rehearsal are explained.

The behavioral techniques discussed in this chapter are those that have been used to alter patterns of sexual arousal with sex offenders. Specifically, these techniques are used to increase arousal to appropriate sexual stimuli and to decrease arousal to deviant or inappropriate sexual stimuli. While appropriate and inappropriate sexual stimuli and activities are culturally defined, in the context of this paper "inappropriate sexual stimuli" are those which involve children or exploitive, or violent sexual activities. "Appropriate sexual stimuli" are those involving consenting adults in nonexploitive or nonviolent activities.

Sexual arousal is the focus of intervention in many sex offender programs simply because it is believed to be a factor in sexually abusive behavior (Laws & Osborn, 1983; Quinsey & Marshall, 1983; Finklehor, 1984; Laws, 1984). No claim is made that it is the only factor, or even the primary factor; nevertheless, it is the case that sex offenders of various types can be differentiated from each other and from nonoffenders on the basis of their patterns of sexual arousal (Quinsey, Steinman, Bergerson, & Holmes, 1975; Abel, Blanchard, Becker, & Djenderedjian, 1978; Quinsey, Chaplin, & Varney, 1981; Laws & Osborn, 1983; Laws, 1984). Moreover, a reduction of deviant sexual arousal does enjoy some measure of predictive validity in terms of recidivism rates among offenders and allows for more predictability of post-therapy success than any other measure yet developed (Quinsey & Marshall, 1983).

The purpose of this chapter is to briefly describe the behavioral methods and the mechanisms underlying their effectiveness. The clinician will be provided with suggestions for the implementation of these therapeutic methods. The behavioral techniques discussed are covert sensitization, assisted covert sensitization, olfactory conditioning, the satiation therapies, aversive behavioral rehearsal, and arousal reconditioning. The first five methods are designed to decrease inappropriate arousal; arousal reconditioning is utilized to increase appropriate arousal patterns.

These techniques have a reasonably good track record. Three reviews of the research on sex offender treatment suggest that behavioral interventions appear to have the best success rate (Kelly, 1982; Kilmann, Sabalis, Gearing, Bukstel, & Scovern, 1982; Lanyon, 1986). While there are more and better studies examining the effectiveness of behavioral techniques, there is still a relative lack of adequately controlled treatment outcome studies. Obviously, more research is needed in this important area.

There has been some controversy, or at least disagreement, about how these procedures actually work. For example, Cautela (1967), the developer of covert sensitization, views this procedure as an imagery-based operant or instrumental punishment procedure. Rachman and Teasdale (1969) argue that these stimuli function as conditioned suppressors which inhibit sexual arousal. Neither of these explanations has fared well. In a series of experiments, Dougher, Crossen, Ferraro, and Garland (1986a, 1987, 1988) have shown the Cautela assumption to be untenable. Also, Quinsey (1973) has shown that the formulation of Rachman and Teasdale is not supported by the results of clinical studies using these procedures. As an alternative, Dougher et al. (1987, 1988) suggest that covert sensitization is a classical counterconditioning procedure by which means deviant sexual stimuli simply lose their capacity to reinforce sexual behavior. The experimental findings support this explanation.

While this discussion may seem to be primarily academic and theoretical, there is real significance for the practical use of these procedures. It is suggested that these procedures must be implemented according to the parameters of classical conditioning. Failure to adhere to these theoretical parameters may result in ineffective treatment interventions.

A final word before turning to the techniques. Except for arousal reconditioning, all of the techniques discussed here are examples of counterconditioning procedures in that they attempt to reduce deviant sexual arousal by pairing sexually deviant stimuli with unpleasant stimuli. Because of this, it is essential that they be used with strict adherence to ethical and legal guidelines, such as prevailing consent decrees or court orders. Informed consent must include detailed descriptions of the procedures and possible side effects. Clear criteria for termination of the procedures should be developed, and a clear rationale for their use should be given.

Types of Techniques

Covert Sensitization

Covert sensitization was first developed by Cautela in 1966 and has been used to treat a wide variety of disorders, includ-

ing alcoholism, obesity, smoking, and sexual deviance (Cautela & Kearney, 1986). A number of studies have reported the successful use of covert sensitization procedures with sex offenders and the reader is referred to them for procedural details (Barlow, Agras, Leitenberg, Callahan, & Moore, 1972; Callahan & Leitenberg, 1973; Harbert, Barlow, Hersen, & Austin, 1974; Brownell, Hayes, & Barlow, 1977; Barlow & Abel, 1981; Kelly, 1982; Laws & Osborn, 1983).

Essentially, covert sensitization is an imagery-based counterconditioning procedure in which clients are instructed to imagine some deviant sexual act or stimulus followed by the imagining of some negative reaction, usually either severe anxiety, terror or nausea. In the fantasy, the imaginary pairing is often accompanied by relief from the imagined aversion, contingent upon the offender's turning away from the deviant act or stimulus. Avoidance scenes are also employed in which offenders curb negative images by imagining themselves avoiding deviant acts and stimuli.

Scenes should be constructed individually for each offender according to his sexual fantasies and specific nausea response. (The reader is referred to Abel, Blanchard, and Becker [1978] for a detailed covert sensitization scene with a rapist.) However, scenes should use words and descriptions that are arousing to the offender, and the characteristics of the victim and nature of the sexual activity should fit his fantasies and previous offenses. Descriptions of sexual arousal and nausea (or anxiety) should be graphic, and emphasis should be given to detailed descriptions of bodily reactions rather than the stimuli that elicit them.

In line with the theoretical processes underlying covert sensitization, the procedure must use nausea scenes that function as unconditioned stimuli. By themselves, these scenes must elicit strong nausea reactions. Offenders should be observed to grimace, swallow, squirm, and show general signs of nausea. If possible, it is useful to measure physiological correlates of nausea, such as heart rate, skin conductance lev-

The Use of Medroxyprogesterone Acetate (Depo-Provera™)

Recently there has been much publicity regarding "chemical castration" through the use of drug treatment with sex offenders. The drug which has been most widely used is medroxyprogesterone acetate MPA, better known by its trade name, Depo-Provera™. This drug is used as a female contraceptive in some countries and as a treatment for some types of gynecological cancer. It is also used by veterinarians in treating aggressive behavior in male dogs. However, while not approved specifically by the FDA for treatment of sex offenders, physicians may legally prescribe it.

The drug acts directly upon the hypothalamus which, in turn, stimulates the pituitary to release hormones which control the production of sperm in the testes. While the level of sexual arousal is decreased, men on MPA are still capable of achieving erections, engaging in sexual intercourse, ejaculating and even impregnating. Thus, it is a total misconception that MPA is "chemical castration."

Its use remains highly controversial. A study published in 1986 indicated that out of 297 adult sex offender programs, only 42 utilized the drug and, of these, only 14 were in residential facilities. However, Maryland, Vermont, Montana and Oregon Departments of Corrections have approved its use. MPA appears to be most appropriately used with offenders experiencing highly intrusive deviant fantasies. These deviant thoughts arise spontaneously, without external stimuli, and are so frequent that they interfere with the offender's ability to concentrate or work. According to Walker and Meyer (1981), pedophiles and exhibitionists appear to be better candidates than rapists, incest fathers, and voyeurs. When MPA is available, it should only be used after less intrusive methods have failed and then only as a part of a comprehensive treatment program.

There are a number of considerations which must be evaluated before a corrections department approves the use of MPA. Because it has not been specifically approved for sex offender treatment, its use may be considered experimental. There may be legal problems posed in states where experimentation with inmates is prohibited. There are also questions regarding an inmate's ability to give informed consent in the coercive atmosphere of a prison (see Chapter 19).

Finally, there is the issue of side effects. The use of MPA has been associated with weight gain, lethargy, headaches, hot and cold flashes, insomnia, nausea, muscle cramping, irritability, and shortness of breath. Testicular atrophy may occur but is reversible. However, long-term effects have not been sufficiently studied, and possible carcinogenic properties remain to be clarified.

MPA appears to have the potential for treating certain types of sex offenders in highly controlled situations. However, it is currently rarely used even in outpatient programs. The variety of problems posed by the special circumstances associated with the use of MPA in a correctional setting (informed consent, legal restraints) suggests that administrators should exercise caution in approving its use. It is suggested that a Medical Advisory Board be appointed to study the latest research and make appropriate recommendations.

—Roger Smith

els, or respiration. With repeated presentations, the nausea scene should be introduced progressively earlier in the deviant sexual scene until it is introduced upon the first mention of sexual arousal. If an offender is unable to clearly imagine the deviant scene or generate nausea to the nausea scene, conditioning will not occur and the treatment will not be effective.

While the duration of the scenes varies somewhat, typical presentations are about two to three minutes. The number of scene presentations per session also varies, but it is not uncommon to find as many as 10-15 scenes per session. Care must be taken, however, to avoid habituation. There are also no clear guidelines in the literature regarding the number of scenes that should be presented to ensure maximum efficacy. Forty scenes is common, but psychophysiological measures of arousal should be used to be sure that the procedures have, in fact, produced significant decreases in deviant sexual arousal. In addition, booster sessions should be scheduled about six months after treatment (Maletzky, 1977).

Assisted Covert Sensitization

Assisted covert sensitization was first used as treatment for a sexual offense by Maletzky (1974). It is used to enhance the effects of covert sensitization, especially when the offender is not capable of generating sufficiently strong nausea reactions to make basic covert sensitization effective. Assisted covert sensitization employs a noxious odor to aid in the development of a nausea response. Different sources of noxious odors have been used, but most procedures use valeric acid or cultured (rotting) placenta. These odors can engender particularly strong nausea reactions.

The underlying mechanisms of assisted covert sensitization can be safely assumed to be similar to basic covert sensitization. Accordingly, the same parameters should be followed. That is, pairing should continue until deviant arousal is significantly reduced. Maletzky (1974) reports satisfactory results with an outpatient population using 10-12 bimonthly office sessions, coupled with 15-25 triweekly "homework" sessions during which clients are instructed to practice the techniques in extra therapy sessions. Booster sessions may be warranted about six months after treatment.

Olfactory Conditioning

Olfactory conditioning is very similar to assisted covert sensitization except that clients are not required to imagine either sexually deviant or nausea scenes. Instead, inappropriate sexual stimuli are presented to clients via slides, audiotapes or videotapes, followed by the presentation of a noxious odor. The first report of the use of olfactory conditioning was by Laws, Meyer, and Holmen (1978). Since then it has been used by Marshall, Keltner, and Griffiths (1974) as a treatment with two cases of fetishism. Although a promising technique, more research is needed to be sure of its long-term effectiveness and limitations.

The Satiation Therapies

Two particularly promising techniques for reducing inappropriate sexual arousal are masturbatory satiation (Marshall & Lippens, 1977; Marshall & Barbaree, 1978; Marshall, 1979; Abel & Annon, 1982) and verbal satiation (Laws & Osborn, 1982).

Masturbatory satiation involves first having the offender masturbate to ejaculation to an appropriate sexual fantasy. The offender should be required to verbalize the fantasy aloud to be sure that the fantasy is, in fact, appropriate. The offender should be encouraged to embellish the appropriate fantasy with feelings of affection, tenderness and warmth. Following this, the offender is required to continue masturbating for a period ranging from fifty minutes to two hours while verbalizing deviant fantasies. At times, the continued masturbation will result in arousal, at which time the offender is instructed to switch to an appropriate fantasy. This process can be minimized if the offender is required to masturbate to ejaculation twice to appropriate fantasies before beginning the satiation procedure. Abel and Annon (1982) report significant reductions in deviant arousal within 12 sessions.

Verbal satiation procedures are similar to masturbatory satiations, except that the offender is simply required to continuously verbalize deviant fantasies after masturbation, and ejaculate to appropriate fantasies. Continuous verbalization is required for at least thirty minutes not less than three times per week. According to Laws and Osborn (1982), significant reduction in deviant arousal occurs within 40-60 sessions. The two satiation techniques have not yet been compared directly for their effectiveness or efficiency.

Aversive Behavioral Rehearsal

Aversive behavioral rehearsal (ABR) was first used as a treatment for exhibitionism but has been extended to the treatment of pedophilia and rape (Wickramasera, 1976). It is an extremely powerful technique but intrusive and potentially humiliating for offenders. Its goal is to decrease sexually deviant behaviors and arousal by making the behavior publicly observable. Because of the nature of ABR, therapists are urged to inform the offenders of the exact procedures to be used, the possible side effects, and available treatment options. Wickramasera (1976), however, reports this technique to be effective with clients where other techniques, including those discussed in this chapter, have failed.

There is no single ABR procedure. Variants on the technique have been employed by different therapists to suit the needs of the offenders with whom they work. What is described here is a general procedure using the techniques common to the various specific procedures.

The procedure starts by having offenders describe in detail

the types of sexual offenses committed and the situations in which they have occurred. From this description, the therapist can determine what props (e.g., mannequins, clothing, apparatus, etc.) should be used in subsequent reenactments of the offense.

Next, the offender spends approximately 30 minutes reliving the offense in the presence of the therapist, other offenders, significant others, and/or other treatment staff. Often these sessions are videotaped. The offender is encouraged by the therapist to relive the offense with as much detail as possible. The offender is required to verbalize his plans for the offense, the method of stalking and controlling his victim, how he was dressed, how he felt at various times during the offense, his thoughts, etc. This process can create an exceptionally emotional session, and some time is usually needed to debrief the offender and help him cope with his reactions to the session. These sessions may be repeated to deal with other offensive acts or fantasies.

During the next phase of treatment, the videotape is viewed by the client, therapist and a group which includes other offenders, treatment staff or the offender's significant others. The offender is required to narrate the tape, explaining his thoughts, feelings and actions. In subsequent sessions, the tape may be viewed again by the client, therapist and others. Wickramasera (1976) recommends follow-up sessions at two, six, nine and twelve months, then once each year as needed to maintain treatment gains.

This technique is extremely intrusive and often results in serious side effects. Common iatrogenic reactions include depression, anxiety, nightmares, secondary impotence, and a general disinterest in sex. Fortunately, these reactions usually dissipate within a few weeks. Some offenders attempt to avoid the powerful impact by cognitively withdrawing from the procedure, or thinking of something else. The therapist can minimize this response by forcing the offender to verbalize in detail his thoughts, feelings and the circumstances of the offense.

Arousal Reconditioning

To this point, the procedures described were designed to reduce inappropriate sexual arousal and behavior. However, it is the case that simply eliminating inappropriate arousal without enhancing appropriate arousal will produce only short-term effects. In fact, Barlow and Abel (1976) recommend that the best clinical strategy is to increase appropriate arousal before decreasing inappropriate sexual arousal. One straightforward method of increasing appropriate arousal is simply to pair masturbation with appropriate sexual stimulation or fantasies. This procedure has reportedly been successful in the treatment of sadomasochism (Davison, 1968; Marquis, 1970) and pedophilia (Annon, 1971).

One problem with this technique is that many offenders, particularly pedophiles, do not exhibit sufficient sexual stimulation to appropriate sexual fantasies to allow for arousal and orgasm. To address this issue, Davison (1968) and Marquis (1970) have employed a thematic shift method in which offenders begin masturbating to deviant fantasies or stimuli but shift to appropriate fantasies at the point of orgasmic inevitability.

Because of the popularity of this procedure, Conrad and Wincze (1976) reviewed the literature and found a disturbing lack of methodological rigor. In a carefully controlled evaluation of this procedure, they were not able to attribute behavioral change to it and concluded that the procedure by itself was suspect.

In response, Abel, Blanchard, Barlow, and Flannagan (1975) and VanDeventer and Laws (1978) have used a procedure of fantasy alteration between masturbatory sessions rather than within sessions. Thus, clients are instructed to masturbate to ejaculation alternately to appropriate and inappropriate fantasies. This procedure produces a simultaneous reduction in deviant arousal and increase in appropriate arousal, although the mechanisms responsible for these effects are unclear (Laws & O'Neil, 1981; Foote & Laws, 1981).

The fantasy alteration approach seems preferable to simple orgasmic reconditioning as it is more reliably effective and more efficient, having the advantage of simultaneously increasing appropriate arousal while decreasing inappropriate arousal. The same, however, is true of masturbatory satiation, as discussed earlier. It seems, then, that therapists are offered a choice between fantasy alteration and masturbatory satiation to increase appropriate arousal. There may be a slight preference for the masturbatory satiation procedure since it is theoretically more straightforward and avoids the problem of having offenders masturbate to inappropriate fantasies.

The behavioral techniques for altering sexual arousal patterns have good track records in the psychological literature and should be included in any comprehensive treatment program. However, by themselves, they are not enough as a treatment program. They must be coupled with other treatment modalities which are discussed in other chapters of this volume.

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Part Four: Aftercare

The reintroduction of the sex offender into the community is a critical part of treatment. As Nancy Steele, Director of the Transitional Sex Offenders Program in Lino Lakes, Minnesota, says, "Treating a sex offender is like having a bear by the tail. It's all in how you let go." States vary widely in the methods used to release offenders.

Sentencing structure may have a major impact on the demands that can be made on releasees. Offenders serving indeterminate sentences may be willing to accept stringent conditions to obtain parole. Offenders with determinate sentences are released when their time expires, regardless of how dangerous they might appear to be. Stipulations may be placed on them, but it is up to parole officers to enforce these conditions. Some states have excellent systems of halfway houses and treatment programs. Others have practically no community programs whatsoever.

The comprehensive sex offender treatment program should strive to slowly release the participant from the institution. It must be remembered that these individuals have often committed their crimes while under stress and particularly when feeling isolated and rejected. Almost all releasees, regardless of their crime, report that these emotions flood them upon their discharge from prison. Any social ineptness they may have experienced prior to imprisonment is accented by the new label of "ex-offender."

Many states do not allow sex offenders to participate in community release programs, such as work release or furloughs. While there is obvious concern on the part of corrections departments for public safety and liability, it must also be remembered that failure to provide slow reintegration may increase recidivism. Because sex offenders have little temptation or opportunity to reoffend while in prison, they need to be briefly exposed to the community and then be able to process the experience in therapy.

The following section describes how prison programs and field services may utilize various techniques to transition the offender. Minnesota's outstanding program gradually works the participants into a special halfway house by initially taking the incarcerated offenders into the house for groups and bringing parolees back into the institution, thus creating a bridge into the new setting.

In Vermont, mental health professionals and parole officers work together to provide community treatment groups and to monitor relapse cycles. Oregon's program also focuses on slow transition and on specially trained parole officers who provide therapy as well as supervision. (See Appendix D for Oregon's special parole conditions for sex offenders.)

The following chapters suggest ways to deal with pre-release issues, to establish transitional programs, and to train field service personnel to maximize their efforts by identifying specific behavior patterns which may serve as warning signals.

Chapter 13: Aftercare Treatment Programs

by Nancy Steele

Abstract

Drawing on her experience as director of Minnesota's Transitional Sex Offender Program, Dr. Steele outlines how sex offenders can be gradually transitioned from a prison program into the community with the use of halfway houses. The importance of this final step in the treatment of sex offenders is emphasized.

Treatment of sex offenders in a secure setting teaches new behaviors and increases control over the older assaultive behaviors. Hopefully, when offenders are released, they will not harm others again. If the lessons taught in treatment are to be transferred to the new and less controlled setting of the community, aftercare or follow-up within that community is essential. Treatment then becomes a vehicle for easing the transition between the artificial living arrangements of confinement to the more realistic living arrangements outside the institution.

A measure of a treatment program's effectiveness is, of course, the reoffense rate of its graduates. The problems of detecting recidivism in sex offenders are frequently mentioned in the literature of the field and are well documented in a study by Groth, Longo, and McFadin (1982). In the few studies available, there is some evidence that the highest rate of known repeated offenses occurs within the first two years of release from a correctional facility (Christiansen, Elers-Nielson, Lamaire, & Sturup, 1965; Soothill & Gibbens, 1978).

In 1979 a study was begun in Minnesota to follow carefully the behavior of 74 untreated sex offenders released from the state prison. In the first year, 35 of them (47%) either absconded or were arrested on a new offense. Not all of these arrests resulted in convictions, but they did indicate varying degrees and types of problem areas the offenders were experiencing in their initial release period. Problems ranged from fights with wives and girlfriends to stabbings to new felony-level sex offenses. The average time to rearrest was 5.1 months after release. Six of them were arrested on new sex offenses within the first six months, with two of these occurring within two weeks of release.

Given these indications that sex offenders just released from prison are at a high risk to reoffend, it seems clear that strong aftercare is a necessary component of institutional treatment programs.

Some research, as well as accepted correctional practice, points to the need for a gradual return of all offenders to the community. LeClair (1981) has reported on a study completed in the Massachusetts Department of Corrections covering releases of 8,121 inmates in a seven-year time period. Recidivism rates for all types of offenders dropped from 25% to 16% with the establishment of a community reintegration model in the correctional system. (Recidivism in this study was defined as a return to prison, for any reason, within one year after release.) The model used decreasing levels of security, the introduction of a furlough system, and a pre-release program that allowed offenders to live in the community where they could find jobs and/or educational opportunities.

The continuation of treatment combined with the increased exposure to the community allows for the transference of learning to the setting where it needs to be implemented. The individual establishes trust with the new community therapist and the group, and his uneasiness, which increases upon release from the correctional facility, can be dealt with in a much more effective way. In addition, the treatment becomes more relevant when the individual is exposed to the community in a gradual, controlled way. The urge to act-out sexually rarely manifests itself within the institution but sometimes floods the individual when he is first exposed to life outside. If he is honest at this point and if the therapist is skillful, it is a great opportunity for him to get help in strengthening his controls. Conducting treatment exclusively in a secure, controlled institutional setting is like teaching someone to swim in a bathtub.

Much of the information about aftercare in this chapter was derived from work with the Transitional Sex Offender Program (TSOP), which has always had a strong community aftercare component. This Minnesota program is administered through a medium security prison about 20 miles north of the Twin Cities. The men are in their last 10 to 12 months of incarceration and are involved in an institutional residential treatment program. The TSOP participants must agree to complete four months of aftercare in a halfway house in Minneapolis. While living in the halfway house, they find jobs and begin to spend more time with their families and friends. Their roommates are men with whom they went through treatment. Participants attend group sessions one night a week and have an individual or couples session with their TSOP therapist once a week.

After moving from the halfway house, the participants must attend the group every other week for three months; thus, over a period of seven months, they gradually decrease their contact with TSOP and its staff. When they complete the program, they are living in the community, reporting to their parole officers and have had time to establish a social support network. This could include referral to community out-

patient treatment which is sometimes necessary, especially for incest families who wish to reunite.

This strong approach to structure and aftercare in the TSOP has yielded promising results. Recently a study was completed by the Research Office in the Minnesota Department of Corrections (Welfling, 1987). It compared return rates to prison of 111 sex offenders who completed TSOP with those of 64 offenders who either quit or were removed from the program and were not involved in the aftercare phase. Two years after release 5% of the TSOP graduates returned to prison with new criminal convictions, and 14% of the program failures returned. This still compares favorably with the general return rate to prison for all adult offenders in Minnesota, which shows a new conviction rate of 20% after two years. This may suggest that while some treatment inside of prison helps, completion of the aftercare component improves the success rate considerably.

Other institutional programs, frustrated with the need for an aftercare component, have begun to bring parole and mental health staff in from the communities in order to train them and develop the needed liaisons for aftercare. One of the biggest problems in developing only institutional programs is that people who could be treated in the community may be sent to prison for treatment. This is not only more expensive for the taxpayer but is also destructive to the individual and the families involved. The best way to protect against this is to develop resources in the community that integrate with institutional services, thus providing continuity of care and control.

Release from the Institution

Many mechanisms have been built into TSOP to ease the sex offenders' transition back into the community and to help them generalize what they have learned in treatment to the situations in the community. About six weeks before their release date, which is established by their sentence, the men begin to attend the outpatient group which meets one night a week at the halfway house where they will be living. Time spent with their inpatient group decreases slightly at this point. The outpatient group gives the men a chance to see where they will be living and to hear the problems and concerns of those who are further along in the program. In general, the more one knows about an upcoming situation, the better one can prepare for it. The men are driven to the halfway house by TSOP staff who run the group and return them to the institution after each session. In many programs, outpatients return to the inpatient setting where they underwent treatment as another way to accomplish the same linkage. However, in these instances the treatment emphasis is on concerns of those in the institution and may not focus so much on community adaptation. In group sessions, if the outpatients are being realistic about their concerns and feelings, it gives the inpatients a chance to preview their own exits from the institution.

Twice a month the participants in the transitional phase report to men still living in the treatment cottage about how the outpatients are doing. Of course, more detailed, informal discussion goes on outside the group and cottage meetings, which keeps the inpatients aware of the progress of the men in the halfway house. Their failures are rarely hidden or downplayed. When the progression of a failure can be traced, especially in those few cases where a new sex offense has been committed, it is reported to the cottage residents in a way that helps them better understand what the man himself could have done differently and emphasizes how each person can learn from the failure of another.

From the program's inception, there has been a call-in line that enables men in the community to contact inmates or staff 24 hours a day, 7 days a week. Although this was first conceived of as a crisis line and is occasionally used that way, it primarily functions as another supportive link between the correctional facility and the community. It allows men to maintain friendships they have made in treatment, to exchange information about the outside world, and to make plans for the future.

Furloughs or day passes are another way for inmates to maintain some contact with the outside world. The use of passes is encouraged so the men can attend AA meetings, visit their families, or participate in social and recreational activities in the community. Sometimes the inmates are encouraged to go out on passes with one another as a way to strengthen their bonds. Some of these friendships and activities have continued for many years after release from the program and have been a healthy influence on the men's readjustment. Feelings, urges, and impulses that arise on these community excursions make excellent topics for group discussion. Thus, the whole group benefits.

Leaving a prison, hospital, or secure treatment setting is a major event in such an individual's life. The longer the sex offender has been confined, the more momentous and frightening the departure. This is especially true if confinement has been since adolescence. The less time the individual has spent successfully in the community, the more he fears another failure and doubts his ability to succeed—no matter how good his intentions. Very few inmates will reveal that they want to stay, yet most of them feel ambivalence toward leaving. They are familiar with and comfortable in their setting. If they have had a good experience in treatment, they are attached to some of the other inmates and, to a lesser extent, some of the staff. These attachments are very important, and it is necessary for the men to talk about how they feel about leaving those to whom they are close. For some, if they have been particularly lonely and alienated most of their lives, the attachments formed in treatment may be the closest and most genuine relationships they have ever realized.

A graduation ritual has been developed in which the exiting man makes a brief speech during his last inpatient meet-

ing with the others. He talks about what he has learned in treatment, what has helped, and what he will miss. This learning to say good-bye is an important part of the process of leaving. The cottage members will often shake the departing man's hand or hug him and wish him well. Sometimes the cottage shares a special meal in his honor.

The anticipation of change begins to affect the inmates about three to four months before their release. In the treatment milieu, there are changes in how they interact and function in their daily living. These changes resemble regressions. Some of their worst behaviors begin to reappear—behaviors they may have exhibited when they began inpatient treatment. They may become more quiet or secretive. Sometimes tempers flare and arguments erupt. They may challenge authority or "the system" to remove the focus from themselves. They may not want to talk about their sexual feelings, thoughts, or crimes. For sex offenders who deal with their anxieties through sex, their sexual fantasies, urges, and use of pornography may very well begin to increase. They may become reluctant to talk about their cycle of sexual assault. These patterns are unique, fixed, and repetitive for each offender. Feeling apprehensive, they are particularly afraid to tell staff anything that might be detrimental to their release. Not talking about feelings or impulses is one of the more common methods which many offenders have learned to control their stress. However, this frequently might contribute to their acting-out. From the beginning of treatment, staff needs to stress that these feelings, impulses, and fantasies will recur from time to time and that the appropriate method of dealing with them is to talk about them and, in so doing, to get some help working through them. If the sex offender denies or hides these feelings, he could be near the brink of a dangerous cycle that will lead to a new sex offense. If there is some understanding and trust between clients and staff and if staff is willing to ask about the existence of these symptoms and impulses in a nonpunitive way, they can be talked about, worked through and, to some degree, defused. Often when a man talks about some very frightening impulse or fantasy, he finds that after it is exposed, it is no longer powerful. Other offenders are often better than therapists at sensing these feelings in one another. If the group culture is healthy, they will encourage the man to talk openly.

One of the most frequent ways the sex offender's exiting jitters are manifested is in a fight with his best friend over some trivial issue or with a staff member on whom he feels too dependent. This fight and the subsequent cool-down of the relationship lessens the pain of saying good-bye. This is obviously a rather primitive and childish way to deal with the end of a relationship, but it is typical of the sex offender's past behaviors and the patterns that led him to the acts of violence for which he was incarcerated.

Once the therapist recognizes and understands the man's behavior, it can be used in a therapeutic manner. The treatment for all these symptoms is similar. The therapist must analyze the man's underlying fear or uncertainty. If the sex offender is given permission to be afraid and to doubt himself, his worst fears can be discussed. The more accurately the therapist can pinpoint the particular fear, the more helpful the therapy will be. For example, is the man worried about looking for a job, fighting with his wife, or performing sexually? Is he concerned about the health of a parent for whom he feels responsible? Does he trust the therapist and/or the group enough to tell them what is really going on? He must learn that disclosure is his best chance for help and that talking about the situation will allow him to master his behavior now and after his release.

It is also important for the therapist to continue to mention how many remaining sessions the man has before he leaves. This gives him some time within the last few weeks to talk about how he feels about leaving. The good-bye process spans many sessions. As previously mentioned, the man's last inpatient meeting is devoted to his saying good-bye. He summarizes what the treatment has been like for him and specifically discusses each group member's contribution to his growth. He may also suggest directions for each member of the group and give final input on how he perceives the other individuals.

The Community-Based Residential Facility

From a treatment strategy standpoint, it is ideal to have a residential setting in the community as a place to conduct treatment and in which the offenders leaving an institution can live for a few months while they adjust to life outside prison walls. However, establishing this facility is not an easy task. It takes an administration with a fair amount of courage and persuasive ability.

In places where this has been done, it has happened gradually. If a halfway house already exists in the community, it is a matter of persuading its administrators to take a chance on admitting sex offenders.

It is essential to be honest and straightforward with other agencies and staff. The program participants' projected behavior should never be guaranteed or oversold. Staff should not take responsibility for what the offenders do—good or bad. It is often better to underpredict the probability of success.

If the first few participants do well, it will leave a good impression and will cushion the program against the more difficult cases which may follow. Credibility and trust are built over time through a willingness to share with other staff and honestly talk about one another's doubts and concerns. Weiser (1986) describes a model program of interagency cooperation in a community-based incest treatment program. How-

ever, ultimately the offenders are the only ones responsible for and able to control their behavior.

Whatever the arrangement with the supervising agent, it is important that each participant understands that he must not keep secrets from the group and that all pertinent information relating to his current behavior will be shared, if necessary, with those officers responsible to the court.

A necessary component of aftercare in the community is a mechanism that ensures attendance. Participants must have a clear understanding that if they miss one appointment without permission, their parole officer will be contacted immediately.

Therapy should concentrate on how the offenders are adjusting to the community. What are their feelings, concerns, and fears? What are their sexual fantasies, urges, and behaviors? Loneliness is often the most persistent problem. The offenders should learn to use the group to plan actions with which to combat these feelings. Aftercare is a safety net from which to build new social networks. If an offender is relying on sex as a way to meet these social needs or counting too heavily on one woman or one individual, he is setting himself up for failure.

Group members need to believe that the therapist will act to confine or curtail the movement of a participant if it appears necessary. They will lose confidence in a therapist who is not willing to intervene. When such action is necessary, it is best for the therapist to be as straightforward as possible with everyone concerned, individual and group, about what is being done and why, and what the consequences will be. Sex offenders depend on staff to help them when they cannot control themselves.

The therapist periodically has to bring up the issues, especially sexual issues; and questions must be asked. One of the best ways to encourage offenders to talk about their more shameful impulses is to confirm their feelings, for example: "I know it is hard to talk about. . . . I can see how bad you feel about it. It takes a lot of courage to share things sometimes. I have a lot of respect for you for being able to say the worst things. I know you don't want to do anything to hurt anyone."

Reoffense Warning Signs

If a treated sex offender is on the verge of committing another offense, he is probably displaying many signs. More than likely, he is failing in treatment, either by becoming more distant about his immediate concerns or by becoming very hostile, belligerent, and uncooperative with the staff. Obvious signs are missed appointments and tardiness.

In general, the sex offender relies too heavily on sex to fill needs that should be met socially or in other ways. Thus, if the group is aware of the individual's increasing problem, they can help him develop plans to change his social and recreational patterns.

If there has been a sudden increase in responsibilities, either on the job or within the family, the sex offender needs to talk about it. He probably has doubts and fears and may need to hear that even if he fails, he will still be a valuable, worthwhile person. Also, it is not uncommon for the sex offender to fail when he suddenly experiences great success on the job or in other areas of his life.

The therapist and group members need to be aware if a member who is a child molester is spending more time with children than with adults. Does he seem to prefer the company of children and become animated when he talks about children or a particular child? By contrast, does he seem flat or disinterested when he talks about his adult friends? Is he befriending and wanting to live only with women who have children? Does he seek out jobs that will put him in contact with children?

The therapist needs to ask how the person is functioning sexually, either with his partners or in his fantasies. Is he having trouble getting an erection or ejaculating? Can he accomplish this only by thinking of children? Is he feeling sexual demands or pressures from an adult and does this overwhelm or frighten him? Is he self-confident enough to turn someone down sexually and still feel good about himself? Is he involved with a partner who never wants to have sex with him? It is also important for the therapist to notice if the child molester is feeling sorry for himself and blaming others for his problems. This could definitely signal a reoffense.

If an incest family wishes to reunite, it is a bad sign if the offender, or any of the family members, begins to minimize or downplay the original conviction. An article by O'Connell (1986) describes in detail rules for incest families who wish to reunite. These rules could be required reading for an incest offender and his family. They could also be discussed specifically with the family before the beginning of home visitations.

The therapist and group members should always have knowledge of each participant's offense pattern and the events that preceded or triggered the last offense. For example, in one case the sex offender picked up a child in a park and raped her two weeks after his wife had a baby. When he was released six years later, he met a woman, moved in with her and, two weeks after the birth of their child, raped again. Although the parole officer knew it was a vulnerable time for this man and did his best to question him carefully about his feelings and impulses, the offender all along continued to deny adamantly that anything was wrong. This last occurrence took place nearly a year after the offender had finished treatment, but apparently he did not trust anyone enough to be honest about his feelings.

The most common trigger for a rapist is rejection from a woman upon whom he is emotionally dependent. This can be perceived either as sexual rejection or a rejection of the entire relationship. An important sign is the rapist's escalating anger. He may become very hostile with a therapist or group member for little or no reason. He might refuse to talk about any sexual issues and become irrationally angry when asked to do so. Abuse of alcohol or other drugs is very common for a few days or weeks before a rapist's reoffense.

A rapist motivated by a desire for power will be overwhelmed with feelings of inadequacy and incompetence. He may experience a recurrence of deviant fantasies or fetishes. He may try to force his sexual partner to comply with increasingly bizarre sexual behavior. In general, the rapist is likely to feel helpless in his relationship with a woman. It is possible that he feels he has lost control or is being used. He may be reluctant even to bring up or work on these issues or to deal directly with the woman involved. Nevertheless, the therapist must pursue these points.

A rapist may succumb to a strong urge to visit prostitutes, massage parlors, or to use pornography. He may begin cruising certain neighborhoods where he had previously found victims. Again, it is very important for the therapist and other group members to be aware of prior assault patterns.

Staff should not be afraid to meet, discuss, and, in a sense, perform an "autopsy" on failures. Whatever is learned should be shared with program participants. The offenders are usually as upset, if not more so, than staff. Group discussion of their fellow member's recent sex offense will help control their own fears of a relapse.

The therapist should be willing to talk to the relapsed offender. Although the therapist might be angry or disgusted, too much valuable information is lost if he/she is unwilling to do so. For example, a new session can reveal trouble signs that the offender may have been exhibiting and that the therapist missed, or a use of chemicals that went unnoticed, or a discomfort or frustration with the group that kept the offender from being honest and seeking help. It is possible to learn far more from a single failure than from a string of successes.

Treatment Termination

An implicit part of the treatment contract is that it will terminate when some goal is achieved and/or when a set period of time has elapsed. One of the objectives of treatment is to prepare the sex offender for the time when he will no longer need a therapist. When the individual enters the final stages of treatment, the therapist should periodically mention how many sessions he has left (as he has been conditioned for release from prison) so that the individual and the other group members will be well prepared.

In some cases, the sex offender and his family may be referred to another therapist or agency in the community. It is helpful for the two therapists to do a combined session or two. It encourages the individual to relinquish his dependency on the first therapist, and it sanctions the transference of this dependency so the client does not feel confused about his loyalties. Because different therapists may use different methods, the combined session(s) can be used to help the individual feel comfortable with the new therapist's techniques. It is essential for the old therapist to share the offender's pertinent treatment history so the new therapist does not have to cover the same ground.

If treatment is going to end without further therapy, the final sessions should be gradually spaced out. Participation in Sexaholics Anonymous/Sex Addicts Anonymous (SA/SAA) groups could be encouraged. These are self-help groups led by people who have completed treatment and want to continue to be involved helping others. Functioning like Alcoholics Anonymous, SA/SAA groups are common in various parts of the country, and all indications are that they will continue to spread and develop. Along the West Coast, a similar group called Parents United includes a support network for the entire family. If a group makes use of the 12-step model developed by AA, it can be very effective. Sometimes sexual issues are even discussed in AA groups, but this is risky for the sex offender who could be ridiculed for talking about these matters. It is possible that in some communities, AA will be the only support group available to the sex offender; but, if the therapist believes it could be helpful, participation should be encouraged.

It is a good idea to maintain a telephone crisis line for formerly treated offenders in desperate need. Just a chat with a former therapist can be quite helpful. At other times the individual may need a referral for treatment on a new or related problem.

Sometimes the therapist has to make it very clear to the offender that his therapy has ended and that if the individual needs further treatment, he will have to go elsewhere. And though it is flattering to the therapist to feel needed, such a dependency can be destructive for the sex offender.

Some programs have developed annual reunions so clients can renew old acquaintances and let staff know how they are doing. This is a good morale booster for the staff, who are generally all too aware of failures but seldom of successes. It can also be helpful for the current program participants to see that former group members are succeeding after therapy. These reunions can be especially important for men who have spent a good portion of their lives in prisons or institutions and who have no family or other support system in the outside world. Their contact keeps staff abreast of events and successes in their lives. And for staff, this can be the greatest reward of all, a reminder of why they chose to be therapists in the first place.

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Chapter 14: Relapse Prevention

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with Georgia Cumming, Linda Beal, William Young, and Richard Turner

Abstract

Dr. Pithers was the first in the field of sex offender treatment to adapt the concept of Relapse Prevention—a treatment modality initially developed to enhance maintenance of change in substance abusers—for use with sex offenders. He outlines how he expanded the concept from a self-management process relying solely on the offender to one that improves supervision of the offender by others, including probation and parole officers, employers, and family members.

The model emphasizes that sex offenses typically are not impulsive criminal acts, but more commonly are planned. The need for multidisciplinary teams of mental health and corrections professionals is stressed. This model appears to offer considerable promise as a method of assisting offender change and improving community safety.

All therapeutic interventions for sexual aggressors share the goal of deterring subsequent victimization. Treatment of sexual aggressors is conducted not to assist offenders in attaining blissful, productive lives (although that might be ideal), but in an effort to decrease the probability of subsequent victimizations. Empirical evidence demonstrates that specialized treatment, focused on specific factors predisposing each offender to engage in sexual abuse, can effectively diminish the likelihood of additional sexual violence.

Other chapters in this monograph describe interventions currently offering the best outcomes for intensive treatment of sexual aggressors. These interventions may facilitate offenders' recognition of the harm inflicted upon victims of sexual abuse, motivating them to initiate the difficult journey of behavioral change.

Many offenders will begin their therapeutic journey within prison. However, regardless of the adequacy of treatment programs for sex offenders within institutions, the safety of a society of potential victims will be protected only if aftercare is mandated for aggressors upon their release from institutional treatment.

This chapter describes procedures that can be employed by sex offenders, mental health professionals working with them, and probation and parole officers charged with supervising their behaviors in a collaborative effort to support maintenance of behavioral change once sex offenders have returned to society. Only by providing continued post-release treatment and supervision of the sexual aggressor can the ultimate safety of society be protected. The treatment and supervision model presented in this chapter is called Relapse Prevention.

Identification of Precursors to Sexual Aggression

Many theorists propose that sex offenses, particularly rapes, are impulsive acts. Certainly many offenders would have us believe that they had not thought about sexual abuse prior to engaging in it, hoping to appear less culpable. After only a cursory review, sex offenses might indeed appear impulsive. However, closer examination of precursors to offenses often demonstrates that the act was not impulsive at all.

Many offenders engage in careful planning to make it appear their acts were unplanned. Others engage in substance use prior to offending in an effort to blame the act on intoxication. A central premise of Relapse Prevention is that sex offenses are rarely impulsive. Although the victim may be chosen randomly, the activity engaged in during the assault is intentional and has generally been fantasized about for a long time.

Fantasies of most sex offenders are essentially planning sessions for future behaviors. This quality helps to differentiate the abusive sexual fantasies of offenders from those of nonoffenders who may momentarily experience a deviant fantasy but who quickly reject it as disgusting. If one accepts the premise that specific precursors to sex offenses exist, efforts to identify these factors may enable the development of enhanced treatment and supervision of men who perform these acts.

In a pilot study attempting to discover if common precursors to abuse existed among one sample of convicted sex offenders, Pithers, Buell, Kashima, Cumming, and Beal (1987) analyzed case records, psychological assessments, and physiological evaluations of 200 clients whose files were randomly selected from the clinical records of the Vermont Treatment Program for Sexual Aggressors. Of the 200 offenders included in this study, 136 had sexually abused children and 64 had raped women during their most recent victimization. In reviewing each subject's data, the authors attempted to identify precursors, or risk factors, that may have been related to commission of the crime.

Precursors to offenses determined to have occurred within six months of the subjects' offenses are presented in Table 14.1. Risk factors noted to have taken place at an earlier point and that may have generally predisposed the offenders toward abusive behavior are contained in Table 14.2. Readers are cautioned that the results of this pilot study may not be representative of other offender populations. Risk factors were derived from a thorough analysis of all available information on only 200 sex offenders and cannot be considered to exhaust

Table 14.1

IMMEDIATE PRECURSORS TO SEXUAL AGGRESSION

Precursor	Rapists (%) (N = 64)	Pedophiles (%) (N = 136)
Anger		
At event	3	3
Interpersonal conflict	3	4
Generalized, global	88	32
Anger towards women	77	26
Anxiety	27	46
Assertive skills deficit	42	23
Boredom	45	28
Cognitive distortions	72	65
Compulsive overworking	0	8
Depression	3	38
Deviant sexual fantasies	17	51
Disordered sexual arousal pattern	69	57
Divorce	2	2
Driving car alone without destination	17	1
Emotionally inhibited/ overcontrolled	58	51
Interpersonal dependence	30	48
Low self-esteem	56	61
Low victim empathy	61	71
Opportunity (e.g., finding a hitchhiker)	58	19
Peer pressure	2	3
Personal loss	6	14
Personality disorder	61	35
Photography as new hobby	0	4
Physical illness	14	6
Planning of sex offense	28	73
Pornography use	2	7
Psychiatric hospitalization	0	7
Sexual knowledge deficit	45	52
Social anxiety	25	39
Social skills deficit	59	50
Substance use/abuse		
Alcohol	42	23
Other substances	14	7

Table 14.2

EARLY PRECURSORS TO SEXUAL AGGRESSION

Precursor	Rapists (%) (N = 64)	Pedophiles (%) (N = 136)
Cognitive impairment (IQ < 80)	9	10
Divorce (more than 5 years before act)	14	15
Exposure to violent death of human or animal	22	2
Familial chaos	86	49
Late sexual experience (older than 25 at initial activity)	0	4
Limited education (< grade 9 completed)	44	26
Maternal absence/neglect	41	29
More than one prior sex offense	14	17
More than one known victim	30	60
Parental marital discord	59	45
Paternal absence/neglect	59	54
Physically abused as child	45	7
Pornography use (habitual)	14	33
Precocious sexuality (<12 years at time of first act of penetration not considered abuse)	14	30
Prior arrest for nonsex offense	44	15
Sexual anxiety	39	58
Sexual dysfunction	11	11
Sexual victimization		
Prior to age 12	5	56
Between ages 12 and 18	11	6
Use of female prostitutes	30	8

the entire constellation of potential risk factors for all sex offenders. Also, one must be careful not to conclude that any individual who has engaged in one or more of the risk factors is necessarily an unidentified sex offender. For example, countless childhood victims of sexual and physical abuse have never abused others as adults.

Several differences in the immediate precursors of rape and pedophilic acts were identified by the study. A greater percentage of rapists than pedophiles exhibited generalized anger (88% of rapists versus 32% of pedophiles), anger towards women (77% versus 26%), acted in opportunistic situations rather than after protracted grooming interactions (58% versus 19%), and engaged in substance use prior to offending (56% versus 30%). In contrast, depression seemed more common among pedophiles than rapists (38% versus 3%), and pedophiles were more likely than rapists to acknowledge having planned their offenses (73% versus 28%). During the clinical evaluation, a greater proportion of pedophiles than rapists (51% versus 17%) acknowledged harboring abusive sexual fantasies.

Some precursors identified in this analysis did not appear in differential proportions among rapists and pedophiles. Variables occurring in relatively high proportion among both samples included: cognitive distortions (72% of the rapists sample and 65% of the pedophiles), low self-esteem (56% and 61%) and emotional inhibition or overcontrol (58% and 51%). Upon clinical evaluation, the majority of both groups exhibited a disordered sexual arousal pattern (69% of the rapists and 57% of the pedophiles). The discrepancy between the percentage of rapists who self-reported deviant fantasies (17%) and the percentage yielding deviant arousal during physiological assessment of sexual arousal patterns (69%) is greater than that evidenced in pedophiles (51% self-reporting deviant fantasies and 57% demonstrating disordered arousal patterns).

Examining early precursors to sex offenses, a greater proportion of rapists than pedophiles experienced the violent death of a human (e.g., hunting accident) or animal (e.g., pig slaughtering) during childhood (22% versus 2%), chaotic fam-

ily lives involving parental altercations or extramarital affairs witnessed by the subject (86% versus 49%), and physical abuse as a child (45% versus 7%). Pedophiles revealed a greater proportion of sexual victimization prior to age 12 than rapists (56% versus 5%). In contrast, a slightly greater proportion of rapists than pedophiles were sexually victimized during adolescence (11% versus 6%).

Generally, these data suggest that precursors to sex offenses are identifiable. Some of the risk factors do not appear disproportionately represented among rapists and pedophiles, while others are distributed more uniquely among one of the two groups. The nature of these precursors suggests that truly impulsive, unplanned sex offenses are exceptionally rare.

However, the greatest value of identifying risk factors is not apparent in group comparisons, but rather in the analysis of specific precursors for each unique offender. When discerned individually, precursive risk factors may provide information about the client's relapse process that can enhance the efficacy of treatment and parole supervision.

Determinants of Relapse: A Common Sequence of Precursors

In examining offense precursors, a common sequence of risk factors culminating in sexual violence was frequently identified (Pithers, Marques, Gibat, & Marlatt, 1983). The initial change from the offender's characteristic behaviors was emotional. While offenders often were unable to define this emotional change precisely, analysis of their comments revealed that pedophiles typically felt depressed and rapists more commonly experienced an increase in chronic anger.

The second stage of the relapse process was marked by an increase in the frequency and/or strength of abusive sexual fantasies. Often, these fantasies occurred as offenders masturbated in a dysfunctional effort to cope with their negative emotional state after an attempt to express these emotions had been unsuccessful. Acquisition of pornography was noted most commonly at this stage, likely as a means of heightening arousal during repetitive masturbation to deviant fantasies.

In the third stage of relapse, abusive sexual fantasies were transformed into cognitive distortions. Offenders commonly devised rationalizations to minimize the deviance of their fantasies, either by objectifying women or attributing adult traits to children. Distortions characteristic of this stage included: "All women are whores at heart" and "Since my teenage daughter is about to start dating and experimenting sexually, she should learn about sex from someone who really cares about her rather than some teenager who'll take advantage of her."

As the relapse process unfolded, offenders appeared to "passively" develop a plan to enable commission of their fantasized behavior. They seldom sat down and charted out a plan of attack; rather, passive planning was accomplished while fantasizing. Nuances in the setting, timing, and nature of the assault were developed that might enable victimization without detection.

In the final stage of the relapse process, the plan was enacted. Substance use often preceded the sex offense. However, it is essential to note that offenders typically had not indulged in substance use to such an extent that their cognitive functioning was severely impaired. This degree of substance use appeared to have two purposes: (a) minimalization of personal responsibility for the abuse, and (b) reduction of moral inhibitions that may have interfered with actual commission of the offense.

Thus, a distinct sequence of offense precursors was often discerned: Emotion-Fantasy-Cognitive Distortion-Plan-Act. The relapse process entailed specific precursors that could be addressed during treatment or used to enhance supervision of the offender.

The Relapse Process

Relapse Prevention proposes that a variety of factors influence whether a sex offender will commit another abusive act. Factors affecting the probability of relapse are presented in Figure 14.1 and explained below.

Once a sexual aggressor enters treatment, he essentially takes a vow of abstinence, declaring an intent not to reoffend. While abstinent, the offender perceives himself as possessing successful self-management skills. He anticipates being able to handle life's difficulties without undue distress. Occasionally, his attitude may become unrealistic, approaching a level of superoptimism that fosters a lack of attention to behavioral maintenance.

This comforting self-assuredness increases until the offender encounters a high-risk situation (e.g., a rapist who spots a female hitchhiker while driving his vehicle to escape an angry interaction with his spouse; a pedophile who is asked to babysit for a neighbor). A high-risk situation is defined as a set of circumstances that threaten the individual's sense of self-control and thus increase risk of relapse.

If an abstaining offender manages to cope with a high-risk situation, his sense of self-management survives. As long as his expectation about his ability to handle future high-risk situations remains realistic, the probability of relapse decreases. However, should the offender fail to respond adaptively to a high-risk situation (e.g., purchases pornography while in a book store), his sense of self-management decreases and a tendency to passively yield to the temptation of the next high-risk situation ensues.

Generally, each time an offender fails to cope with a high-risk situation, he will engage in one of the behaviors involved

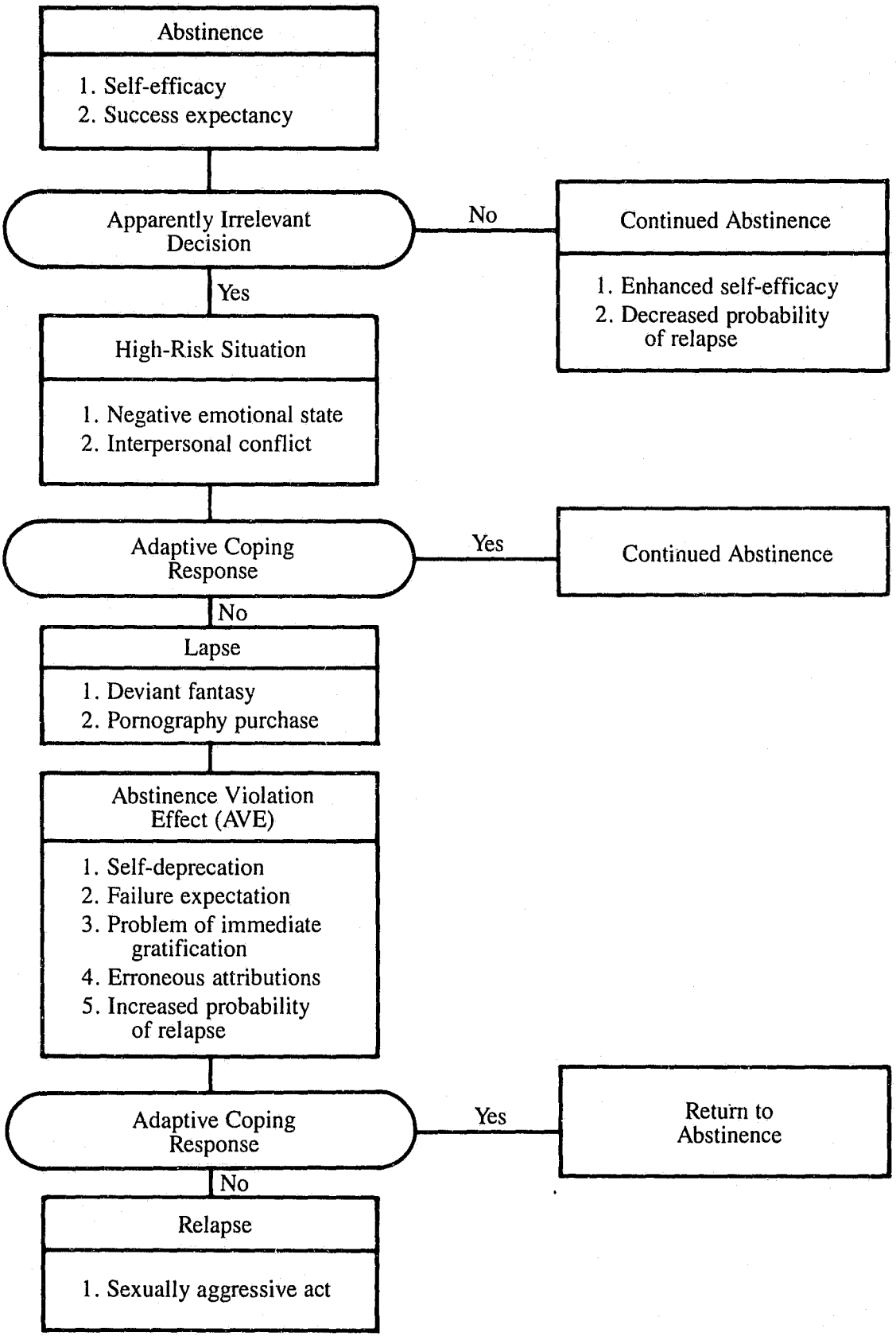


Figure 14.1. **A COGNITIVE-BEHAVIORAL MODEL OF THE RELAPSE PROCESS**

in his relapse process (i.e., Emotion-Fantasy-Cognitive Distortion-Plan-Act). In this sequence of precursors to sexual aggression, the initial change differentiating sexual aggressors from men who do not offend is the excessive frequency or strength of deviant sexual fantasies. Thus, for most sex offenders, the initial return of deviant sexual fantasy is defined as the earliest identifiable lapse in the sequence.

Thus far, the relapse process has been depicted from the point at which a person encounters a high-risk situation. It is important to note, though, that the Relapse Prevention model also examines events that precede high-risk situations. Although some sex offenders lapse in situations that would have been difficult to anticipate, the majority appear to set the scene for lapses by placing themselves in high-risk situations. One can covertly set up a lapse by making a series of Apparently Irrelevant Decisions (AIDs), each of which represents another step toward a tempting, high-risk situation. Each AID, taken by itself, may seem unrelated to reoffending; nevertheless, each choice leads the aggressor closer to the point where he must make the final decision whether or not to reoffend.

If a sex offender has not been prepared to cope with an AID-precipitated lapse, he may attempt to hide his error from therapists and parole officers. He may believe that acknowledging even a momentary deviant fantasy will be viewed as an indication that he is totally out of control and lead to revocation of parole. Any effort to bury a lapse typically leads to additional lapses that move him closer still to reoffending. Thus, the probability of reoffending is increased.

In the Relapse Prevention model, recurrence of deviant sexual behavior defines a relapse. Several factors, subsumed by a concept referred to as the abstinence violation effect, determine whether a lapse becomes a relapse. A major component of the abstinence violation effect is a conflict between the individual's definition of himself as an abstainer and his recent indulgence in a behavior that is part of his relapse process. One method of resolving this dissonance is for the individual to decide that his treatment was a failure and that he remains a sex offender.

A second component that heightens the abstinence violation effect is attributing the lapse to personal weakness or failure. To the extent that lapses are considered personal failures, an expectation develops for continued failure, culminating in the ultimate failure, relapse.

A third factor influencing the extent of the abstinence violation effect is the individual's selective recall of positive aspects of his past abusive behaviors. An angry rapist may focus on the gratification derived from the violent release of his hostility during past assaults. The socially isolated pedophile may recollect moments of perceived intimacy from his prior victimizations of children. To the degree that aggressors selectively remember positive outcomes of prior sex offenses, forgetting the delayed negative consequences (e.g., loss of self-respect, arrest, dissolution of family), the probability of relapse increases. Due to the potency of this aspect of the abstinence violation effect, it has received its own title, the problem of immediate gratification, and acronym, the PIG phenomenon.

A final factor affecting the abstinence violation effect is the individual's expectation about the likelihood of encountering lapses. If an offender believes that successful treatment should have eradicated any vestige of his abusive desires, the effects of a momentary loss of control may be devastating. In contrast, if an offender accepts that cures for sex offenders do not exist and views lapses as opportunities to enhance self-management skills through inspection of acceptable mistakes, benefits may be derived from lapses. In such cases, an offender may return to abstinence with improved coping skills and, given his brush with lapsing, have a more accurate perception of the need to be vigilant for the earliest signs of his relapse process. A case example of the relapse process follows.

> Al, 34, was recently released from prison. He had served two years in prison on his first conviction for committing a lewd and lascivious behavior with a child. He participated in individual therapy while in prison and, even though his sexual attraction to children was rarely discussed, he believed himself cured. As Al left prison, he stated that he was glad he had taken care of his problem so that he wouldn't "need to worry about that stuff anymore."
>
> During his incarceration, Al longed to return home to his spouse, despite the problems they had experienced. He recalled having thought that, compared to prison, living with the wreck of Hesperus would be rewarding. Now that he was out, having just left home after a fight with his spouse, prison no longer seemed so awful. He felt bossed around by everyone and her brother. "Never could stand up for myself," he thought as he drifted down the sidewalk. He found himself wondering just what Betty, his spouse, did during her long absences away from home. "I bet," he thought, recalling her comment about going shopping. "Shopping for what?," he wondered.
>
> While he was in prison, he felt lonely, but at least he could imagine being close to Betty when he got out. Now, he felt a loneliness he never knew existed. Feeling unable to express his emotions to Betty, he decided to do the next best thing and entered a corner store to buy a beer or two. Returning to the sidewalk, he sulked into depression. His energy waning, he slumped onto a park bench to rest, hardly noticing the nearby school. He wished there was something in life to look forward to, something or somebody that would make him feel alive. Someone who would appreciate everything he did for them. A relationship in which he felt equal and loved, not some servant to be bossed around.
>
> Lost in his thoughts, he scarcely noticed the clanging bell dismissing school. Turning his vacant gaze toward

an ever-increasing clamor, he saw happy children surging away from the school building. "Damn, I shouldn't be here," faintly passed through his thoughts. However, before he could muster the determination to get moving, a softball rolled up to his feet, followed closely by an impish little rogue with a devilishly coy smile and dirty clothes. As Al reached out to hand back the ball, the boy looked directly into his eyes, met his gaze for several long moments, and smiled broadly. Al thought about how cute the kid looked, "Real friendly smile. Reminds me a lot of myself at that age. Wonder if he's as lonely as I was then. Probably could use a friend." He recalled how, when depressed in the past, being close to a child would make him feel better.

Noticing that the boy glanced in his direction, Al thought, "That little rascal. He must have known what I was thinking about." Al speculated, his depression beginning to dissipate, "I wonder if he's interested in me." Rising from his perch, Al neared the boy, thinking about sharing a soda, and possibly more, with this good-looking, mature boy.

Al's story illustrates the relapse process. When released from prison, he minimized the difficulty of abstaining from child sexual abuse (apparently irrelevant decision). He returned home with an unrealistic expectation of his relationship with his wife (apparently irrelevant decision). When his expectation of the relationship went unmet, he felt dominated, resentful, and depressed (high-risk situation). Al chose not to express his dissatisfaction to his spouse (lack of coping response), taking walks to avoid her whenever he felt lonely or depressed (apparently irrelevant decision). When walking did not dissipate his negative emotions, Al imbibed alcohol in an effort to deaden them (high-risk situation). Already engaging in a high-risk behavior by drinking, he exacerbated the situation by sitting on a park bench (apparently irrelevant decision), "hardly noticing the nearby school." Seeing the school boy's smile, he interpreted a friendly expression as one implying seduction, attributing adult intent to a child (cognitive distortion). Rather than respond constructively to this lapse, he recalled the immediate comfort he had experienced from his past sexual abuse of a child (fantasy and abstinence violation effect). Remaining in the high-risk situation, instead of leaving it immediately, he felt overwhelmed by an urge to approach the boy (abstinence violation effect). Although he excused his approach as an innocent offer of a soda to a boy who obviously was not cared for adequately by his parents (cognitive distortion), he used the offer as a method of grooming the boy for sexual abuse (plan and act).

Clearly, each of these decisions brought him closer to a situation where he was in imminent danger of relapse. Yet, during his initial interview with a therapist upon returning to prison for child sexual abuse, Al sadly shook his head and commented, "It just happened." He appeared unaware of the chain of choices and behaviors that enabled him to establish an opportunity to reoffend.

Potential Uses of Identified Offense Precursors

Identification of precursive risk factors by mental health clinicians may serve several important functions. Analysis of risk factors by clinicians can assist delineation of behavioral excesses and deficits that must be addressed therapeutically. By monitoring risk factors during treatment, therapists may be better able to confront clients about elements of their relapse processes and also assess efficacy of treatment in an ongoing manner.

Relapse Prevention asserts that offenders engage in certain behaviors antecedent to sexual assault and that these signs represent distinct changes from the offender's typical behaviors. Probation and parole officers may discern periods when each offender is at high risk of relapse by monitoring for the presence of his high risk factors. The Relapse Prevention model allows probation and parole officers to monitor specific risk factors related to the client's sex offenses, rather than attempting to keep an eye on all his behaviors, many of which have no bearing on his offending. Probation and parole officers can also develop collateral contacts (e.g., employers, spouse) to assist in monitoring the offender's risk factors. Use of the model thereby increases the efficiency of the probation and parole function.

Beginning Relapse Prevention with Sexual Aggressors

While there is little a pedophile can do to avert sexually offending when he has reached the point where he is depressed, alone with a child, thinking about his gratification from past episodes of abuse, and fantasizing about becoming sexual with the child on his lap, he can accept responsibility for initiating the entire chain of events that got him there in the first place. He can also learn to recognize each of the precursors involved in his relapse process and be prepared to intervene before it's "too late."

Whether one is a mental health clinician or probation/parole officer, Relapse Prevention begins in the same fashion. Clients must abandon common misconceptions about the likely outcome of treatment and be provided a more realistic description of reasonable therapeutic goals. Relapse Prevention continues by engaging the client in a thorough assessment of his high-risk situations, which are the conditions under which relapse has occurred in the past or is likely to occur in the future. Apparently irrelevant decisions that may have set up each high- risk situation are explored. The initial assessment also includes an analysis of the client's coping resources, since any situation can be considered high risk to the extent that the client is unprepared to cope with it. After apparently irrelevant decisions, high-risk situations, and coping resources

have been identified, a specific therapeutic intervention is designed to teach the client how to minimize the frequency and strength of lapses, and how to prevent lapses from triggering a relapse.

Goals of Relapse Prevention

The overall goals of Relapse Prevention are to increase the client's awareness and range of choices concerning his behavior, to develop specific coping skills and self-control capacities, and to create a general sense of mastery or control over his life. To attain these goals, Relapse Prevention includes intervention procedures designed to help the client anticipate and cope with the occurrence of lapses, and procedures designed to modify the early antecedents of lapses. Selection of interventions to be used with a particular client is based on an assessment of his high-risk situations and coping skills. Thus, the Relapse Prevention treatment program is not applied as a standardized package, but as an individualized program tailored to meet each client's unique needs.

As mentioned earlier, many sex offenders enter treatment expecting that their desire for unacceptable sex acts or objects will be eliminated. In the Relapse Prevention model, although the client participates in procedures designed to reduce his deviant interests and arousal patterns, he is also prepared for the possible return of these problems.

In introducing Relapse Prevention to the client, emphasis is placed on the development of realistic expectations about the process of therapy, and an active, problem-solving approach on the part of the client is encouraged. Clients are explicitly informed that no cure exists for their disorder. Clients are told that, while treatment will diminish their attraction to abusive sexual behaviors, fantasies about these behaviors will recur at least occasionally in the future. Clients are informed that the return of an abusive fantasy does not signify that they are necessarily going to reoffend and that a critical part of their treatment involves learning what to do when they feel attracted to abusive sexual activity again. Clients are instructed that they will discover a variety of situations in which apparently irrelevant decisions will actually lead them closer to offending again or will take them away from that danger. They are encouraged to develop an ability to recognize these situations and enact alternatives to reduce the likelihood of reoffending.

Two Models of Relapse Prevention

Internal, Self-Management Dimension

Relapse Prevention was originally developed as a method of enhancing maintenance of change by clients who had been in treatment for compulsive behavioral disorders (e.g., substance abuse, compulsive gambling, etc.). As originally articulated by Marlatt and colleagues, Relapse Prevention was designed to strengthen self-control by providing clients with methods for identifying problematic situations, analyzing decisions that could precipitate compulsive behavior, and developing strategies to avoid or cope more effectively with these dangerous circumstances (Chaney, O'Leary, & Marlatt, 1978; Marlatt & Gordon, 1980, 1985; Marlatt, 1982). Thus, as originally proposed, Relapse Prevention represents a method of enhancing self-management skills.

When first modified for application to sexual aggressors, Relapse Prevention remained solely a means of enhancing offenders' self-control (Pithers, Marques, Gibat, & Marlatt, 1983). The initial application of Relapse Prevention in the Vermont Treatment Program for Sexual Aggressors demonstrated that the maintenance model appeared effective in aiding self-management (Pithers, 1982). Relapse Prevention successfully accomplished the goals of increasing the client's awareness and range of choices concerning his behavior, developing specific coping skills and self-control capacities, and creating a general sense of mastery over life. This aspect of the modified Relapse Prevention model is referred to as the Internal, Self-Management Dimension.

Unfortunately, while the Internal, Self-Management Dimension of Relapse Prevention often worked well, sexual aggressors neglected to employ their acquired skills at certain critical moments. Although the importance of acknowledging lapses to therapists and probation and parole officers had been repeatedly stressed during therapy and the mythical goal of attaining behavioral perfection was consistently dismissed, clients leaving our inpatient treatment unit still neglected to inform staff of their lapses, apparently believing they were expected to maintain perfect self-management. Occasionally, lapses were reported to the treatment team by an offender's spouse, friend, or co-worker, but not by the client himself. Even when offenders recognized that those who self-reported lapses had been reinforced by receiving therapeutic intervention and maintaining access to the community (as opposed to those whose lapses had been reported by a third party), the trend toward secrecy at critical moments remained.

Generally, Relapse Prevention appeared to enhance sex offenders' self-management skills by decreasing the frequency of lapses. However, when lapses occurred, offenders often did their best to deny them to individuals involved in their treatment and supervision, and possibly to themselves. Offenders either believed that acknowledging lapses would lead to their being returned to prison for parole violations or that problems would go away if not acknowledged. Thus, although the Internal, Self- Management Dimension of Relapse Prevention was beneficial in enhancing self-control, it did not prove adequate by itself.

External, Supervisory Dimension

In order to enhance community safety, an External, Supervisory Dimension of the Relapse Prevention model was developed

(Pithers, Kashima, Cumming, Beal, & Buell, 1987, 1988). Since offenders are at times unreliable informants regarding lapses, creating other methods of gaining access to information was considered essential. Three functions of the External, Supervisory Dimension were identified: (1) enhancing efficacy of supervision by monitoring specific offense precursors; (2) increasing the efficiency of supervision by creating an informed network of collateral contacts who could assist the probation officer in monitoring the offender's behaviors; and (3) creating a collaborative relationship with mental health professionals conducting therapy with the offender.

Traditionally, probation or parole supervision of sex offenders has been a challenging enterprise. Gaining information essential to adequately supervise a sex offender was considered a nearly impossible feat. Sex offenders were generally reported to be hard workers by employers. Parole violations noted frequently among many offenders (e.g., intoxication, neglect of supervision appointments, failure to pay restitution) were rarely noted among sex offenders. Often, the lack of detailed information about the offender's behaviors produced a feeling of attempting to supervise within a weightless vacuum, a disquieting position in an age of heightened professional liability.

In contrast, specification of an offender's apparently irrelevant decisions, high-risk situations, and offense precursors provides probation and parole officers with identifiable indicators of impending danger of relapse. They are able to monitor specific risk factors related to the client's sex offenses, which increases the efficiency of probation and parole supervision. Whenever the probation or parole officer detects the presence of an offense precursor, he or she can intervene in the sex offender's relapse process. Since offense precursors appear most commonly in a distinct sequence (i.e., Emotion-Fantasy-Cognitive Distortion-Plan-Act), the type of precursor exhibited provides an indication of the imminence of potential relapse. With this information, the parole officer can determine the type of intervention required by an offender's lapse (e.g., additional condition of parole, consultation with offender's therapist, parole revocation).

A second element of the External, Supervisory Dimension of Relapse Prevention entails instructing collateral contacts on the principles of Relapse Prevention. All members of the collateral network (e.g., spouse, employer, co-workers, friends) are informed about apparently irrelevant decisions, high-risk situations, lapses, the abstinence violation effect, and offense precursors. They learn that assisting the offender's identification of factors involved in his relapse process will increase the likelihood of his avoiding a reoffense. In the offender's presence, network members are encouraged to report lapses to the parole officer or therapist.

Care must be exercised in evaluating the ability of collateral contacts to serve this function. A fearful spouse, who has been battered into total submissiveness, is unlikely to disclose information about her husband if she fears additional abuse. Similarly, a spouse who is overly dependent on her husband may be reticent to risk providing any information that could potentially get him into trouble. Employers who treasure the compulsive work habits of some sex offenders may be reluctant to mention information that could lead to loss of the employee. Certain religiously devout individuals, who believe they can show their love for others by forgiving their misdeeds, may do so rather than tell others. Community members who express hatred for the offender may fabricate reports about him in an effort to damage him. Management of the collateral network demands good judgment.

The offender is required to inform network members about his offense precursors. The probation or parole officer later requests each network member to summarize what he/she was told. By following this procedure, two goals are accomplished. First, the accuracy and completeness of information presented by the offender can be evaluated, enabling the parole officer to estimate how well the offender understands his offense precursors and the importance of others to his behavioral maintenance. Second, informing the offender's extended network about his offense precursors destroys the secrecy necessary for commission of sexual aggression. Behaviors that once may have seemed unimportant to others but are centrally involved in the relapse process can then be recognized as signs for concern.

The final element of the External, Supervisory Dimension of Relapse Prevention is the liaison between the probation officer and mental health professional. Many clinicians are reluctant to work with sexually aggressive clients, correctly believing that traditional training has not prepared them to provide therapy to such a unique clientele. Other clinicians hesitate because they fear clients will not pay for services or that they will be exposed to aversive courtroom experiences. Given the dearth of specially trained professionals, probation officers face a challenging task when assigned responsibility by the court to locate a competent therapist for the client.

Where clinicians experienced in working with sex offenders cannot be located, other mental health professionals with potential for working with these offenders might be identified. Effective substance abuse counselors generally become excellent sex offender therapists. They have experience working with clients who deny existence of problems, minimize the likelihood of relapse, and manipulate situations to enable resumption of their problematic behaviors.

Prospective counselors should be skilled at confronting clients' misrepresentations in a frank, yet supportive, manner. Ideally, they have learned that clients are not always honest, but do not dismiss every statement as a lie. Prospective therapists should agree to conduct therapy with full, or partial, waiver of confidentiality, enabling free exchange of information with the probation officer. The prospective counselor should agree to attend monthly case staffings. Clinicians who view behavioral change as an indication of therapeutic progress generally are preferable to those who trust verbalized assertions.

Prospective clinicians should be willing to learn and employ behavioral assessment and treatment techniques. Therapists should agree to appear in court as needed to testify about treatment group requirements, probation violations for nonparticipation in therapy, or modification of probation or parole conditions. They should appreciate that some sex offenders have been victimized themselves, but should not consider this to be an explanation for their sexually abusive acts. Mental health professionals should agree to conduct group therapy or a mixture of group and individual treatment, not individual therapy alone. They should recognize the advantage of having a co-therapist of the opposite gender. He/she should agree to develop, with input from the probation/parole officer, a treatment contract that specifies the offender's responsibilities for participating in and paying for treatment. Finally, therapists should possess a sense of humor or the stress inherent in working with this population will make their involvement short-lived. In our experience, therapists meeting these criteria generally work well in a collaborative relationship with probation/parole officers to deter relapse of sex offenders.

Regularly scheduled meetings involving the probation/parole officer and mental health professional are essential. By reviewing case-specific information, the probation/parole officer and mental health clinician may discern aspects of the offender's behaviors that were previously unknown. During outpatient treatment, it is not unusual to discover that the offender has discussed an important issue with only one of the professionals involved in his care. In other instances, the offender may depict an event differently to each professional in his treatment and supervision network.

During regular meetings between the probation/parole officer and mental health professional, the extent and consistency of the offender's disclosures can be compared. In addition to ensuring that each professional possesses all available information, these meetings enable detection of the client's efforts to create disharmony ("divide and conquer") within his supervisory team. Since these scheduled meetings allow exchange of routine information, telephone calls and messages between meetings are regarded as especially important, often pointing to concerns that have to be dealt with immediately.

In practice, creating specialized teams of probation and parole officers who supervise sex offenders has proven beneficial. A small group of specially trained probation and parole officers facilitates development of supportive collaboration with mental health professionals since frequency of contact and familiarity among the probation/parole officers and clinician is increased. The mutual support engendered by small groups of professionals working earnestly to alleviate a major social problem represents a significant source of strength, offsetting the burnout that occurs when doing difficult work in isolation.

The combined functions of specially trained probation/parole professionals, collateral contacts, and the collaborative relationship between probation/parole and mental health professionals are referred to as the External, Supervisory Dimension of the Relapse Prevention model. Since offenders are not consistently reliable informants regarding their own relapse processes, establishing these additional resources is vital to adequate treatment and supervision and ultimately contributes to the safety of society. Taken together, the internal and external dimensions of Relapse Prevention offer improvements over traditional approaches to treating sex offenders.

Agreement in Risk Factor Identification Among Professional Groups

In order for the Relapse Prevention model to have practical utility, mental health practitioners and probation and parole professionals must be able to identify and agree on what risk factors exist. The Relapse Prevention model would have little utility if clinicians and parole officers could not agree on an individual's specific offense precursors.

To assess the extent of agreement among professional groups, two psychologists and two probation and parole officers reviewed case records of 10 convicted pedophiles, which were drawn from an initial sample of 200 sex offenders (Pithers, Buell, Kashima, Cumming, & Beal, 1987). The level of agreement in identification of immediate precursors reached 85% among the psychologists and 75% among the probation and parole officers. For early precursors, the psychologists agreed on 76% of their ratings, while the probation and parole officers agreed 57% of the time. Comparing level of agreement across professions, the mental health clinicians and probation and parole officers agreed on 76% of the immediate precursors and 66% of the early precursors.

Thus, levels of agreement on immediate and early offense precursors, both within and across professions, are relatively high. It must be emphasized that these ratings were not performed on pre-determined, dichotomous variables where the chance probability of rater agreement is .50. Since ratings were based solely on information gleaned from reading clinical case files, with no structure provided to guide reporting of risk factors, one may argue that the probability of chance agreement between raters was closer to zero than to .50. Therefore, the percentage of agreement on risk factors identified within, and between, the two professional groups appears impressive. Given this high level of agreement, offense precursors appear to represent meaningful concepts among psychologists and probation and parole officers acquainted with the Relapse Prevention model.

Effectiveness of Training in Risk Factor Identification

In order for the Relapse Prevention model of treatment and supervision of sexual aggressors to be used widely, the abil-

ity to train inexperienced professionals to discern offense precursors must be developed. To assess the ability to transfer skills to professionals inexperienced with Relapse Prevention, social workers participating in a six-hour training session completed a pretest and posttest that required them to identify risk factors contained in a fictional narrative about an adolescent offender (Pithers, Buell, Kashima, Cumming, & Beal, 1987).

The training session covered the central concepts of Relapse Prevention, interviewing strategies, introducing Relapse Prevention to clients, working within the treatment model, dealing with lapses in a therapeutic manner, assessing the potential of imminent relapse, and enhancing relationships with mental health professionals. Didactic presentations, videotaped interviews, illustrative slides, and case vignettes were employed as training media.

Upon reviewing the narrative describing an adolescent sex offender, four Relapse Prevention experts reached consensus that 21 risk factors were present. Prior to the workshop, participants correctly identified 38% of the risk factors contained in the disposition summary. Upon conclusion of training, an average of 68% of the offense precursors were correctly reported, a statistically significant increase. The percentage of erroneously identified risk factors (i.e., 6%) did not change. Additional supervised experience after the workshop was expected to further hone the social workers' skills. Therefore, brief training in the Relapse Prevention model appears effective in increasing participants' abilities to accurately discern precursive risk factors.

Relapse Prevention Assessment Procedures

Relapse Prevention assessment entails three primary goals: (1) analysis of the client's high-risk situations (and the apparently irrelevant decisions that enabled access to those situations), (2) identification of coping resources that may be employed in high-risk situations (or the absence of those skills), and (3) evaluation of change during and after treatment. Among the assessment procedures employed in the Relapse Prevention approach are analysis of case records, structured interview, direct behavioral observation, and self-monitoring and self-report measures.

Analysis of Case Records

Assessment of offense precursors should begin even before meeting the sexual aggressor. By carefully analyzing background information, such as prior offenses listed in a computerized criminal record, police reports, victims' statements, the offender's statement, psychological or psychiatric evaluations, and presentence investigations, the examiner can gain information pertinent to discrimination of offense precursors.

By reviewing available information, one may discover that the client has performed other sexually aggressive acts that have been plea bargained to lesser, nonsex offenses. Thus, a first-time date rapist, who arguably might receive outpatient treatment under carefully sculpted conditions of probation, may be found to have performed numerous sexual assaults that were legally processed as simple assaults. A pedophile, arrested for the first time in a given state, may possess a vocational history containing numerous short-term periods of employment. Such a work history may reflect a fixated pedophile who has sexually abused countless children over many years moving each time his secret world was about to be publicly revealed by a victim's report. A man arrested for sexually abusing his stepdaughter may have had several prior marriages, each to a partner who had a daughter his preferred age. Thus, a thorough inspection of the offender's records may yield important information and reveal issues for further exploration in a structured interview.

Structured Interview

After reviewing all available information about the offender's history, the probation/parole officer or mental health professional is prepared to conduct a thorough interview. In order to create a relatively comfortable environment to maximize initial disclosures, it is recommended that the interview begin by examining non-threatening topics. Care must be exercised in deciding how to begin the interview. Safe topics are not the same for everyone. While one offender may be totally at ease discussing his educational background, another may view his academic performance as the worst embarrassment of his life. Generally, safe topics can be discerned during the case record review.

During the interview, both process and content should be observed. Does the offender openly discuss most issues but become suddenly reticent when his sexual or criminal behaviors are questioned? When summarizing his sex offense, does the offender become more animated and develop the glazed appearance of complete absorption in a revivified event, or does he exhibit self-disgust? How socially adept does the individual appear? To what extent does the offender accept responsibility for his sexually aggressive acts (e.g., total denial; displaces responsibility for the offense on to the victim; accepts factual responsibility for the offense, but denies any harm to the victim; minimizes harm done; acknowledges physical and emotional trauma)? To what degree does the offender's story correspond to the victim's report of the abuse? Does this person seem to have always been walking on the edge of criminality? How does the offender's affect compare to the topic he is discussing? Has the offender glossed over any periods of time? How does this individual respond to confrontation, support, or expression of incredulity about some aspects of his responses? Each of these observations may yield information important to treatment and supervision of the offender. They may also facilitate determination of the appropriate location for treatment of the sex offender (i.e., outpatient or inpatient).

The Structured Interview

In the structured interview, clients are requested to detail circumstances associated with past offenses. Both situational and personal (cognitive and affective) antecedents should be identified, and apparently irrelevant decisions made enroute to the offense should be explored. Since the concept of apparently irrelevant decisions may be new to the client, we introduce the concept with an explanation and a few examples:

Each of us makes many decisions each day that seem so minor that they could have absolutely no significant impact on our lives. Yet regardless of their apparent irrelevance, some of these decisions profoundly alter the range of behaviors that are subsequently available to us. The cumulative effect of all of these apparently irrelevant decisions can dramatically alter the major events of our lives. An example may help to clarify this point.

Let's take the case of George, an alcoholic who has recently sworn never to drink again. Imagine him walking down a dimly-lit city sidewalk close to midnight. He reaches into his pocket for a cigarette and discovers that he's out. He anxiously looks around for a store and notices a flashing neon sign up ahead. As he draws closer, he realizes that the sign says BEER. He pauses only a moment to deliberate, deciding that he really needs a cigarette. He enters the bar and goes directly to the vending machine. Reaching for change, he realizes he has none. He asks two men playing pool if they can change a dollar, but both shake their heads. He turns toward the cash register at the bar to get change and hears his name called, "George!". Turning toward the sound, he stares through the drifting blue cigarette smoke and recognizes the foreman of a construction crew he works with. The foreman immediately turns to the bartender and says, "Fill up a brew for George!" Debating only a second, George begins to sip the foaming beer. That was only the first of many he took that night.

Now that you've heard this story, you may be able to see that George made a series of decisions that led up to his final decision to drink beer. At each one of these choice points, George could have made a different decision that would have taken him away from a dangerous situation. Did he really have *to have a cigarette? Did he have no alternative but to enter the bar? Could he have refused the beer his foreman bought him? I think you can see that George made a series of decisions, some of which appeared irrelevant to his abstaining from alcohol, but each of which brought him closer to finally taking the drink of beer.*

Looking at your decision to have a sexual relationship with a female child in this way, can you tell me the earliest point at which you decided to seek that out? (Pithers, Marques, Gibat & Marlatt, 1983)

At this point, the client may provide any of a wide range of responses, none of which should be severely criticized or ridiculed. If the client responds with a statement such as, "I didn't decide, it just happened," the therapist can offer another example or proceed with other questions designed to clarify the client's high-risk situations, such as "If you were to become sexually involved with a child again in the future, how might it occur?" or "What particular situations or events would make you feel like raping again?" (Note the importance of phrasing questions in a way that suggests you expect the client to produce examples of predisposing circumstances.)

Direct Behavioral Observation

Some sex offenses are motivated by disordered sexual interests. Some pedophiles choose to victimize children at least partly because they experience much greater sexual attraction to children than to adults. For these men, the notion of sexual intimacy with a peer is far less interesting than abuse of children. In a similar fashion, some rapists regard acts involving a fusion of sexuality and violence to be far more desirable, at least under certain precursive conditions (e.g., anger, alcohol consumption), than sexual expression of affection and intimacy. Certainly, such sexual arousal disorders must be regarded as factors predisposing a person toward sexual abuse.

Research has demonstrated that direct behavioral observation in many cases enables discrimination of men who harbor disordered arousal patterns from those who do not. The technology enabling behavioral assessment of sexual arousal patterns is the penile plethysmograph (see Chapter 9, Penile Plethysmograph).

Under laboratory conditions, the client's sexual responses to audiotaped or visual depictions of various sexual scenarios may reveal high-risk factors that the client has not recognized or has not been willing to self-report. Offenders who possess a sexual preference for children or rape may pose special difficulties for a supervising probation officer. Such individuals may be less inclined to report reentering a relapse process than clients who do not exhibit sexual preference for abusive sex acts. If excessive sexual arousal to stimuli of child abuse or rape is discovered, specialized behavioral interventions may effectively diminish the disordered preference (see Chapter 12, Behavioral Techniques). However, one must avoid the pitfall of assuming that once a sexual arousal pattern has changed, the arousal pattern remains altered permanently. Follow-up evaluation, supervision, and booster sessions remain essential.

Self-Report and Self-Monitoring

Obtaining direct behavioral measurement of sexual arousal involves use of specialized technology not available in many settings. Where the plethysmograph is unavailable, therapists and parole officers must rely on self-report measures, such as questionnaires (see Chapter 8, Clinical Assessment), structured interviews, or self-monitoring records.

Since individuals entering treatment may still be experiencing frequent urges to perform the problem behavior, encouraging the offender to self-monitor his behaviors may enable identification of offense precursors. Documentation is an essential aspect of self-monitoring. Whenever the offender detects an urge to engage in any aspect of his relapse process (e.g., affect, fantasy, cognitive distortion, planning, behavior), he should chart or tape record the following information: (a) time of day, (b) description of internal events (feelings and thoughts that preceded and accompanied the urge), (c) a detailed review of the external situation, and (d) numerical ratings of the strength of the urge, his difficulty tolerating the urge, and his resulting mood. Analysis of self-monitoring records may reveal a pattern of precursors that is associated with urges to engage in the relapse process.

Although self-report and self-monitoring can yield useful information from men desiring to alter their damaging behaviors, individuals who wish to obfuscate the assessment process can easily distort their responses to these measures. Therefore, information from additional sources should be sought to confirm or refute the offender's representation of himself.

Situational Competency Test

The Situational Competency Test evaluates an individual's ability to cope with high-risk situations. In this procedure, the client is required to articulate the first coping response he can think of when a variety of high-risk situations are described. The offender's response is scored along several dimensions, such as response latency, length, content, adequacy, and number of coping alternatives mentioned. Problematic situations are considered present whenever the offender cannot formulate a coping strategy, offers his response only after a prolonged delay, describes a response that would not realistically minimize risk, or elaborates on the described high-risk situation by detailing a related sexual fantasy or past crime of his own.

The following scenario might be employed to determine if a same-sex pedophile is prepared to deal effectively with people who encourage him to keep his offense pattern secret:

> You have been taken to religious retreats, on furlough from the prison, for several weeks by the same volunteer. The volunteer really seems to have developed an interest in your welfare. You appear to be developing a friendship with him. Finally, he invites you to his home for Sunday dinner with his family. He has never mentioned his family to you before and you are surprised to hear him speaking proudly about his 9-year-old son. At that moment, you recognize that you have never informed him about the details of your offense. You begin to say that you need to talk with him about your offense, but he interrupts, saying, "I don't need to know all about your offense, I know you as a person already and that's all I need to know." What do you do?

Analysis of the offender's response to this scenario enables the probation officer or therapist to discern if the offender is prepared to confront an individual colluding with his relapse process by encouraging secrecy.

Relapse Fantasies

Relapse fantasies may be employed to assess a client's coping skills and his willingness to acknowledge the limitations of his self-management skills. This procedure requires an offender to imagine a constellation of precursors that would surmount his ability to cope and evoke a relapse. Typically, offenders who have recently entered treatment are unable to accomplish this task. However, individuals more meaningfully participating in therapy generally are able to depict a variety of circumstances that could overwhelm their coping resources.

Relapse Prevention Treatment Procedures

Relapse Prevention subsumes a wide variety of treatment procedures. These interventions may be divided into two major categories on the basis of their intended effect: (1) procedures for avoiding lapses, and (2) techniques for preventing a lapse from precipitating a relapse. Figure 14.2 shows the correspondence between these treatment components and offense precursors of the relapse process.

Although we introduce the concept of offense precursors, or risk factors, during the early phases of therapy, Relapse Prevention treatment strategies are not broached until the offender has recognized the trauma his acts have inflicted upon victims. Since Relapse Prevention employs interventions that are highly cognitive, employing these therapeutic components too early in treatment may encourage denial of the actual extent to which he has harmed victims. We regard development of empathy for victims as an important aspect of any therapeutic program and as essential to motivating offenders to refrain from future sexually abusive acts.

Interventions to Avoid Lapses

Identification of Offense Precursors

Although some lapses in self-management are unavoidable, Relapse Prevention proposes that many circumstances pre-

disposing lapses can be anticipated and circumvented. The initial phase of assisting sex offenders to avoid lapses entails teaching them to accurately recognize offense precursors involved in their relapse processes. Although this task was introduced as an assessment technique, identification of high-risk situations, apparently irrelevant decisions, and offense precursors continues throughout treatment. As the client continues in therapy, he will discern behavioral and attitudinal subtleties that previously were not regarded as related to his offenses. Continued self-monitoring and analysis of case examples in group therapy sessions foster the offender's ability to detect offense precursors.

Identification of lapses is necessary but not sufficient in itself to deter relapses. In many treatment programs, offenders are instructed to identify a warning signal that will alert them that they are getting into trouble. Unfortunately, although many interventions train offenders to detect their warning signal, they often neglect to prepare the individual to respond adaptively when the warning signal is noted. Thus, clients are aware that they are in extreme trouble yet have no idea how to extract themselves from danger.

In contrast, Relapse Prevention engages in treatment activities to provide offenders with strategies to minimize frequency of lapses and to prepare them to cope more effectively with momentary breaches in self-management. Offenders are instructed to think of lapses not as signs of absolute failure, but as opportunities to enhance self-management by learning from mistakes. Once a lapse is reported by an offender, he and the therapist analyze the circumstances that preceded it. By determining the factors that overwhelmed the offender's self-control, coping behaviors can be developed to decrease the likelihood of lapses occurring again in similar situations. Thus, the offender will know precisely what must be done to prevent a lapse from becoming another relapse.

Stimulus Control Procedures

If external stimuli provoke lapses, simply removing these stimuli from the offender's daily environment may enhance his self-control. For example, a rapist whose anger toward women is aggravated by alcohol use should be prohibited from possessing alcohol or even residing in a location where it is present. Similarly, individuals whose abusive sexual fantasies are evoked by pornography or a department store catalog may be advised to remove these items from their surroundings.

Avoidance Strategies

Similar to stimulus control procedures, treatment and probation conditions may be developed to mandate avoidance of specific circumstances that may elicit lapses. A pedophile should be prohibited from developing a relationship with any woman who has children of the same gender and age of those he has victimized repeatedly. Rapists who have predatorily driven in search of a hitchhiking female should be restricted to using a vehicle only for traveling to work or only when an adult deemed responsible by the probation/parole officer accompanies him.

Escape Strategies

No matter how thorough the preparation, offenders are unlikely to be able to remove or avoid every situation that could precipitate a lapse. Thus, they should be prepared to enact effective escape strategies whenever unexpected risk factors are encountered. Escape strategies should be employed as soon as an offender recognizes that he has encountered a high-risk situation that he is not prepared to handle. Offenders who delay, hoping that the risk will go away if they just refuse to attend to it, are at an increased risk of reoffense.

The most important aspect of an escape strategy is the speed with which it is enacted. Offenders who find themselves in unexpected risk situations may be compared to individuals who discover themselves alone in a room with a ticking time bomb. In both cases, individuals who make hasty exits survive dangerous circumstances. A quick response may not appear very elegant, but it may interrupt a chain of events leading to disaster. Once the survivor reaches safety, he can take time to review the situation, identify the source of danger, and prepare to defuse the "bomb" should he encounter it again.

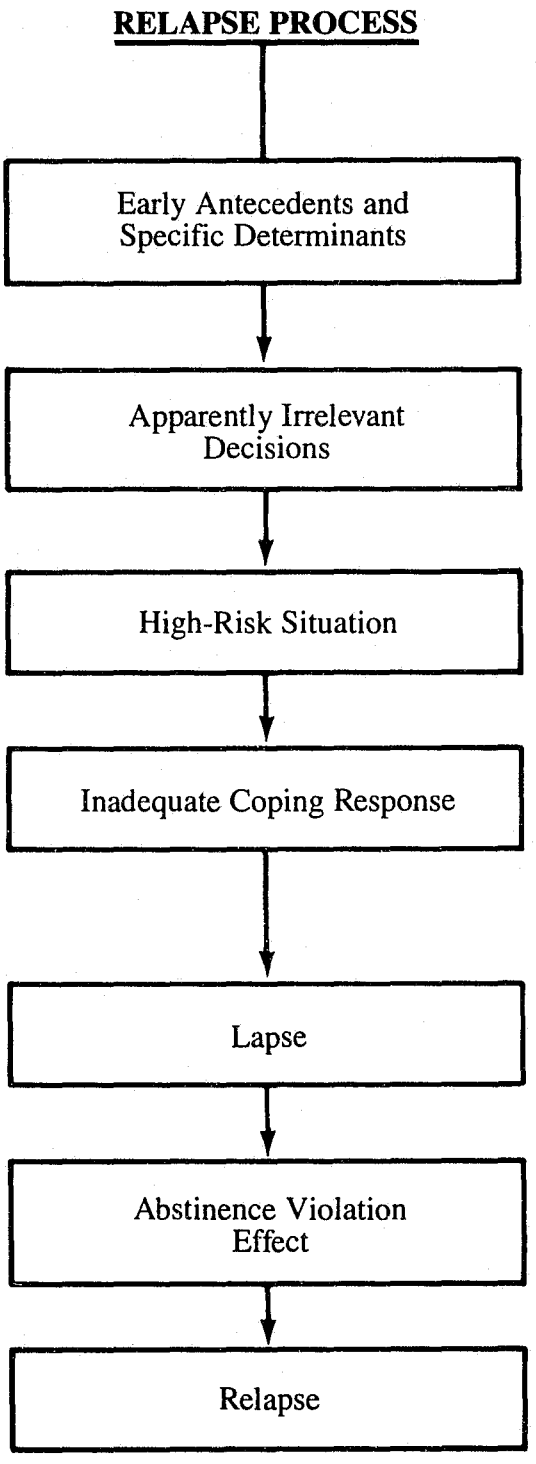
Programmed Coping Responses

If offenders can anticipate confronting a specific high-risk situation, programmed coping responses can be devised. The client is requested to engage in a standard problem-solving process, which involves a routine sequence of stages: (a) a detailed description of the problematic situation, (b) brainstorming to generate potential coping responses, (c) evaluation of the likely outcome of each potential coping response, and (d) an estimation of his ability to enact the optimal coping behavior.

Once the ideal coping response has been identified, the offender should be given abundant opportunities to practice it and receive feedback. Repeated practice of coping behaviors resembles the instructional drills used by piano teachers who seek to have pupils' hands dance "naturally" across a keyboard or by athletic coaches who drill players to exhaustion so they will respond "instinctively" in important game situations. These natural and instinctive skills result from intense, repetitive work.

Coping with Urges

Sexual aggression generally results in some form of immediate gratification for the offender. The power rapist may regard his ability to coerce a victim into uttering favorable comments about his sexual performance as a sign of personal superiority.



RELAPSE PREVENTION INTERVENTIONS

For Avoiding Lapses

Lifestyle interventions
Relaxation training
Reeducation groups
Treatment of sexual dysfunction
Alteration of deviant sexual arousal pattern
Recognition of relapse precursors
Stimulus control procedures
Programmed coping responses
Escape strategies
Anger and stress management
Interpersonal skills enhancement
Avoidance procedures
Problem-solving and self-control skills

For Minimizing the Extent of Lapses

Coping with urges
Lapse rehearsals
Decision matrix
Cognitive restructuring
Maintenance manuals
Contracting
Reminder cards

Figure 14.2. **TREATMENT COMPONENTS TO DISRUPT RELAPSE PROCESS**

A socially isolated pedophile may feel pleased that he has finally found someone with whom he perceives intimacy.

In comparison to immediate gratification, negative consequences of sexual abuse typically are delayed. Only after the satisfaction of feeling powerful during a rape has faded does self-disgust reemerge. The pedophile may later become depressed as he recognizes that his "intimate relationship" must be kept secret. Often, realistic fears of arrest, social disapproval, and incarceration occur only after the temporary gratification from the act has vanished.

Selectively remembering the gratifying aspects of offenses, while neglecting the negative after-effects, increases the probability of relapse. In compulsive behavioral disorders, these positive outcome expectancies are experienced as urges to perform a prohibited behavior. Positive expectancies are particularly problematic if they occur when an individual is in a high-risk situation. Thus, an abstaining smoker, currently in distress, may find himself thinking about the relaxation induced by the first puffs of a cigarette, forgetting about the struggle he went through for several months to quit smoking so he would not develop lung cancer.

In order to deal with positive outcome expectancies or urges, we instruct offenders about the biphasic nature of responses to sexual aggression: initial gratification is followed by a delayed negative effect. Offenders are informed that, contrary to their expectation, urges do not increase in intensity over time, do not become more difficult to resist, and cannot be viewed as overwhelming one's better intentions. Rather, giving in to an urge is an active decision that the offender makes, an intentional choice for which he is responsible. In addition, offenders are instructed that, if they are able to refrain from choosing to submit to an urge, it will grow weaker and pass away with time. Self-statements, such as "Rape doesn't leave anyone feeling good" or "Two minutes of power isn't worth twenty years of prison," may be employed to counter urges. Inclusion of aversive images and outcomes is a potent method for dismantling urges. For example, an offender may be encouraged to visualize his favorite deceased relative looking over his shoulder as he contemplates an urge to fellate a boy. Such images may deter a tendency to passively submit to an urge, giving the offender time to consider the negative consequences of the act.

Interventions to Prevent Lapses from Becoming Relapses

Regardless of the adequacy of treatment, lapses in self management will occur. By understanding this, offenders are better able to mitigate the negative impact of the abstinence violation effect when a lapse is encountered and the likelihood of a lapse precipitating a relapse is lessened. In addition, Relapse Prevention employs several specific treatment procedures to enable offenders to pull out of a downward spiral before they "crash".

Cognitive Restructuring

In order to counter the self-defeating cognitive and emotional aspects of the abstinence violation effect, offenders are instructed to cognitively restructure their interpretation of lapses. In the Relapse Prevention model, offenders are prepared to view lapses as mistakes that present opportunities to learn something new about their relapse process and deficiencies in coping skills, thereby increasing their self-control. Rather than attributing a lapse to an invariable, negative personal characteristic (e.g., "I am a monster"), the lapse can be viewed as a slip in self-management. Offenders are encouraged to recognize that a lapse may remain a single event that can be coped with and is not necessarily a predictor of impending doom.

To assist in restructuring their interpretation of lapses, offenders are required to carry a reminder card that summarizes this material. Whenever a lapse is encountered, the offender should immediately review the contents of the card. The card should contain items such as: (a) that a lapse means a slip in self-management and does not mean irreversible loss of self control, (b) a description of the abstinence violation effect and the negative self-attributions that may accompany it, (c) reassurance that he does not need to yield passively to deviant urges and that they will weaken over time, (d) instructions to examine the precursors to the lapse to discern what might be learned from the event to enhance his personal control in the future, and (e) a list of coping responses that may be enacted if he feels a need for additional assistance to refrain from relapsing. Some offenders also list telephone numbers of therapists, treatment group members, and supportive friends on this card for use when they have difficulty coping with a lapse.

Contracting

A therapeutic contract, signed by the offender when he enters treatment, specifies the limits to which he may permit himself to lapse. The therapist and offender work together to identify the "lapse limit," but the therapist must ensure that this limit is not excessive.

The relevant portion of a treatment contract for a pedophile, for whom acquisition of child pornography is an offense precursor, might read as follows:

(1) When feeling an urge to leave my current location and go out to purchase pornography, I agree to wait 30 minutes before leaving my location. During this time, I agree to pause and consider my desire and the risks it may pose to my reoffending. If, at the end of this 30-minute period, I decide to leave my location to purchase pornography, I will be making an intentional choice, rather than passively yielding to an uncontrollable urge.

(2) If I decide to travel to a location where I may purchase pornography, I will buy only one mag-

azine. I also agree to inform my probation officer and therapist about this lapse at my next meeting with each of them. I promise to give possession of the pornography to whomever I meet first (i.e., probation officer or therapist). At that time I will also donate an amount of money equal to the purchase price of the pornography to the local victim/witness program.

In this manner, the contract specifies the limit to which lapses will be tolerated by the treatment team (i.e., probation officer and therapist). It requires the offender to view his behavior as a clear choice and mandates a delay during which the urge to perform the offense precursor may wane. Additionally, the contract limits the offender's exposure to a stimulus predisposing sexual abuse and demands that some penalty be paid for choosing to lapse. The offender is required to address the lapse at his next treatment group meeting. The contract may also specify that if a lapse is reported to the treatment team by someone other than the offender, an effort to revoke his probation may ensue.

Maintenance Manuals

Each offender can develop his own maintenance manual that can be used to refresh his memory after the intensive phase of treatment has concluded. Depending on the client, the manual may contain items such as his reminder card; avoidance and escape strategies; emergency telephone numbers; a list of his apparently irrelevant decisions, high-risk situations, and offense precursors; self-statements; and self-monitoring forms. Maintenance manuals are particularly useful during an offender's transition from residential treatment to outpatient therapy. In such cases, the manual may enhance maintenance of change and assure continuity of treatment. Offenders should update their maintenance manual periodically and should remain vigilant for the development of new risk factors.

Relapse Prevention Compared to Traditional Treatment Models

Multiple Sources of Information Versus Reliance on Self-Report

Sex offenders have numerous incentives to misrepresent their progress in treatment. In traditional treatment, evaluation of progress relies almost exclusively on clients' self-reports and therapists' intuitions. Relapse Prevention formalizes mechanisms for acquiring information from others who frequently observe the offender's behaviors. In this fashion, the offender's behavioral maintenance and therapeutic compliance can be examined more thoroughly. The parole officer and therapist will be less likely to make important decisions about the offender on the basis of misinformation.

A Continuum of Treatment Versus Treatment Solely in Institutions

Life in many prisons is not easy for sex offenders, who are viewed with contempt and harassed by others. While maintaining a gratifying lifestyle in prison may be problematic, survival within society is generally more continuously challenging. In prison, inmates are required to exhibit few of the survival skills needed to exist in free society. They are awakened in the morning without needing to remember to set an alarm the night before, meals are prepared and awaiting their arrival, clothes are cleaned for them, a minimal level of vocational skill is required to gain employment, adequate work performance is seldom necessary to ensure longevity in one's position, bills for housing and related expenses are always paid, and arguments can be settled without concern for another person's feelings.

In such settings, an offender may discover his level of tension is lower than in society, attribute his comfort to internal change rather than to a changed environment, and anticipate that he now will be able to make it on the streets. Given his increased comfort, the offender may decide that he does not need to work on the problems that predisposed him toward his crimes. He may be deceived into believing that behavioral change has occurred when only compliance to expectations within a less demanding environment has taken place.

Thus, the major challenge in treating sexual aggressors comes after the offender has left prison and returned to a society replete with distressing life events, risk factors, and potential victims. Only after release from prison can the actual impact of treatment be discerned. Inpatient programs that do not entail prolonged periods of specialized outpatient treatment and parole supervision will fail.

Therapeutic and Supervisory Control Versus Therapeutic Cure

Historically, many treatment programs for sexual aggressors operated exclusively within prisons or maximum security state hospitals. The premise of such programs adhered to the best tradition of a central tenet of the medical model: treatment enables cure.

With many disorders, the medical model functions quite well. Bacteria causing diseases can be annihilated, ruptured appendices removed, weak hearts and lungs replaced. However, in regard to sex offenders, the treatment programs adhering to the medical model concept of cure have themselves been replaced.

For some disorders, cure is not possible. Epilepsy cannot be cured, but proper treatment controls its seizures. If medication is not provided, the likelihood of seizures recurring is quite high. Therefore, epileptics are provided medication to control their disorder.

Sexual aggressors cannot be cured. To permit offenders (and anyone treating them) to have hope of complete, irreversible eradication of their disorder is to establish an expectation that assures failure. No living being has ever maintained total control over his or her behaviors across time and situations. Encouraging offenders to pursue the unrealistic goal of behavioral perfection, thereby ensuring a sense of personal inadequacy when lapses in self-management are encountered, may be tantamount to aiding and abetting their reoffending. However, just as medication can control but not cure epilepsy, specialized treatment interventions can empower sex offenders to gain enhanced control over their disorder.

Integration of Parole and Mental Health Versus Mutual Distrust

All too frequently profound disaffiliation exists between mental health practitioners and correctional professionals. These attitudes develop because the two professional groups seldom work in an integrated fashion.

The notion of working together appears alien because the goals of the professionals often seem divergent and little trust exists. The structure of Relapse Prevention helps to mend this professional chasm. By working together with a common goal of deterring sexual victimization of others, each profession learns how the other can facilitate its own effectiveness. By sharing information under a full waiver of client confidentiality, once disaffiliated professional groups develop a supportive collaboration with a common goal.

Effectiveness of Relapse Prevention: Outcome Data

Through offender interviews, clinicians' reports, contacts with community groups, and review of official records, Pithers, Kashima, Cumming, Beal, & Buell (1987, 1988) studied the recidivism status of 124 sex offenders who had been involved for a minimum of 2 years and a maximum of 4½ years in the outpatient phase of the Vermont Treatment Program for Sexual Aggressors. The sample consisted of 104 pedophiles and 20 rapists. (Two hundred seventeen offenders are currently receiving services in the Vermont Treatment Program for Sexual Aggressors. However, 93 offenders had been in outpatient treatment less than the 2-year criterion for inclusion in the outcome study.)

The Vermont Treatment Program for Sexual Aggressors made the first use of Relapse Prevention with sex offenders. At the time of this report, the treatment program consisted of 2 inpatient units housed in community corrections facilities and 27 outpatient therapy groups operating primarily in community mental health centers. The sample of 124 convicted sex offenders in this study represented a mixture of individuals who had received probationary sentences and/or terms of incarceration from which they had been paroled.

Table 14.3

RECIDIVISM RATES FOR CONVICTED SEX OFFENDERS WHO PARTICIPATED IN RELAPSE PREVENTION

	Rapists	Pedophiles	Total
Offenders in outpatient therapy between 2 & 4½ years	20	104	124
Relapses*	2	3	5
Relapse Rate	10%	3%	4%

*Relapse is defined as a reconviction or admission of another sex offense of any type.

The recidivism status of the 124 offenders is presented in Table 14.3. Two of 20 rapists had performed an additional act of sexual aggression during the 2- to 4½-year follow-up period. Of the 104 pedophiles, 3 individuals engaged in further acts of child sexual abuse. Of the three relapses by pedophiles, two occurred within five months of their starting outpatient therapy.

Statistical comparison of the efficacy of Relapse Prevention with rapists and pedophiles has not been performed. However, one might speculate that significant differences in behavioral maintenance could emerge as a reflection of the underlying psychological dynamics of rape and child sexual abuse.

The difference in etiology of rapists' and pedophiles' offenses may be discerned in data regarding the post-treatment periods during which they relapse with the greatest frequency. Sturgeon and Taylor (1980) assessed the recidivism status of every sex offender released in 1973 from treatment at California's Atascadero State Hospital or from prison without benefit of therapy. Their data revealed that rapists' highest risk of relapse occurred within the first year after release from institutional treatment or confinement. In contrast, pedophiles recidivated with the greatest frequency two to three years after discharge. (It should be noted that specialized outpatient treatment for offenders released from institutional treatment programs in California was virtually non-existent at the time of the Sturgeon and Taylor study.)

The discovery that the highest frequency of rape relapses occurs during the first year after release may reveal the influence of anger and power as the predominant motivations for sexual violence. Eruptions of anger and feelings of disempowerment have precipitous, explosive onsets. In individuals for whom these issues are problematic, loss of behavioral control can take place rapidly. Extending this premise to the efficacy of Relapse Prevention as a maintenance procedure for rapists, one can envision how the model may be challenged. That is, rapists may manifest few precursive risk factors prior to their offenses. They may transition from periods of adequate self-management to relapse within a relatively short time.

The finding that pedophiles relapse with the highest frequency several years after discharge may represent their misguided efforts to obtain "intimacy" and "relationships." Many pedophiles groom victims, gaining the familiarity that enables sexual access. Development of any human relationship, even the profoundly disturbing, coercive interaction of a pedophile and a victim, takes time. The greater quantity of time needed for the preparation of pedophilic acts may be responsible for the later period of highest risk of relapse for child molesters as opposed to rapists. Extending this hypothesis to the potential efficacy of Relapse Prevention as a maintenance procedure for pedophiles, one might expect the model to offer favorable results. Pedophiles may be more likely than rapists to display precursive risk factors over a relatively lengthy time. These characteristics may afford greater opportunity for identification of precursors, therapeutic intervention, and restoration of self-control.

Although the sample size and length of follow-up are too small to enable conclusive statements about the effectiveness of Relapse Prevention as a maintenance and supervisory model for sexual aggressors, the data appear supportive at this point. Additional data acquired over a longer follow-up period will determine the ultimate utility of this procedure, however.

Conclusions

Relapse Prevention provides sex offenders with specific procedures to facilitate behavioral self-management. In addition, this model of behavioral maintenance enhances the efficiency and effectiveness of offender treatment and supervision. Since probation/parole officers monitor the presence of specific precursors rather than the entirety of the offender's behaviors, the efficacy of their supervision is increased. Relapse Prevention facilitates development of a network of professional and nonprofessional collateral contacts who may assist in checking the offender's precursors, enabling the probation or parole officer to perform more efficiently. In addition, the Relapse Prevention model enhances communication between professional groups that often appear disaffiliated. Since probation or parole officers and mental health professionals provide each other with information that makes their work more effective, mutual respect and appreciation are engendered.

Studies presented in this chapter demonstrate that probation and parole officers, clinical psychologists, and social workers who deal with delinquent adolescents are able to employ the Relapse Prevention model with equal facility. Brief training provides professionals with adequate proficiency to implement the maintenance model. Research data reporting a 4% recidivism rate among 124 participants in the Vermont Treatment Program for Sexual Aggressors, which has employed the Relapse Prevention model for several years, demonstrate that this approach holds promise for enhancing the safety of society.

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Chapter 15: Community Management of Sex Offenders

by Randy Green

Abstract

In this chapter, Dr. Green discusses the issues and problems associated with community supervision of the sex offender on probation and/or parole. The need for cooperation between the field service professional and the therapist is accented. The need for carefully planned transition of this type of offender is stressed.

Even the best and most comprehensive treatment program for sex offenders will fail in its objective if the offender does not know how to apply what he has learned in the treatment program to his life after discharge. Adequate aftercare strategies are developed by translating generalized coping skills to each offender's particular dynamics and helping him implement those skills over a lifetime. Communication between the offender, therapist, correctional personnel, and the offender's support system is essential in the early stages of community reintegration and desirable thereafter.

Issues relating to sentencing conditions, community-based correctional settings, and transition back into the community by the offender will be discussed in this chapter. It is the purpose of this chapter to encourage maximum interagency awareness and cooperation in the aftercare management of sex offenders in order to minimize the likelihood of future instances of sexual assault.

Aftercare Defined

Following the most active phase of treatment intervention for the sex offender, whether in a correctional institution, residential facility, or community-based treatment program, there is an inevitable reduction in the intensity of treatment and supervision. In the initial and most optimum end of the continuum, treatment has been comprehensive and intensive, but treatment and supervision are gradually reduced with the demonstrated responsibility of the offender. At the most pessimistic end of the continuum, treatment becomes quite fragmented until both treatment and supervision are finally terminated. In either case, the aftercare component of a treatment program should be viewed not as an afterthought but rather as an integral part of a comprehensive rehabilitative and case management program for the sex offender.

Aftercare is essentially that portion of the offender's program in which positive changes which have been made are maintained on a day-by-day basis. A responsible aftercare approach should assume that the sex offender is never "cured." There is no point in time that a sex offender or case management personnel can relax and conclude that the offender will never perpetrate another sexual crime. In fact, the first sign of a possible relapse might occur when the offender adopts the optimistic posture that he will "never let it happen again." Such professions of overconfidence, frequently made with all sincerity and often believed by the offender's personal support group, can nonetheless signal the first significant erosion of the offender's defenses against reoffending. This attitude, unfortunately, is quite prevalent and highly resistant to being dislodged. Treatment personnel, therefore, attempt to let the offender know from the outset that his efforts toward rehabilitation will not be easy. The hope to "maintain without pain" has just as many adherents as those who hope to "gain without pain." Sex offender programs should endeavor to prepare the offenders with a reality-based view that responsible living, though difficult, is far easier than the alternative.

Statistical support for the contention that sex offenders should always consider themselves at risk to reoffend comes from several sources. Soothill and Gibbens (1978) reported that, after 22 years, the reconviction recidivism rate for 174 untreated British incest offenders, rapists, or sexual abusers was 48%. Significantly, they reported that the highest reconviction rate occurred during the first two years following an initial conviction. In that high-risk time, 16.8% of the total group, or one-third of the recidivist group, were reconvicted. However, their study also revealed some other significant findings. One such finding was that the recidivism rate continued to increase an average of 2-3% annually, with nearly 25% of the reconvictions occurring more than 10 years after the initial conviction. According to this information, there is no point at which it can be assumed that untreated offenders are no longer at risk. It is probable that this is more true of child molesters than of forcible rapists. Jurisdictions throughout the United States are grappling with the phenomenon of the grandparent child molester, the age range for victim-creating behavior by child molesters being potentially very protracted. Furthermore, statistics kept on those offenders who have been treated for sexual deviancy reinforce the conclusion that there is never immunity from offending.

A treatment program should incorporate as great a degree of control, structure, treatment intensity, and correctional supervision as possible. As an offender demonstrates motivation, commitment, trustworthiness, follow-through, and integration of treatment principles into behavior patterns—including arousal patterns—it becomes possible to gradually reduce program control and increase the offender's own sense of responsibility for daily life management. This process is best facilitated in residential programs in which the offend-

er's access to the community is restricted until such time as appropriate insight, stability, maturity, and responsibility are demonstrated. Then the offender can enter a gradual community transition and a subsequent aftercare phase. Institutional programs in which there is no access to the community until after discharge handicap the inmates who are progressing in treatment. Some assimilation into a community, like a halfway house, is vital.

Community programs, on the other hand, attempt to work with the lower risk, less impulsive, less antisocial clients from the outset. They have a lower capacity to monitor their offenders in treatment but do have an early opportunity to observe the degree of self-motivation and follow-through which the offender himself is willing to provide. Much earlier in treatment, there is a need to address how the offender can successfully manage in the community. Because the offender who is initially sentenced to outpatient care is usually without any prior treatment for sexual deviancy, it is advisable that sentencing orders be particularly clear about the limits of contact and movement for those individuals. The treatment and community corrections personnel, as well as the offender, need all the rules clearly defined.

Sentencing Issues

Nearly all sex offenders are referred to treatment through court mandate. That being the case, the manner in which the court order is written for such a mandated client is critical. The best of intentions by the court may translate into either glaring omissions or, alternately, extremely rigid and inflexible orders.

As defined by law and within the limitations of resources available for treatment, incarceration, and community supervision, it is desirable to create the optimum conditions to accomplish a two-fold purpose:

1. Encouraging those who are amenable for treatment to actively participate in available treatment, while
2. Identifying those currently unamenable to available treatment and separating them from society for the maximum time possible.

With regard to sentencing, whenever possible it is advisable to have a presentencing report available for the court. This report should include an assessment from an experienced clinician regarding the specific issues which were addressed earlier.

Additionally, it has proven helpful in Oregon for treatment providers and specialized probation/parole personnel to develop a list of possible sentencing conditions which can be included in the sentencing order (see Appendix D). This list provides a set of conditions which can be tailored to the specific dynamics of each individual sex offender.

The concepts and sentencing provision options can be shared with the state judiciary. The State Judiciary Association or the State Supreme Court, as well as the parole board, could provide a helpful agency through which these issues and concerns can be addressed and communicated. Many judges and parole board members are also struggling with how best to respond to this societal problem. Many may welcome assistance in the preparation of possible sentencing or release conditions which can be effectively incorporated into their sentencing orders.

Topical areas addressed in the list would include general probation/parole conditions addressing the recommended frequency of contact between probation/parole officer and the sex offender, community access, the offender's contact with children or significant others, limitations on high-risk or pre-assault behaviors, conditions related to drugs, and conditions specifically involving low-functioning sex offenders. This list is clearly nonexhaustive and can be improved as experience dictates. This list could also be made available to any other state agencies who control the offender's access into the general community. A state's parole authority would be a primary example.

Aftercare Issues for Agencies Involved with Recovering Offenders

The overriding issue for public or private officials involved with treating or monitoring the recovering offender is to insure that they have taken the proper steps to best perform this duty. In setting a proper tone in the relationship, the therapist or community correctional officer is advised to inform the recovering offender of the manner in which questionable or potentially problematic situations will be handled, including the procedures to warn or report. A signed statement to that effect may be helpful to prevent law suits for alleged violation of confidentiality. Should any questionable situation arise, the staff person should immediately consult with another professional and discuss the matter with the recovering offender, carefully documenting each action taken. In cases where there is potential harm to an identifiable victim, the therapist has the responsibility to notify that victim and/or the police/community corrections officer immediately (see Chapter 20, Confidentiality and Privilege).

In this era of malpractice suits, no one feels safe or immune from the potential risks which can arise in the area of aftercare and community management of the recovering offender. Awareness of statutes, sentencing orders, and typical case management issues, coupled with a practice of clear, direct, assertive communication, minimizes the likelihood of difficulties in this sensitive area. A willingness to obtain consul-

tation and to provide accurate documentation is also vitally important.

Aftercare Components

When a recovering offender is transitioning into a community, even in a probation situation involving community-based therapeutic intervention, the therapist should develop a community contract as soon as possible. Primary responsibility for development of the contract rests with the recovering offender, who works within a general format and philosophy provided by the therapist. Approval prior to implementation should be obtained by the recovering offender's probation or parole officer and should be appropriately shared with significant others who will be involved in the recovering offender's life.

A sample "Discharge Contract" is provided by F. Knopp (1984). The primary components of the contract include the following.

- A thorough description of the recovering offender's sexually deviant outlet. Range of ages and sex of victims are identified. The pre-assault process, observable behavior cues, fantasy and thought patterns, and actual sexually deviant activities are enumerated in detail. In addition, the recovering offender should state those specific interventions at each stage which have the greatest likelihood of interrupting the pre-assault pattern. Support system personnel should be listed with their phone numbers and addresses.
- Methods to avoid relapse: Behaviors, activities, persons, situations or locations which are likely to sabotage the aftercare plan should be listed and avoided as specified. Use of chemicals and pornography should be specifically addressed (see Chapter 14, Relapse Prevention).
- Plans to pursue therapeutic support as well as accountability and practice assigned behavioral "booster sessions" should be specified. Pre- and post-probation/parole plans regarding these responsibilities should be listed.
- Plans for employment and/or education should be specifically identified.
- Living arrangements should be described fully.
- Social/vocational goals should be developed in detail.
- Current relationship plans should be discussed.
- Budget and transportation arrangements should be clearly developed.

This document should be one which is shared with any therapist, case manager, significant other such as spouse, fiance or live-in partner, roommate, or treatment group with whom the recovering offender interacts. In order to remain viable, the contract should be revised whenever there are significant changes, updating so that anyone reading it would have a current and accurate picture of the recovering offender's community living plan.

Aftercare/Community Case Management Components

Interagency cooperation is imperative. Traditional concepts of confidentiality should always be defined by a clear awareness of the potential danger to identifiable victims, including children of incest offenders wishing to reunite with the children. Under the best of circumstances, coordinating case management of recovering offenders is very challenging. Interagency hostility and poor communication can create a situation in which the offender or the family members can manipulate the system to serve their own purposes.

There appears to be a developing trend towards specialization among probation/parole officers which is worth mentioning. These specialists have a real interest in providing responsible intervention and case management duties for sex offenders. Those individuals with an interest in working with sex offenders, either in treatment or case management, may be motivated by a desire to directly impact on this major societal epidemic. These individuals may wish to update their skills through continuing education.

In addition to capitalizing on increased motivation and commitment, there are other arguments for more specialized training for both treatment providers and probation/parole personnel. Knowledge of offender dynamics, typologies, differential risks to the community, unique case management issues, and pre-assault cycle patterns is highly desirable for personnel working with these individuals. Knowledge of the strengths and limitations of available behavioral interventions and psychophysiological technology is also very desirable. Quality evaluations, both clinical and presentence, as well as ongoing intervention and supervision, are enhanced when there are knowledgable and experienced personnel trained to do this work. Specialists also become more aware of community resources and support systems and can be more effective in coordinating with the network.

If a community correctional agency works towards the development of specialized officers for sex offenders—and perhaps other types of offenders as well—it should also develop a policy statement regarding the scope of the officer's authority. When probation/parole officers become highly involved, committed and specialized, there can be a tendency to blur role distinctions, for example, between case worker and therapist. Where such a line is drawn is a matter for each agency to decide and depends upon its mandate, resources, and workload issues, among others. Clarification of the issue at the outset can possibly avoid later frustrations.

In certain jurisdictions where specialization has occurred, probation/parole officers have co-led supervision/therapy groups with a clinician who specializes in this area. This max-

imizes their communication and provides the officer with an opportunity for participation in group supervision. It provides the officer with the added perceptions of the sex offender's peer group, who also provide direct feedback and monitor behavior. Of course, this presupposes probation/parole officers who are comfortable in such roles and able to be empathic and facilitative, as well as confrontive, in group situations. Pre- and post-sessions between the probation/parole officers and the therapist provide the necessary time to review and plan.

In Oregon, specialized community correctional officers have actually formed a nonprofit professional association in which topics of mutual concern are discussed. Meeting periodically, they may invite another colleague or a clinician to discuss a particular topic. In addition, this motivated group, with the support of correctional administrators, has been actively involved in lobbying for a change in state laws pertaining to the sentencing process and probationary guidelines for sex offenders. One specialized probation/parole officer was faced with the unenviable addition to his caseload of five indigent sex offenders who were in denial and who had been determined unamenable for treatment in other settings. He established a group composed of "deniers" who were on probation and, within two months, had utilized the group forum to break through the denial problem, thus preparing the group members for subsequent treatment interventions. Needless to say, this will not always happen but it does serve to illustrate the potential of such groups for a state system grappling with such desperate problems.

For those sex offenders in aftercare following institutional or residential treatment or those who began their probation within the community itself, it is useful for community correctional personnel to establish an approved list of recognized clinicians who are experienced in the assessment and treatment of sex offenders. Furthermore, it is helpful to clarify the specifics regarding communication between probation/parole personnel and the therapist. Guidelines, such as phone or written contact once every three months to update corrections regarding the sex offender's status, are advisable. In addition, any change in behavior or situation suggestive of a lapse, or a change of situation which could possibly place the offender in a high-risk situation should be communicated to the probation or parole officer.

In essence, community corrections is best served by identifying its philosophy of case management of sex offenders, by clearly articulating that philosophy and concurrent expectation, and choosing those assessment and treatment providers who are willing and able to work compatibly with those standards.

Aftercare Issues for Recovering Offenders

Recovering offenders must be able to balance the precariousness of their situations with their worth and significance as human beings. They also must accept that, despite the reality of the past and the potential for sexually deviant fantasies and behavior in the present and the future, they can still achieve a sense of belonging and acceptance from others in order to make their lives worthwhile. Many recovering offenders have an understandably difficult time keeping this tension in balance, but it is important for them to learn to do so.

Recovering offenders must retain some trust in order to be able to appropriately "disclose" to potentially significant others in their community. This group would typically include prospective employers, prospective dating partners, and close friends. Such issues are filled with emotionality, explosiveness, and danger. Certain general guidelines may be useful in most instances.

- Though it goes without saying, the recovering offender should abide by any statutory or sentencing requirements in terms of reporting or disclosing information to specific individuals.
- In job-search situations, the recovering offender should be encouraged to prepare functional resumes which emphasize skills and experience, in contrast to the chronological resume which would more likely highlight gaps in time. Generally, minimal information regarding criminal history is sufficient unless the nature or location of the job opportunity would make it appropriate to be more disclosing.
- Disclosure to prospective friends or dating partners is no less sensitive. In general, it appears to be appropriate if the recovering offender does not disclose to casual friends. Those who are seen on a frequent basis, who are demonstrating a sensitivity and trustworthiness, and with whom the offender would like to spend more time, should probably be told. Disclosures at this stage may avert uncomfortable situations in a longer term friendship where the friend feels betrayed by having had such information withheld.

  Disclosure becomes even more critical with sexually intimate companions. It is preferable to disclose general information in the early stages of a potentially serious or ongoing relationship. This is expecially true whenever the recovering child molester desires to date someone with children. It is reasonable that the other party make the decision to date a recovering offender on the bases of "informed consent."

In conclusion, this chapter has reviewed issues pertaining to community management of the sex offender. Neither public nor private officials involved with treatment or supervision should be complacent regarding the need for daily maintenance of acquired behavioral changes. A comprehensive, informed interagency network at the community level is essential to maximize the achievement of the goal. The

cooperation of the state's legislative, judicial, correctional, and mental health resources is needed to minimize future victimizations. Approaching the task from a clear problem-solving perspective at state and local levels can replace counterproductive "turf" issues with the mutual collaboration needed both to protect society and to rehabilitate those who may be reintegrated back into that society.

References

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Part Five: Legal Issues in the Treatment of Sex Offenders

In the next section, Mr. Cohen analyzes a variety of legal issues related to the treatment of sex offenders. Sex offenders have held a special place in the legal history of this country because, as a group, they have straddled the line between mental illness and criminality. Their care and containment has fluctuated between mental hospitals and prisons and in some places combinations of the two. Special sex offender statutes, known in various states as "Sexual Psychopath," "Mentally Disordered Sex Offender" or "Sexually Dangerous Persons" Laws grew out of Defective Delinquent Laws. During the early part of this century, there grew a trend to identify certain individuals whose behavior was particularly offensive as being inherently defective and therefore in need of indefinite confinement. This movement was strongly influenced by Caesare Lombroso, an early French criminologist, who stated that certain criminals were "atavists"—genetic throwbacks. These unfortunate individuals, apparently born with a condition which made them a threat to others, needed to be kept away from society.

These laws were finally found unconstitutional after they were utilized to confine political undesirables. However, the concept lived on in the form of Sexual Psychopath Laws which represented a type of civil commitment devoid of the constitutional rights inherent in criminal procedures. These laws represented a type of forced treatment, although in actuality treatment was rarely provided. While most states have repealed these statutes, a few remain in existence, usually in modified form.

Opposed to the issue of forced treatment is one of the right to treatment. From a legal standpoint, Mr. Cohen makes an interesting differentiation between treatment, rehabilitation, and habilitation or training. "Treatment," according to Mr. Cohen, is a medical model term tied to the concept of disease. The courts have established that confined individuals have a right to the treatment of a serious disease. "Rehabilitation," however, involves the restoration of an individual to a more socially acceptable level of functioning. Apparently the courts have assumed that certain individuals adopt aberrant behaviors, such as alcohol or drug abuse or sexual misconduct, which impair their values and socialization. Substance abuse and sexually deviant behavior are considered "statuses," not "diseases."

"Habilitation" is reserved for those individuals who have never had a higher level of functioning, e.g., the developmentally disabled. The courts have established that individuals do have a right to training to enhance their safety and minimize the need for restraint. While legally offenders do not have the right to treatment for "sexual psychopathology" or for being a "sex offender" because these are not recognized diseases, it remains untested whether they have a right to be treated for "pedophilia," "voyeurism," or "exhibitionism," which are listed as mental disorders by the American Psychiatric Association's *Diagnostic and Statistical Manual*. While the overall right to treatment has not been established, this right has been affirmed in the case of individuals incarcerated under Mentally Disordered Sex Offender Laws, where a mental disorder is recognized and release is dependent on improvement of that condition. The Oregon State Hospital Sex Offender Program was established under such a mandate.

An issue of prime concern to correctional administrators is that of negligence. The possibility of a newly released sex offender committing a vicious and widely publicized new offense is the dread of therapists, parole boards, field service officers and corrections departments in general. Regardless of the actual facts, some sort of negligence is usually assumed by the public, although very rarely established. Damage cases may be brought against corrections departments. At this point, the standards for negligent release on the part of a parole board or other releasing authority are quite generous. Basically, as long as the decision cannot be classified as "reckless" or made with "absolutely no reasonable reason" to believe that this person can succeed in the community, then it will be protected. Negligent supervision usually involves a failure to inform citizens of a known danger, e.g., allowing a paroled pedophile to work in a day care center.

Clinicians must also be sensitive to their duty to inform individuals who have been threatened by offenders in the course of therapy. The need to maintain high professional and ethical standards, as well as clear and complete records, is emphasized as a protection against liability claims.

A number of legal issues dealing with treatment are also considered at length. Suggestions for insuring the program participants' rights in regard to confidentiality, privilege, and informed consent are offered.

Some therapeutic modalities used in the treatment of sex offenders may have unique legal problems associated with them, e.g., the use of pornography. Suggestions are offered

to insure that programs stay within court-established guidelines.

Every correctional administrator, therapist, and field service worker must have a thorough familiarity with his/her legal responsibility in dealing with the highly sensitive area of sex offender treatment. However, he/she should not let the fear of sensationalized failure, with accompanying threats of law suits, impair sound professional judgment.

Chapter 16: Introduction to Legal Issues

by Fred Cohen

Abstract

In his introductory comments, Mr. Cohen elaborates on the definition of the term "sex offenders" and comments briefly on Sexual Psychopath Laws. These statutes mandated civil commitments for individuals labeled with a vague, outdated, quasi-clinical definition. These laws are being replaced with criminal statutes which sanction the act, rather than a psychological condition.

Persons who violate laws involved with sexual misconduct no doubt plague society more than the laws themselves. But the laws surrounding this area of misconduct do constitute a troublesome body of legal problems which encompass both criminal and civil law and which range over matters as fundamental as just who is a sex offender, as well as more concrete yet no less difficult problems such as the use of allegedly obscene material in a behavioral modification program.

But this discussion must necessarily be abridged. In order to provide a full discussion of the legal issues associated with "sex offenses" and "sex offenders," one would have to engage in an elaborate analysis of the criminal law on point: criminal sentencing; the variety of Sexual Psychopath (or Mentally Disordered Sex Offender) Laws which still exist; the entire range of correctional law problems as they touch on sex offenders; issues related to the treatment relationship (e.g., confidentiality and consent); liability for injuries inflicted by released sex offenders—and much more.

4 Since this is a chapter and not a book, the coverage outlined above simply is not possible. It is possible, however, to mark out a legal framework of the area and to highlight some problems and deal more extensively with others. What is covered and omitted, highlighted or dealt with extensively, is partly a matter of the author's judgment and partly reflective of questions posed by clinicians and program staff who attended several recent conferences on the treatment of the sex offender.[1]

In some respects this is an odd time for a demonstration of heightened concern for sex offenders, certainly insofar as that concern is expressed as a need for special treatment. The rehabilitative ideal, if not dead, certainly is *in extremis*.[2] Ask what works in treatment and many will answer: "Nothing!" Ask again and others will say: "Some things work, sometimes, with some types of disorders."[3]

A recent survey suggests that the number of sex offenders has increased in more than two-thirds of our prisons. The total number of sex offenders in prison was reported to be about 55,000,[4] an increase that is not surprising since abuse-type offenses are increasingly reported and prosecuted. What may be surprising is a heightened concern for these offenses in the form of treatment programs in prison, which are pursued without any special sentencing structure.

In 1977, the Group for the Advancement of Psychiatry stated, "We see special sex offender legislation as an approach to sex psychopaths that has failed, and consequently we feel that these statutes should be repealed."[5] And, indeed, the legislative trend is strongly and unequivocally in the direction of such repeal. Writing in 1985, Barbara Weiner found Mentally Disordered Sex Offender (MDSO) laws in only 16 states and the District of Columbia.[6]

Professor George Dix, a leading authority in the field, writes, "The history of programs for abnormal offenders (including sex offenders) clearly seems now to have entered a fourth stage, characterized by repeal and abolition."[7]

Disenchantment with MDSO-type laws and their abandonment is not easily ascribed to only one or two causes. It is certain that there exists a combination of causes which includes failure to provide adequate resources along with a belief that what was expended was wasted. In some quarters there is a concern for the infringement on civil liberties that accompanies the seemingly arbitrary and unduly extended periods of detention. There is a general mood that harsh punishment is the only acceptable alternative, particularly for those who rape or sexually victimize our young.[8]

For the purpose of legal analysis, there are two points that alone strike a near-fatal blow to the MDSO-type laws. First, it is now generally argued that "sexual psychopathy" is not a clinical entity and is not a proper psychiatric diagnosis.[9] Further, the category of "sexually dangerous" also lacks clinical validity and actually is a legal term in diagnostic clothing.[10]

Second, the term "sex offender" is as imprecise and misleading as "sex psychopath" or "sexually dangerous," although for different reasons. Sex offenses may include forcible rape, a variety of homosexual practices, a variety of "fondling"-type offenses dependent on age and competency, prostitution, obscenity, obscene gestures in public, voyeurism, bigamy, adultery, and more.[11] Obviously the behavior and the proscribed harm attributable to this listing of sex offenses are enormously varied. The point is that the term "sex offender" does not encompass either a group of offenses or offenders with enough shared characteristics to make the term useful.[12] The term is evocative, but in law that is a failing, not a strength.

Beyond this semantic and conceptual problem is the fact that while it is colloquially acceptable to speak of "murderers," "rapists," and "burglars," it is not legally precise to do so. Persons are convicted of murder, rape, and burglary and they are then sentenced within the statutory limits of the offense.[13] Outside of special offender laws, individuals are not convicted for being sex offenders, and if they were, it defies the imagination to understand the uses to which the designation would be put. Again, there are simply too many different people violating too many different norms for the designation to have any significant legal meaning.

Thus, we encounter an area where the diagnostic-sounding categories are renounced as clinically improper and the legal-sounding categories are condemned as imprecise and misleading. Stating this, however, is not synonymous with saying that there is no potential either in treatment programs or in continuing research on persons who commit various sex offenses. The problem is with the flawed conceptual and policy reason for selecting one group of inaptly described offenders for inappropriate legal and clinical responses. In other words, it makes perfectly good sense to pursue treatment or research based on sound diagnostic principles and more specific categories. It is also supportable penal philosophy to enhance punishment for unlawful sexual conduct which involves force, a minor child, where the home is invaded, or where there is a gang assault.[14]

Footnotes

1. These conferences were conducted at the NIC National Academy of Corrections in Boulder, Colorado. The author was involved in three such conferences, lecturing on the topic of this chapter and learning a great deal from the participants.
2. See generally F. Allen, *The Decline of the Rehabilitative Ideal* (1981).
3. Martinson, *What works? Questions and answers about prison reform*, Pub. Int., Spring 1974, at 22. Compare Martinson's "nothing works" with a slightly more hopeful view of sex offender treatment by D.J. West, *Sexual Crimes and Confrontations*, Ch. 10 (1987).
4. See *Corrections Compendium 5* (May, 1987). Regrettably, the survey report does not indicate which offenses are included in the survey, and, since it is a self-report survey with various states using different criteria, we must be cautious about the data.
5. *Psychiatry and Sex Psychopath Legislation: The 30's to the 80's*, 839 G.A.P., Pub. No. 98, April 1977 (hereinafter referred to as GAP Report).

   The American Bar Association, Criminal Justice Mental Health Standards, recently took the same position. See Standard 7-8.1 (1st Tent. Draft, 1983).
6. Weiner, *Legal Issues Raised in Treating Sex Offenders*, 3 Behavioral Science & Law 325, 326 (1985). Those jurisdictions are: California, Colorado, Connecticut, District of Columbia, Florida, Illinois, Massachusetts, Minnesota, Nebraska, New Hampshire, New Jersey, Oregon, Tennessee, Utah, Virginia, Washington, Wyoming.

   A review of the statutory provisions for those jurisdictions reveals that three of those states have repealed their MDSO laws. Those states are California, which repealed Welfare and Institutions Code Sections 6300 to 6316.2 in 1981; New Hampshire, which repealed its Dangerous Sexual Offenders Statute Section 173-A in 1983; and Florida, which repealed its MDSO statute, Chapter 917, in 1985.
7. G.E. Dix, "Special Dispositional Alternatives for Abnormal Offenders: Developments in the Laws," *Mentally Disordered Offenders* 133, 136 (1983) (hereinafter Dix, "Special Dispositional Alternatives").
8. See e.g., H.N. Pontell, *A Capacity to Punish*, Ch. 1 (1984).
9. GAP Report, above Chapter 16, note 5, at 840. Also see D.J. West, *Sexual Crimes and Confrontations* 242 (1987).
10. GAP Report, above Chapter 1, note 5, at 859.
11. In Bowers v. Hardwick, 107 S.Ct. 29 (1986), the Supreme Court upheld the constitutionality of Georgia's sodomy law at least as applied to adult males, even when the conduct is in private. The Court noted that some 24 states and the District of Columbia criminalize such activity although the Model Penal Code Sec. 213.2 (P.O.D. 1962) urges decriminalization.

    The point, of course, is that while such conduct remains subject to the criminal law and is characterized as a sex offense, it would be unthinkable to view those engaged in this behavior as the equivalent of violent rapists, child molestors, or even exhibitionists.
12. The term "sex offender" will be used in this chapter but only in the interest of verbal economy and never as the primary foundation for treatment or for just punishment.
13. True, it is acceptable in most sentencing schemes to take into account certain individual characteristics of the defendant. That does not, however, convert a convicted person into a burglar; it is to array and utilize factors deemed significant in sentencing for the offense.
14. The crucial sentence values in the text are derived from U.S. Sentencing Guidelines, Sec. A 231, 232, 233, Commentary (Revised Draft, Feb. 5, 1987). The points in the text are offered only as examples of the type of consensus on values that should be sought and made explicit as opposed to simply condemning "sex offenses."

Chapter 17: A Brief History and the Supreme Court's Involvement

by Fred Cohen

Abstract

In this chapter, Mr. Cohen discusses the histories and legal challenges to Sexual Psychopath Laws. These civil statutes were used in more than half the states to commit sexually dangerous persons to mental hospitals. Determination of whom to apply this label to and when to release these individuals was vague and done, in many cases, without respect for the civil rights of the offender. The issue of whether such laws are civil or criminal in nature is discussed in the context of Allen v. Illinois, a recent Supreme Court case.

The first Sex Psychopath statute was enacted by Michigan in 1937 and soon adopted by many other states.[1] These Sexual Psychopath Laws are traceable to the earlier but less popular Defective Delinquent Laws.[2] Defective delinquents were viewed as feeble-minded and antisocial persons whose chronicity and defective genes called for indeterminate confinement in special institutions. In the period 1900-1921, "Bolsheviks" and immigrants were frequent targets of the Defective Delinquent Laws. Mental testing and the eugenics movement converged in a type of "medical model" whereby the "genetically impaired" were civilly confined in lieu of criminal prosecution and imprisonment. Thus, one encounters an early example of a crime control movement in the guise of therapeutic intervention.[3]

As Hahn further points out "in some states such as Vermont, defective delinquent provisions were incorporated into Sex Psychopath Laws. (Although this was not the case in New York, it is worth noting that New York's sex offender legislation of 1950 resembled its Defective Delinquent Law and also grew out of a campaign led by the Prison Association.)"[4]

Various states are now getting in line to repeal their MDSO-type laws, just as they once lined up to pass them. Sutherland's classic study of the diffusion of these laws revealed this pattern: highly publicized, often terrifying sex offenses led to community agitation. Then a committee was created, often dominated by psychiatrists, which resulted in the formulation and passage of sex psychopath legislation.[5] A misguided scientism and inappropriate medical model served temporarily to allay community fears. Although these laws often promised treatment, they more often failed to deliver.

In *Minnesota ex rel. Pearson v. Probation Court* (1940),[6] the Supreme Court upheld a constitutional challenge to the Minnesota "sex psychopath" law, providing the judicial imprimateur for the earlier legislation and easing the way for other jurisdictions to follow. The Court was confronted with a due process/vagueness challenge and an equal protection/under-inclusion challenge, and upheld the Minnesota law on both counts. The portion of the statute challenged as vague:

> defines the term "psychopathic personality" as meaning "the existence in any person of such conditions of emotional instability, or impulsiveness of behavior, or lack of customary standards of good judgment, or failure to appreciate the consequences of his acts, or a combination of any such conditions, as to render such person irresponsible for his conduct with respect to sexual matters and thereby dangerous to other persons."[7]

The Minnesota Supreme Court previously interpreted this statute so that it was:

> to include those persons who, by a habitual course of misconduct in sexual matters, have evidenced an utter lack of power to control their sexual impulses and who, as a result, are likely to attack or otherwise inflict injury, loss, pain or other evil on the objects of their uncontrolled and uncontrollable desire. It would not be reasonable to apply the provisions of the statute to every person guilty of sexual misconduct nor even to persons having strong sexual propensities. Such a definition would not only make the act impracticable of enforcement and, perhaps, unconstitutional in its application, but would also be an unwarranted departure from the accepted meaning of the words defined.[8]

The Supreme Court accepted this interpretation as binding and simply found that these underlying conditions, calling for evidence of past conduct pointing to probable consequences, are as clear and susceptible to proof as criteria frequently applied in criminal prosecutions.[9] Parenthetically, while this language might also pass muster today, the vagueness challenge would be aimed not only at the ease with which those who are the objects of the law might understand the statute, but also at the amount of discretion afforded those who must administer and apply the law.

The equal protection/under-inclusion claim, equally unavailing, argued that the statute selected one group (sex psychopaths) from a larger group (all psychopaths), thereby unconstitutionally singling out the smaller group. In rejecting this claim, the Court stated that the test is whether the line-drawing had any rational basis to it and not whether a larger group might reasonably have been included.

> The class it did select is identified by the state court in terms which clearly show that the persons within that class constitute a dangerous element in the community which the legislature in its discretion could put under appropriate control. As we have often said, the legisla-

ture is free to recognize degrees of harm, and it may confine its restrictions to those classes of cases where the need is deemed to be clearest.[10]

In *Specht v. Patterson* (1967),[11] the Supreme Court decided a procedural challenge aimed at the Colorado Sex Offenders Act. This time the law did not survive the challenge. Petitioner was convicted of "indecent liberties," an offense with a ten-year maximum. He was not sentenced as a felon but subjected to an indeterminate term of one day to life (as a sex offender); this was done without notice or a full hearing.[12]

The trial judge, based on an *ex parte* decision, sent the petitioner to a mental hospital for examination. On completion of this examination, a psychiatric report was prepared and given to the judge prior to the sentencing. The critical determination that the petitioner met the criteria of the Act was made without confrontation and cross-examination of adverse witnesses, without the presentation of his own evidence by use of compulsory process, and on the basis of the hearsay report to which he had no access.

Justice Douglas, for a unanimous Court, determined that the Act required new findings of fact, for example, threat of bodily harm, as a prelude to greatly enhanced criminal punishment. Before such a radically new result might constitutionally be reached, "due process . . . requires that he be present with counsel, have an opportunity to be heard, be confronted with witnesses against him, have the right to cross-examine, and to offer evidence of his own. And these must be findings adequate to make meaningful any appeal that is allowed."[13]

Specht, at first reading, seems procedurally protective of persons facing the application of a sex psychopath-type law. It must be emphasized, however, that Justice Douglas stated that "the invocation of the Sex Offenders Act means the making of a new charge leading to criminal punishment."[14] Thus, the Justice, without fully exposing the basis for his reasoning, characterized the Colorado law as more nearly criminal than civil. If this Act had been characterized as more nearly a civil commitment law, with the criminal event—either a charge or a conviction—serving as a trigger for civil commitment, then the *Specht* ruling would not apply.[15] That is, the less demanding procedural format of civil commitment law would have been invoked.

Also, if Colorado had simply determined that a conviction for "indecent liberties" might subject the offender to a term of life imprisonment, then the far less demanding procedural format of criminal sentencing would apply.[16] A challenge that such a law violates the Eighth Amendment's proscription of cruel and unusual punishment in that the punishment is wholly disproportionate to the offense also would likely fail.[17]

Neither *Pearson* nor *Specht* dealt with the substantive issue of a sex offender's possible right to treatment. In *Humphrey v. Cady* (1972), the Petitioner argued that his confinement under a Sex Crimes Act led to commitment to the state prison with no treatment, whereas a commitment to a mental hospital would have increased the likelihood of treatment.[18] The Court decided that this was not an argument that could be dismissed out of hand, but since the petitioner was released before a final determination could be made, the issue never was resolved.[19]

The Supreme Court's most recent encounter with Sex Psychopath-type Laws came in *Allen v. Illinois* (1986),[20] a fascinating case involving the question of whether the proceedings under Illinois' Sexually Dangerous Persons Act (SDPA) are criminal within the meaning of the Fifth Amendment's protection against compulsory self-incrimination. The Court, in a 5 to 4 ruling, held against the petitioner, and in deciding the Fifth Amendment claim also answered, although obliquely, some other questions about sex offender laws.

In *Allen*, the petitioner was charged with unlawful restraint and deviate sexual intercourse but he was not tried on those charges. Instead, a petition was filed under the SDPA and the petitioner was ordered to submit to two psychiatric examinations.

Allen apparently acknowledged during the examination that he had been involved in deviant sexual behavior since the age of 10 and that he had, in fact, forced a woman into his car where he forced her to perform fellatio.[21] The trial court ruled that the petitioner's statements were not of themselves admissible but that the psychiatrists could give their clinical opinions based on the petitioner's statements.[22] Illinois courts had ruled previously that no statements compelled under the SDPA could be used in any subsequent criminal proceeding. Thus, the claim here does not involve prohibited future use in a criminal case but the sharply defined issue of whether the SDPA itself is sufficiently criminal-like to invoke the Fifth Amendment.[23]

The petitioner's strongest arguments were that the Act requires that a criminal charge be brought, with at least one proven act or attempted sexual assault, and that he, the petitioner, was housed at Menard Psychiatric Center with other SDP's and prisoners from other institutions in need of psychiatric care.[24] Justice Rehnquist replied by stating that Illinois need not apply the Act to the larger class of mentally ill persons who might also be sexually dangerous. By imposing on itself the requirement of proof of a criminal act—a discretionary legislative judgment—Illinois did not lose the right to view the SDPA as a civil procedure and thereby avoid the strictures of the Fifth Amendment.[25]

The petitioner also failed to convince a majority that he was, in reality, serving time in a maximum security prison as a result of a procedure denominated civil. Justice Rehnquist stated:

The State serves its purpose of treating rather than punishing sexually dangerous persons by committing

them to an institution expressly designed to provide psychiatric care and treatment. That the (facility) houses not only sexually dangerous persons but also prisoners from other institutions who are in need of psychiatric treatment does not transform the State's intent to treat into an intent to punish. . . . Petitioner has not demonstrated, and the record does not suggest, that "sexually dangerous persons" in Illinois are confined under conditions incompatible with the State's asserted interest in treatment. Had petitioner shown, for example, that the confinement of such persons imposes on them a regimen which is essentially identical to that imposed upon felons with no need for psychiatric care, this might well be a different case.[26]

While the SDPA is upheld as a civil proceeding, the Court also strongly suggested that a statutory treatment scheme does, in fact, create a right to treatment. That is, in exchange for a right as basic as the privilege against self-incrimination, the State needs to deliver on its statutorily promised treatment.

In addition, any lingering questions about whether the unconvicted may constitutionally be required to comingle with the convicted, assuming a common base of psychiatric needs and care, were laid to rest.

The four dissenters in *Allen*, with Justice Stevens writing, assailed the logic and the result reached by the majority. Justice Stevens found that the criminal law occupies a central role in a SDPA proceeding. After a review of the various points of involvement Justice Stevens summarized the dissents' position stating:

> The Illinois "sexually dangerous person" proceeding may only be triggered by a criminal incident; may only be initiated by the sovereign state's prosecuting authorities; may only be established with the burden of proof applicable to the criminal law; may only proceed if a criminal offense is established; and has the consequence of incarceration in the State's prison system—in this case, Illinois' maximum security prison at Menard. It seems quite clear to me . . . that the proceeding must be considered "criminal" for purposes of the Fifth Amendment.[27]

Focusing on the majority's acceptance of the goal of treatment as a primary reason for accepting the civil label applied to the SDPA, Justice Stevens argued:

> A goal of treatment is not sufficient, in and of itself, to render inapplicable the Fifth Amendment, or to prevent a characterization of proceedings as "criminal." . . . If this were not the case, moreover, nothing would prevent a State from creating an entire corpus of "dangerous person" statutes to shadow its criminal code. . . . The goal would be "treatment;" the result would be evisceration of criminal law and its accompanying protections.[28]

What is fascinating is that Illinois expressly protects a civil commitment's right to silence.[29] It is only the SDP who may be compelled to give evidence on which a deprivation of liberty may be based and to wear the stigmatic label of sex offender, thereby subjecting himself to possible treatment.

In brief, the four dissenters appear to be arguing that if it looks, feels, and sounds like criminal law, then that's what it is. The majority is content to accept Illinois' terminology and to continue a general policy of deference to the states' approaches to a variety of deviance.

Footnotes

1. Dix, "Special Dispositional Alternatives," see above Chapter 16, note 7, at 134-37. Much of the historical discussion in this text will be replicated in Dix, the GAP Report, and F. Cohen, *The Law of Deprivation of Liberty*, Ch. 6 (1980).
2. See N.F. Hahn, *The Defective Delinquency Movement: A History of the Born Criminal in New York State, 1850-1966* (Ph.D. Thesis, May 1978, SUNY at Albany, School of Criminal Justice) (hereinafter, Hahn, "Defective Delinquency Thesis.")
3. Ibid., at IV.
4. Ibid., at 543.
5. Sutherland, *The Diffusion of Sexual Psychopath Laws*, 56 American Journal of Society 142 (1950).
6. 309 U.S. 270 (1940).
7. Ibid., at 272.
8. Ibid., at 273.
9. Ibid., at 274.
10. Ibid., at 275. We should note that the Minnesota law upheld did not require conviction. In the more recent decision in Allen v. Illinois, 106 S.Ct. 2988 (1986), the Court upheld the propriety of confining together unconvicted sex psychopaths and convicted but psychiatrically disturbed prisoners.
11. 386 U.S. 605 (1967). The Colorado Act required a conviction to trigger the sex offender inquiry and process.
12. Ibid., at 608.
13. Ibid., at 610. Justice Douglas also noted that the Minnesota Act upheld in *Pearson* contained the procedural safeguards now mandated in *Specht*.
14. Id.
15. This is not the occasion to elaborate on procedural due process and civil commitment. It is sufficient to say that civil commitments are within the ambit of the liberty protected by due process, but the procedural requirements are not as rigorous as those of the criminal law. For the leading case in this area, see Lessard v. Schmidt, 349 F. Supp. 10789 (E.D. Wisc. 1972). This case wound its way through a number of federal courts until being reaffirmed at 413 F. Supp. 1318 (Ed. Wisc. 1976). The case as first cited, however, is the one to read.

Also see Addington v. Texas, 441 U.S. 418 (1979), holding that "clear and convincing" is the constitutionally permissible evidentiary standard for civil commitments.

See Humphrey v. Cady, 405 U.S. 504, 511 (1972).

16. And that basically is a right to be present, with counsel, and make a statement (allocution). See Mempa vs. Rhay, 389 U.S. 128 (1967).
17. Compare Rummel v. Estelle, 445 U.S. 263 (1980) with Solem v. Helm, 463 U.S. 277 (1983).
18. 405 U.S. 504, 514 (1972).
19. See also O'Connor v. Donaldson, 422 U.S. 563 (1975), where the Court also avoided the right to treatment issue.
20. 106 S.Ct. 2988 (1986).
21. Ibid., at 2999, n. 18 (Stevens, J., dissenting).
22. Ibid., at 2991.
23. Ibid., at 2992.
24. Ibid., at 2993-94.
25. Ibid., at 2993. Note how this issue resembles the equal protection claim raised in *Pearson* and also there decided in the State's favor.
26. Ibid., at 2994.
27. Ibid., at 2997 (Stevens, J., dissenting).
28. Ibid., at 2998 (Stevens, J., dissenting).

Actually Justice Stevens does not face the full implications of his own argument. That is, if the only choices available are labeling the SDPA civil or criminal, and he opts for criminal, then the entire package of criminal law and procedure would seem to apply in one fell swoop.

That may or may not be desirable. It seems preferable to analyze the proceeding as criminal-like—in the tradition of *Gault* for juvenile proceedings—and make protection-by-protection decisions based on a functional analysis of the particular proceedings.

The Court appears to have reverted to its pre-*Gault* posture of battling over labels instead of the more difficult debate over the reality of a particular proceeding.

Indeed, Justice Rehnquist simply gives the back of his hand to *Gault*, writing, "First, *Gault's* sweeping statement that 'our Constitution guarantees that no person shall be "compelled" to be a witness against himself when he is threatened with deprivation of his liberty' is plainly not good law." 106 S.Ct., at 2994.

See In re Gault, 387 U.S. 1 (1967).

29. See Ill. Rev. Stat., Ch. 91 1/2, Sec. 3-208 (1985) which requires that the examiner inform the prospective patient that he need not talk to the examiner; that any statements he makes may be disclosed at a court hearing on the issue of involuntary admission; and if the subject is not so informed then the examiner may not testify to any admission.

Chapter 18: The Right to Treatment

by Fred Cohen

Abstract

In this chapter, Mr. Cohen explores the right to treatment under the United States Constitution. Basically, the right revolves around definitions of three terms. "Treatment" involves the alleviation of pain or the effecting of a cure for a disease. "Rehabilitation" apparently refers to the restoration of an inadequately socialized person to some former level of competence. "Habilitation" refers to a maximization of functioning, typically in reference to developmental disabilities. Constitutionally, the right to "treatment" for an inmate extends only to forbidding deliberate indifference to serious medical, including psychiatric, conditions. So far the courts have ruled that sex offenders committed under criminal laws do not have a constitutional right to treatment. However, if an individual is confined under a Mentally Disordered Sex Offender (MDSO) Act, based on a finding that there is some type of mental disorder, then he has a constitutional right to adequate treatment.

The right to treatment is, in many respects, central to the overall set of legal issues involving the sex offender. There are many issues, some of which are painfully complex, that flow from a treatment relationship and they will be considered subsequently. At this point, however, legal foundations for such a relationship need to be examined; is treatment required by law and, if so, is the source of any such requirement constitutional or statutory; what does a treatment mandate require; what does the term "treatment" mean in the legal context; and does any type of institutional "programming" qualify as treatment?

One fundamental question is posed. Does the United States Constitution in some fashion mandate treatment of persons convicted of sex offenses and sentenced to prison? The answer is "no." There is no right to treatment unless, quite apart from the offense or the formal or informal designation as sex offender, the inmate independently suffers from a serious medical or psychiatric disorder.[1]

Should an inmate who is labelled a sex offender be given an enforceable legal right to treatment, the right will most likely arise from the language employed in an MDSO-type statute itself, and also involve the prospect of confinement beyond the statutory norm for the underlying offense, or involve confinement in a setting and under conditions indistinguishable from regular criminal confinement.[2]

Given no federal constitutional right to treatment based either on the nature of the offense or the informal designation as a sex offender, is there some legal basis for such an offender to successfully claim a right to rehabilitation? Once again, the answer is "no" at the federal constitutional level, and almost certainly "no" based on any state statute.[3]

Before further developing the above points, a brief excursion into the special world of legal terminology is in order. Having just embarked on this section, the reader already must grapple with the term "treatment," and the assertion that treatment may well have different legal sources and, by implication, be subject to different demands depending on the source. Also, the term "rehabilitation" has made an appearance and it, too, needs explanation. Finally, the terms "treatment" and "rehabilitation" should be compared with and contrasted with the terms "habilitation" and "training."

"Treatment" and Other Helping Terms: A Legal Lexicon

Treatment, in general, refers to a process of diagnosis, intervention, and prognosis designed to relieve pain or suffering or to effect a cure.[4] In law, the concept of treatment is superimposed on a disease (or medical) model. Whether the claim to treatment is made on behalf of a civilly committed mental patient, a convicted prisoner suffering with a psychiatric diagnosis, or a sex offender confined under an MDSO-type law, the required treatment need never be state of the art for the particular illness. Treatment will, however, rest on a disease/sickness model but, more importantly, not every ailment will be recognized as a disease for the purpose of a legal right to treatment.[5]

The significance of this point is our earlier established agreement that "sex psychopathy," "sexually dangerous," and "sex offender" are not clinically valid terms.[6] Thus, to the extent that the constitution requires a disease as a predicate for a duty to treat, and most certainly when it requires a serious disease as in *Estelle v. Gamble* (1976), persons in the categories noted above do not, per se, qualify.

Let us now briefly examine the term "rehabilitation" and, in particular, the statement made earlier: "Inmates have no federal constitutional claim to rehabilitation." Rehabilitation

> refers to the process of restoring the individual to behaviors and values which fall within the social definition of what is acceptable. Socially acceptable behavior, and values are by definition not "illegal." Thus, it is assumed in the rehabilitative process that the individual formerly held socially acceptable values with appropriate behavior . . .[7]

Conspicuous is the absence of any reference to a disease or an illness as the predicate for rehabilitative efforts. The

implicit causal assumptions associated with rehabilitation seem to be that an absence of adequate socialization has somehow created a poorly socialized person who requires "restoration." With the concept of treatment, the basic requirement is that disease or a serious medical disorder be present. For reasons best left unexplored here, persons are not held responsible for the mental diseases which "invade" them. The rehabilitation model carries with it implications of culpability, of a kind of personal blight that needs restoration to some former luster.

Parenthetically, rehabilitation seems to be used both in the sense of a process and as a desired outcome. Treatment, on the other hand, clearly refers only to a process. Cure or relief, for example, are among the desired outcomes of treatment.

To complete the picture then, it might be added that rehabilitation also is aimed at such statuses as alcoholism, drug addiction, or sex psychopathy. Whether or not these conditions also may be viewed as medical problems for other purposes, for example, medical insurance or contracted-for medical services, they are not within the laws of the disease-medical care model.

We may now add the term "habilitation" and contrast it with "rehabilitation." A Wisconsin court recently dealt with this definitional task in a succinct fashion by stating, "Habilitation means the maximizing of an individual's functioning and the maintenance of the individual at that maximum level. Rehabilitation means returning an individual to a previous level of functioning."[8]

Habilitation tends to be confined in its usage to the developmentally disabled, and it focuses on a variety of activities and programs designed to achieve the maximum potential of the impaired individual.[9] The term "training" has now also crept into the legal lexicon of helping terms and it, too, will be briefly addressed.

In *Romeo v. Youngberg* (1982), the Supreme Court dealt with a 33-year-old, profoundly retarded (IQ between 8 and 10), institutionalized person who was claiming the constitutional right to a safe environment, to freedom from undue restraint, and to training or habilitation.[10]

Justice Powell, for the Court, almost casually recognized the claimant's right to safe conditions, reasoning that if persons convicted of crimes enjoy that right, as they do, then surely it extends as well to the wholly innocent in government-operated institutions.[11] Similarly, the right to avoid what this author believes is meant to mean "undue" restraint also applies to the civilly confined.[12]

Justice Powell then grappled with the claims to habilitation or training, concluding that if all that *Romeo* demanded was that sort of minimal training which is related to safety or restraint, then the Court would have no trouble in providing a constitutional basis for the claim. Thus, the State is obliged to provide that minimal help, or "training," which is designed to enhance a resident's safety and to minimize additional restraint.[13]

The interesting question is whether the Court intended to carve training out of the larger concept of habilitation or, given Romeo's extremely low IQ and conceded inability to live at large, whether training and habilitation were meant to be functional equivalents?

This dilemma need not be resolved here. The purpose is simply to introduce the reader to the key legal terms used when describing a possible affirmative obligation required of government. The threshold inquiry remains: the right to treatment for sex offenders.

Treatment: Constitutional Basis

Two somewhat distinct arguments seem available on behalf of a sex offender who claims a right to treatment. One argument flows from the basis for the loss of liberty, that is, being confined under a special offender law and labeled as having a mental disorder arguably creates a statutory basis for a constitutionally enforceable right to treatment.

This argument and its variations will be explored in the next chapter. At this point it is enough to say that this is the analysis that is most likely to be productive for the inmate's claims.

The other argument stems from the convicted person's status as an inmate. The nature of the underlying offense, an opinion about the offender (i.e., sex offender) or even a clinical- sounding diagnosis (i.e., sex psychopath) are incidental to this argument.

Prison inmates have a constitutional right to treatment based on the Eighth Amendment, which prohibits cruel and unusual punishment.[14] In *Estelle v. Gamble* (1976),[15] the Supreme Court was confronted with a Texas inmate who sustained a back injury while in confinement and who claimed that the care provided him was inadequate.

On the facts presented, the Court refused to find a violation of the inmate's rights. It did, however, for the first time establish that deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain and, thus, the infliction of cruel and unusual punishment.

The "deliberate indifference" standard does not encompass mere medical malpractice. The quality of care provided or the standard by which to measure omissions of constitutionally required care must offend evolving notions of decency and not simply be violative of the general standard of practice in the community.

Estelle dealt with serious medical needs. Whether or not serious mental disorders also were intended to be included was answered clearly and in a representative fashion in

Bowring v. Godwin (1977) where the Federal Appeals Court stated:

> We see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.[16]

The court went on to state:

> We therefore hold that Bowring (or any other prison inmate) is entitled to psychological or psychiatric treatment if a physician or other health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial.[17]

The rationale behind the constitutional basis for medical and mental health care is clear. Inmates are captives of the State. They have no freedom to seek medical or psychiatric care and must look to their captors for the preservation of life and health regardless of the cause of the illness or harm.

Under *Estelle*, the illness must be serious while the treatment need not be state of the art. The courts will invariably require some sort of classification-diagnostic procedure to identify the seriously ill; an acceptable medical records system to assure continuity of care; and some type of regular interaction, based on a treatment plan, between the clinician and the inmate-patient.

The goal of constitutionally mandated treatment is simply relief of suffering and control of the basic symptoms—in a word, short-term relief from acute distress. Where psychiatric treatment may be forward-looking and include efforts to achieve personal growth, insight, happiness—what some refer to as cultivation of functioning—it is beyond the mandate of the Eighth Amendment.[18] This is not to say that mental health professionals will not and should not strive to do more, or that some prison systems do not strive to do more. This is only to contrast that which is minimally required with that which may be highly desirable.

The sex offender, then, when he is simply an inmate who has been convicted of a sex offense or is one who may also have been informally labeled a sex offender, has no federal constitutional claim to treatment. The claims fail at the doorstep of *Estelle*'s requirement of a "serious medical (psychiatric) condition." Only if such an inmate is independently diagnosed as seriously mentally ill will the federal constitution require treatment and that treatment need not be aimed at a sexual deviance or practice. It need be aimed only at such symptoms as withdrawal, efforts to injure or kill oneself, or acting out in an aggressive manner.[19]

The discussion thus far has had far more to say about treatment than about the concept of disease. Clearly, the medical profession serves as the gatekeeper for entry into the world of disease. Although the term "disease" is traditionally associated with pathology of tissue, in the context of mental disease (or illness) it more nearly resembles a logical or theoretical construct which is not demonstrably valid or invalid.[20] Thus, the various diagnostic categories of mental disease and disorders, as well as individual diagnosis, are in the hands of doctors and other mental health professionals.[21]

It is possible to construct a logical argument that at least some sex offenders are mentally ill. This is particularly easy if the symptoms of mental illness are rule-breaking and deviance.[22] Adults who coerce children into sex, sadistic rapists, and adults who are sexually aroused by pictures of very young children seem to almost automatically qualify as "sick."

In labeling such an offender as "sick," however, one is doing little more than offering a theory about why the person engaged in that conduct and, by implication, urging a particular approach. That is, sick people should be helped or treated; bad people may be punished.

To further illustrate the point, a recent article makes a strong case for the constitutional right to treatment for imprisoned sex offenders who are diagnosed as paraphiliacs.[23] The author adopts what he terms the "psycho-organic" model of human behavior in the belief that psychological and organic factors underlie mental disorders and, therefore, both psychotherapy and organic therapy are required for treatment.[24] This is a predicate for his argument that paraphiliacs have a constitutional right to treatment and that such treatment should—perhaps must—be Depo-Provera™ along with psychotherapeutic intervention.[25]

In this writer's view, the author's enthusiasm has caused him to confuse a theoretical and policy position with an empirically validated and constitutionally mandated position. If one seeks to enhance treatment mandates for certain inmates, then the author's approach is quite understandable: simply posit a certain pattern of activity as a disease, refer to *DSM-III* as authority, argue that it is a serious disease which causes the inmate needless pain (overlooked by the cited author), and then prescribe one's preferred treatment.

This argument is not likely to work, however, unless there is a general consensus on the behavior as indicative of a serious disease, and the preferred treatment is the only known or acceptable approach to the relief of symptoms or even cure. This writer does agree that the *Estelle* deliberate indifference standard is much too restrictive and deferential to prison authorities. Evolving standards of decency—a traditional aspect of cruel and unusual punishment analysis—should accommodate new approaches to treatment.

The argument is made, "Where alternative treatments are

proposed, lower courts should not automatically defer to the prison physician's choice of treatment, but should instead compare the alternative treatments in light of present medical standards."[26] If the proposed treatments have shared goals and similar results, then courts ought to stay out of the business of deciding.

In *State v. Reddick* (1985), the Nebraska Supreme Court recently was confronted directly with the interplay of *Estelle*'s mandate of treatment and the disease implications of being labeled an MDSO.[27] Reddick was convicted of sexual assault and was thereafter examined and found to be an MDSO who was untreatable. The "untreatable" finding meant that the trial judge had to sentence the defendant for the offense.[28]

Reddick argued that it was unconstitutional to punish him as opposed to treating him. The Nebraska Court stated that this misconstrued *Estelle* and that "it is the need either to alleviate pain or to effect a probable cure which triggers the State's duty to provide treatment . . . .We now hold that a mentally disordered sex offender for whom a program of treatment will not lead to a cure is 'non-treatable' (for the purposes of applying criminal sanctions). There is no evidence that Reddick's disorder causes him pain which can be alleviated."[29]

Perhaps the most important implication of this analysis, as far as corrections is concerned, is that sex offender treatment programs—like alcohol or drug treatment programs—are not constitutionally mandated. Whether or not such a program is created, funded, and implemented is a local policy decision.

The fact that a particular program or treatment option is not mandated does not mean that authorities have an entirely free hand in its structure and operation. There was a time when the flawed right-privilege analysis held sway, and it might then be argued that since public education (for example) was not then required, its creation and operation was utterly at the discretion of government. Access to public education, it was argued, was a privilege.

Today, whether or not a program or a service is mandated is not determinative on such basic questions as selection or rejection for such a program or service. The same is true for permissible intrusiveness of treatment, the need for consent, criteria for rejection, and other similar matters. Thus, in the formulation of a sex offender treatment program, it is mandatory (and simply prudent) to reflect on the legal issues which will be involved. Many of those issues will surface in the next chapter, and others will be identified and analyzed in subsequent chapters.

Treatment: Statutory Basis

If a sex offender or MDSO can successfully enforce a right to treatment, as noted earlier, it will arise from the statutory provision which creates the special dispositional alternative. Using Professor George Dix's detailed study of MDSO laws in five states as a guide, this author will first provide the reader with a general overview of those laws, and then focus more closely on the treatment issues.[30]

While Dix's survey showed that all of these laws included some reference to a crime, in some a criminal charge was sufficient while in others a conviction was required to invoke the MDSO law.

In determining an inmate's subsequent rights, this aspect of the law may be quite significant. That is, is one in fact dealing with a convicted person turned prison inmate, or a person charged with a crime turned civil patient?[31]

The criteria for commitment varies greatly but will always contain some reference, however inaccurate, to some form of psychological impairment. For example, mental disease, defect, or disorder were the criteria in California, whereas Washington referred to "psychoneurosis." It is important to note that "most of the statutes, however, make no effort to define the impairment requirement in clinical or diagnostic terms."[32]

A finding of dangerousness is a common requirement. There is, however, a lack of clarity or consistency on the likelihood of the danger or the degree of harm required. As one would expect, the danger consistently refers to the repetition of sex offenses, but without a mention of whether the reference is to all or only similar sex offenses.

There invariably will be a requirement that a clinical inquiry be made as a precondition to the MDSO hearing.[33] Once again, there is wide variation on where the examination occurs, the duration of the commitment for observation,[34] and under what conditions a court may or must proceed to the hearing.

Ohlinger v. Watson (1980)[35] continues to be the leading decision recognizing and enforcing a state-created right to treatment based on a sex offender statute. Under the Oregon sex offender statute, since repealed, a court had the authority to issue an indeterminate life sentence on a finding that the victim was under the age of 16 and the defendant had a mental condition predisposing him to the commission of certain sex offenses to such a degree that the person was a "menace."[36]

The appellants were in the Oregon State Penitentiary, having pleaded to sodomy and having been given indeterminate life sentences in lieu of the statutory maximum of 15 years imprisonment. Ohlinger had been confined about 20 years at the time of this proceeding. The appellants' basic claim was that they were denied adequate treatment for their mental illness in violation of rights claimed under the Fourteenth Amendment's due process clause and in violation of the Eighth Amendment's proscription of cruel and unusual punishment.[37]

The Ninth Circuit Court of Appeals agreed completely with

the inmates. In announcing its decision, however, the court confused the concept of treatment with the concept of rehabilitation and then used a misleading standard by which to measure the adequacy of the required treatment. On the latter point, one is referred to the court's statement, "Constitutionally adequate treatment is not that which must be provided to the general prison population, but that which must be provided to those committed for mental incapacity."[38]

As noted previously, prisoners in general have no constitutional right to treatment or rehabilitation.[39] Seriously mentally ill prisoners do. Assuming that is what the court meant, then *Ohlinger* does provide something of an answer to the question of whether the source of a right to treatment is determinative of the required level of care.

In establishing the treatment mandate, the court's approach was clear and straightforward. "Having chosen to incarcerate appellants on the basis of their mental illness, the State has determined that it no longer has any interest in punishing appellants, but rather in attempting to rehabilitate (*nee* treat) them."[40] Treatment, stated the court, is not only desirable but is constitutionally required. Otherwise, the State is punishing someone on the basis of their status (sex offender) and that is, per se, a cruel and unusual punishment.[41]

Indeed, the real argument between the parties was the requisite level of treatment which had to be provided. The court held that what is required is individual treatment which will give each of them a realistic opportunity to be cured or to improve his mental condition.[42] The question of what to do if no cure or improvement was likely or possible was not explored.

The court then found overwhelmingly that appellants were not receiving adequate treatment at the prison. There was some group therapy available, but this was not viewed as effective or sufficiently available.

Interestingly, the court endorsed evidence which "indicates that appellants require intensive individual therapy which includes a program concentrating on development of social skills, a reconditioning process, work in sexual fantasies and dreams, and community passes to gradually integrate them into the community."[43] Earlier, it was indicated that appellants were not asking for the best possible treatment nor demanding cure.[44]

Whether *Ohlinger* was merely summarizing the evidence or imposing a particular treatment regimen is speculative. In all likelihood the court, in then requiring that the appellants be transferred to the state hospital, approvingly noted the treatment summarized above but left it to the hospital staff to create an adequate treatment program.[45]

Before leaving *Ohlinger*, we must emphasize that the decision located a right to treatment in the State's designation of these inmates as "sick" sex offenders, in the extraordinary duration of the possible confinement, and in the fact of confinement in a prison without adequate mental health services.

Finally, it is reasonably clear that the *Ohlinger* court meant to distinguish the level of care mandated by the Eighth Amendment and the level of care also constitutionally enforceable but arising specifically from state law.[46] The latter is more demanding but in what precise fashion is unclear. This author would suggest that the *Ohlinger* standard more nearly resembles the standard of care offered in the community, as opposed to *Estelle*'s standard of "deliberate indifference."[47]

Ohlinger was noted in a subsequent and important decision by the Ninth Circuit involving the Washington State Penitentiary. In *Hoptowit v. Ray* (1982), the court indicated that *Ohlinger* stands for the proposition that persons committed for mental incapacity have a constitutional right to adequate treatment.[48] "The rationale of *Ohlinger* does not extend to those serving criminal sentences. Indeed, *Ohlinger* supported the proposition that those serving criminal sentences have no constitutional right to rehabilitation."[49]

Ohlinger clearly influenced the outcome of a broad based legal challenge to the Idaho State Correctional Institution in *Balla v. Idaho State Board of Corrections* (1984). The Federal District Court determined:

> The Idaho State Legislature, in enacting Idaho Code Sec. 20-233, precludes the release on parole of even a model prisoner serving a sentence for the crimes enumerated in that section, or whose history and conduct indicate that such inmate is a sexually dangerous person except upon the examination and evaluation of one or more psychiatrists or psychologists. This statutory scheme requires indeterminate incarceration of sex offenders absent rehabilitation. Thus, having chosen to incarcerate inmates categorized as sexually dangerous persons because of their mental illness, the State of Idaho has determined that it no longer has an interest in punishing the inmate, but rather in attempting to rehabilitate such categorized inmate. This rehabilitative rationale is not only desirable, but it is constitutionally required. (*Ohlinger v. Watson*, 652 F.2d 775 (9th Cir. 1980). The Idaho Code Sec. 20-223 inmates are perhaps not crying out for the best possible treatment, nor are they seeming to demand a guarantee to be cured of their mental incapacity or inadequacies. They are, however, entitled to a treatment program that will address their particular needs, with the reasonable objective of evaluation and rehabilitation, to have some history or reasonable basis worked up during their incarceration whereby a psychiatrist or psychologist could then give a reasonable evaluation or opinion to the parole commission indicating whether or not such sexually dangerous person is fit to return to society. Such constitutionally required treatment is not that which must be provided to the general prison population, but rather, that which must be provided to those committed under

any of the categories set forth in Idaho Code Sec. 20-223. Certainly due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed. In these cases, adequate and effective treatment is constitutionally required, for absent such treatment, a Section 20-223 categorized individual inmate could be held indefinitely.[50]

The focus of the Idaho case is a bit different than *Ohlinger*'s. That is, *Balla*'s express concern was with a fair opportunity for release on parole, while *Ohlinger* impliedly focused on "releasability" in general and the duration and places of confinement. Inmates in California, Nebraska and Colorado, in two recent decisions, did not fare as well.

People v. Sherman (1985) involved a defendant convicted of child molestation who was then committed as a MDSO for a five-year maximum.[51] Before expiration of the original term, California filed for a two-year extension and it is the extension which was challenged.

The defendant argued that he was being subjected to cruel and unusual punishment in that as a pedophiliac, with no hope of successful treatment according to the two testifying psychiatrists, he likely would be confined for life.[52] He also argued that his retention beyond the maximum term permitted for the underlying conviction inflicted cruel and unusual punishment.[53]

Ohlinger was distinguished on the basis that Ohlinger received no treatment for 10 years, no force was involved in the offenses, and the demand was for treatment simply not available in the prison.[54] Except for the last point, it is difficult to understand the relevance of these supposed distinguishing factors.The court then stated that amenability to treatment may be a prerequisite for the initial commitment but it is not a condition precedent to retention.[55]

The *Sherman* court recognized that indefinite extensions of the commitment were possible but determined that this was not violative of any constitutional rights. In effect, the California court cloaked the California law in the garb of a civil commitment and said that so long as treatment is available and attempted (as it apparently was), then a "no cure is possible" argument fails. The outlook is a judicially sanctioned life term.

In the Colorado case, after the defendant's conviction of a sex offense, he was proceeded against under the Sex Offenders Act.[56] The interesting point here is the claim that the Act violates equal protection in that it does not afford periodic judicial review on the justification for continued confinement, only annual review by the parole board. The Colorado Supreme Court held:

> Such a right is afforded to involuntary civil commitments . . . criminal defendants found not guilty by reason of insanity . . . and criminal defendants found incompetent to proceed. . . . In contrast, defendants confined under the provisions of the CSOA receive no judicial review following the initial determination of dangerousness; rather, the parole board annually reviews the defendant's continued confinement. . . . The denial of equal protection inherent in these inconsistent statutory schemes, the defendants assert, is particularly acute where defendants are confined under the CSOA beyond the statutory maximum prison term they might have received for their underlying crimes.
>
> Because the classification of sex offenders under the CSOA neither creates a suspect class nor infringes upon a fundamental right, the statutory scheme will survive an equal protection challenge if the state can demonstrate that the classification bears a rational relationship to a legitimate inmate state purpose. . . . The state must show, in other words, that "a distinction made has some relevance to the purpose for which the classification is made." [citations omitted][57]

That these individuals had been convicted of a crime, as opposed to being merely civilly committed, allowed the court to characterize the procedural distinction as rational. Review by the parole board, then, was upheld as satisfying any procedural due process owed the offender, and especially so since the board does not initially determine dangerousness, but only whether there have been post-confinement changes.[58]

The equal protection analysis here—generally known as the "reasonableness test"—will be of particular interest when we examine the question of inclusion and exclusion from a nonmandated sex offender treatment program.

Footnotes

1. Estelle v. Gamble, 451 U.S. 454 (1976), established that prison officials may not display deliberate indifference to the serious medical needs of prisoners and thereby inflict unnecessary and wanton pain and suffering.

   This decision, and its consequences, is discussed in detail in *Sourcebook on the Mentally Disordered Prisoner*, F. Cohen, "Legal issues and the mentally disordered inmate" 31, 48 et seq. (National Institute of Corrections, March 1985) (hereinafter referred to as F. Cohen, "Sourcebook—Legal Issues").
2. The leading case on point is Ohlinger v. Watson, 652 F.2d 775 (9th Cir. 1980). See also Allen v. Illinois, 106 SCt. 298 (1986).
3. See generally, Marshall v. United States, 419 U.S. 899 (1974).
4. See generally, F. Cohen, "Sourcebook—Legal Issues," above Chapter 18, Note 1, at 52 et seq. Much of the text which follows this note is derived from the author's earlier work cited above and the sources referred thereafter.
5. In re Rosenfield, 157 F. Supp. 18 (D.D.C. 1957), is

a well known example of a psychiatric flip-flop whereby psychopathy was not a mental disorder on Friday, but a weekend vote of the mental hospital staff converted it to a mental disorder by Monday.

This occurred within the context of determining what would be recognized as a mental disease or defect for the purposes of an insanity defense.

Amnesia was held not to be a mental disorder for the purposes of determining competency to be tried in People v. Francabandera, 310 N.E.2d 292 (N.Y. 1974).

6. See above Chapter 16, nn. 15 & 16.
7. M.B. Santamour & B. West, *Retardation and Criminal Justice: A Training Manual for Criminal Justice Personnel* 25 (1979).

   Professor Francis Allen views the rehabilitative ideal as concerned with changing the offender both as a means of social defense and to contribute to the welfare and satisfaction of offenders. F.A. Allen, *The Decline of the Rehabilitative Ideal* 2 (1981).
8. Matter of Athans, 320 N.W.2d 30,32 (Wis. Ct. App. 1982).
9. One expert argues that:

   Active habilitation requires a written individualized plan:
   1. based on a comprehensive assessment of the individual's social, psychological health, and vocational capacities and liabilities;
   2. based on the goals of improving the individual's adaptive capability and the ability to live independently;
   3. based upon objectives related to these goals;
   4. comprised of defined services, activities, or programs related to the objectives;
   5. specific as to the responsibilities for the conduct of such services or activities;
   6. specific as to a means to measure the program or outcome;
   7. clear as to periodic review and revision of the plan.

   K.D. Gaver, reaction comment in *The Mentally Retarded Citizen and the Law* 411, 414 (1976).

   See also Ellis & Luckasson, *Mentally Retarded Criminal Defendants*, 53 Geo. Wash. L. Rev. 414, 423-425 (1985).
10. 457 U.S. 307 (1982).
11. Ibid., at 2458.
12. Id. While Justice Powell did use the term "undue" or "needless," the author believes that is an intended modifier.
13. Ibid., at 2459.
14. This section is a condensation of material earlier published by the author in "Sourcebook—Legal Issues" 48 et seq. See above Chapter 18, note 1. The reader is referred to the Sourcebook for a more complete version of the material presented here.
15. 451 U.S. 454 (1976).
16. 551 F.2d 44,47 (4th Cir. 1977). No post-*Estelle* case to the contrary has been found.
17. Id.
18. Readers who have some familiarity with consent decrees in this area may be puzzled by the text since these decrees often have provisions for mental health services going far beyond the minima referred to in the text. Many settlements do, indeed, go beyond constitutional minima and often it is because the overall conditions in the prisons are shown to be so shocking that at a certain point in the development of the proof process, as, for example, should it develop that a truck driver is performing surgery, the state finds it expedient to "cut its losses."
19. These behaviors are listed as merely representative of the commonly encountered symptoms of mental illness in prison.
20. Swartz, *"Mental Disease: The Groundwork for Legal Analysis and Legislative Action*, 111 U. Pa. L. Rev. 389, 394 (1963).
21. The American Psychiatric Association is responsible for the widely accepted *Diagnostic and Statistical Manual of Mental Disorders-III* (1980) (*DSM-III*). Psychiatric nurses and social workers, along with clinical psychologists, of course, occupy the field of mental disorders in a way that has no parallel in physical medicine.
22. See e.g., T.J. Scheff, *Being Mentally Ill: A Sociological Theory* 31 (1966).
23. Comment, *Medical Treatment for Imprisoned Paraphiliacs: Implementing a Modified Standard for Deliberate Indifference*, 4 Yale Law & Policy Rev. 251 (1985).

    According to *DSM-III* 266-27 (3d ed. 1980), the features of paraphilia are unusual or bizarre imagery or acts which are necessary for the paraphiliac's sexual excitement. Specific paraphilias include fetishism, transvestism, zoophilia, pedophilia, exhibitionism, voyerism, sexual masochism and sadism.
24. Comment, above Chapter 18, Note 23, p. 255, n. 21.
25. Ibid., at 258.
26. Ibid., at 268. Insulin is the current treatment of choice for diabetes, he argues, and thus, there is presently a right to insulin. Should a cure for diabetes which does not use insulin be discovered in the future, then the "cure" would be mandated.
27. 376 N.W.2d 797 (Neb. 1985).
28. Ibid., at 798.
29. Ibid., at 799.
30. See Dix, "Special Dispositional Alternatives," above Chapter 16, note 7, pp. 137-47. The states studied are Illinois, Massachusetts, Oregon, Washington, and California.
31. Ibid., at 145, points out that in California, MDSO's are accorded the full rights of patients, while in Massachusetts, committed persons have the rights of other inmates insofar as that is compatible with treatment.
32. Ibid., at 139.

33. Recall that Specht v. Patterson, above Chapter 16, note 11, involved a commitment based almost entirely on a statutorily mandated examination and report.
34. In McNeil v. Director, Patuxent Institution, 407 U.S. 245 (1972), the Supreme Court dealt with a person who was convicted and sentenced to five years imprisonment. The sentencing court, however, committed the defendant to Patuxent Institution to determine if he should be committed as a defective delinquent.

    McNeil refused to cooperate in the examination, and the Court held that after the criminal sentence expired, Maryland lost the right to hold him and that he must therefore be released.

    A 90-day observation commitment would not raise many legal eyebrows.
35. 652 F.2d 775 (9th Cir. 1980).
36. Ibid., at 776.
37. Id.
38. Ibid., at 778.
39. See Chapter 18, at 2.
40. 652 F.2d at 777.
41. Robinson v. California, 370 U.S. 660 (1961) determined that the Eighth Amendment prohibited punishing an addict for his addiction, although it was plain that an addict might be punished for his conduct. See also People v. Feagley, 535 P.2d 373 (Cal. 1975) on need for treatment. A serious debate exists concerning the lawfulness of "nonpunitive" incapacitation. The Supreme Court recently has upheld the constitutionality of pretrial prevention detention. While this is not the occasion to engage the debate, it must be said that involuntary confinements may have a basis other than punishment or treatment/care and the permissible occasions for "pure" custody, quarantine, public safety-type of confinements will be fought out in the near future. See United States v. Solerno, 41 Cr. L. 3207 (1987).
42. 652 F.2d at 779 (footnote omitted).
43. Id.
44. Id.
45. Oregon does, indeed, have a widely publicized behavior modification program for sex offenders.
46. For example, at 652 F.2d, p. 780, the court is impressed by the fact that the Oregon penitentiary does not minimize American Correctional Association Standards. Such Standards are never constitutional minima.
47. Let it be clear that this is the author's reading of *Ohlinger* and not a clear statement from the Opinion.
48. 682 F.2d 1237, 1255 n. 8 (9th Cir. 1982).
49. Id.
50. Balla v. Idaho State Bd. of Corrections, 595 F. Supp. 1558, 1569 (D.Idaho, 1984).
51. 212 Cal. Rptr. 861 (1985).
52. Id.
53. Id.
54. Ibid., at 864-65.
55. Ibid. at 865.
56. People v. Kibel, 701 P.2d 37 (Col. 1985).
57. Ibid., at 41-42.
58. Ibid., at 44.

Chapter 19: Treatment Modalities and Consent

by Fred Cohen

Abstract

In this chapter, Mr. Cohen discusses some of the more controversial treatments which have been used with sex offenders. He takes a clear stand against the use of castration within the criminal justice system, either as treatment or punishment. However, medroxyprogesterone acetate (Depo-Provera™) is being used in some correctional systems. All inmates being treated with physically intrusive or aversive techniques should be fully informed of all possible consequences. Departments of corrections may choose to extend this principle to a variety of treatment modalities.

Castration and Depo-Provera™

Inmates who happen to have been convicted of a sex offense or who are characterized in some fashion as a sex offender are in precisely the same position as any other inmate on the question of enforced medication or the right to resist intrusive treatment interventions. The fact that certain interventions (e.g., surgical castration or the drug Depo-Provera™)[1] are encountered almost exclusively with sex offenders is an empirical, but not a doctrinal, distinction.

Before turning to questions related to treatment and consent, the matter of castration or utilization of certain drugs as punishment should be addressed. It may surprise the reader to learn that neither the Supreme Court nor any state or federal court has ruled directly that castration as punishment constitutes cruel and unusual punishment under the Eighth Amendment. Indeed, no decision has been found dealing with the legality of castration as a permissible form of treatment.[2]

Although no reported decision has ruled directly on castration as punishment, there are numerous judicial references to castration, along with burning at the stake, breaking on the wheel, hanging in chains, crucifixion, blinding, and cutting off of hands or ears as examples of barbaric and excessively cruel punishments.[3] Under the "evolving standards of decency" test for determining what is cruel and unusual, this author feels confident, even in this era of greater acceptance of more frequently imposed and longer terms of imprisonment, that castration would be found an unconstitutional punishment.[4]

The constitution forbids cruel and unusual punishment, not cruel and unusual treatment. This is not to say that treatment is outside of constitutional restraint, only that the language of the Eighth Amendment is limited to punishment.[5] However, simply calling something treatment does not prevent a judge from analyzing the intervention and determining that it is actually punishment.[6]

One author suggests that "once the treatment exceeds the cure, it is inappropriate to label such action as treatment. The point at which castration exceeds its function to accomplish the intended goal—the prevention of recurring illegal sexual conduct—is the same point wherein treatment becomes punishment."[7]

The author's position appears to be that treatment presupposes an illness and seeks some type of cure or amelioration of suffering. At the outset, there is the issue developed earlier concerning the labels "sex offender" and "sex psychopath" as being both inaccurate as clinical entities and not useful as discrete legal descriptions where the focus is on treatment or deserved punishment.

If one looks beyond those issues and simply assumes that one can identify a group of mentally ill persons who have been convicted of crimes labeled "sex offenses," castration may now be confronted as a measure which is highly intrusive and excessive. While it may prevent or retard protected and unprotected sexual activity, the results are variable and unpredictable, and the procedure is irreversible.[8]

As a punishment, surgical castration should be placed on the same heap of unthinkable measures as crucifixion and amputation of the hands. Judges should not have the power to offer defendants 30 years in prison or the "voluntary" submission to removal of the testicles.[9] If castration is characterized as treatment, there is no doubt that the procedure is so invasive that if it were even to be considered, a knowing and voluntary consent undoubtedly should be required.[10]

Depo-Provera™ (medroxyprogesterone)—at times referred to albeit inaccurately as chemical castration—raises legal issues that are similar to those involved in surgical castration. The use of the drug is reversible and it can be administered at varying levels, which allows for a less restrictive alternative approach unavailable with surgery.[11]

In what is perhaps the leading article on point, the author expresses support for the use of Depo-Provera™, at least with repeat sex offenders. He writes:

> There is neither such a total dearth of knowledge regarding the drug's effects, nor as yet any documented and reliable reports indicating that the drug exhibits an unacceptable degree of certainty or severity of adverse effects sufficient to cause Depo-Provera™ to be classified an unreasonable treatment for male sex offenders. Of the known potential changes . . . the most severe is elevated

blood pressure (hypertension) which can be controlled with medication if necessary.[12]

Not only is the author quoted above generally supportive of Depo-Provera™, but he supports its required use as a condition of parole (and presumably probation) while allowing prisoners to refuse its enforced administration.[13]

In prison, he argues, the State's compelling interest in protecting its citizens is not sufficiently strong to override even the limited intrusion on the inmate's privacy.[14] When a repeat offender is in the community, however, the State's interest in protecting its citizens arguably should prevail and overcome the limited loss imposed on the offender.[15]

State v. Gauntlett (1984)[16] is the only reported decision to address the legality of Depo-Provera™ as a condition of probation. The case itself is almost out of a soap opera in that the offender who was charged with sexual misconduct with his stepchildren is described as a descendant of W. E. Upjohn, the founder of the pharmaceutical company which markets Depo-Provera™.[17]

After the defendant entered a *nolo* plea, the sentencing judge imposed a five-year probation term with the first year to be served in jail; he also ordered that the defendant submit to Depo-Provera™ treatment. Failing that submission, the judge indicated he would set aside probation and resentence.[18]

On appeal, the defendant argued that the Depo-Provera™ condition was unconstitutional and, therefore, incapable of sanction. In a very muddled opinion, the Michigan court found it could avoid the constitutional question while voiding the challenged condition. The exact grounds for decision remain unclear, but the court appeared to focus on the failure of Depo-Provera™ to gain general medical acceptance, problems in obtaining the treatment, and problems in obtaining informed consent.[19]

Gauntlett is of limited value as a precedent and of almost no value because of its reasoning. Another decision is necessary to amplify our understanding of the legality of requiring Depo-Provera™ treatment as an incident of a community disposition and to find out whether or not its attempted use in prison calls for a different approach.[20]

Rodney Uphoff, Director of the University of Wisconsin Law School's legal defense clinic, has argued forcefully that it is the responsibility of defense counsel to explore the Depo-Provera™ option with the client.[21] Uphoff urges careful consideration of the offense and offender, while also insisting that the client's informed consent is an absolute necessity.[22]

None of this is to say that a defendant has a right to the administration of Depo-Provera™ or even to a community disposition. Indeed, it is quite clear that there is no such right. What is interesting here is that Mr. Uphoff is a defense attorney who views Depo-Provera™ as a sensible alternative for some of his clients; he sees this as potentially helpful, less intrusive, and less expensive than long terms of incarceration.[23] For the client, one may agree that "it sure beats the joint."

Consent to Treatment: A General Approach[24]

Whether one is referring to sex offenders or civil mental patients, the basic postulate of the law concerning how treatment decisions should be made is most clearly embodied in the doctrine of informed consent.[25] This section begins with a general norm of the sanctity of the body of a competent adult. This, in turn, implies autonomy in decision-making by the individual whose body, or life or health, is at stake.

The patient has autonomy and the healer has information and expertise. Informed consent strives for some equality concerning the information base of the treater's proficiency in an effort to allow the sick or endangered person to apply his personal value system to the alternatives presented.[26]

This approach—let us call it the traditional model—applies most comfortably to physical medicine outside the area of psychological treatment. A right to refuse treatment where mental disorder may be present raises the question of the competency of the individual to make the decision or, at times, even to absorb the proffered information. When the individual is in penal confinement, the matter is even more complicated, given a conceivably legitimate constitutional right to treatment and the inherent coercion of the institutional setting. In the context of nearly all sex offender treatment programs, it is highly unlikely that competence will be at issue. Nonetheless, it is important to ascertain the inmate's ability to absorb information and to reach an informed decision. It is understood that the full dimensions of the consent to treatment problems are not likely to arise in the context of prison-based sex offender programs. Indeed, it appears that in practice informed consent is the norm and that it is obtained even when not plainly required, e.g., for psychotherapy sessions.

Other chapters in this volume include complete descriptions of the various treatment modalities associated with sex offenders. In determining whether informed consent should be pursued, the reader is cautioned that the greater the degree of intrusiveness, the greater the necessity and desirability of consent. In ranking intrusiveness, one must consider the extent and duration of the intervention, the amount of pain involved, the degree of intrusion into the individual's body, the risk of adverse side effects, the experimental nature of the modality, and the acceptance by the medical/treatment community.

Consent should be the norm in these programs and, while not plainly required in the various verbal therapies available, even there it is a good idea to obtain consent, preferably in writing. In those rare instances where psychotropic medication is a part of these treatment programs, then the more recent case law developments increasingly insist on informed consent.

Footnotes

1. Depo-Provera™ is a tradename for a drug manufactured by the Upjohn Company. The drug is a synthetic progestogen known technically as medroxyprogesterone.
2. See Comment, *Castration of the Male Sex Offender: A Legally Impermissible Alternative*, 30 Loy. L. Rev. 377, 394, n. 111 (1984).
3. See Wilkerson v. Utah, 99 U.S. 130 (1878); Weems v. United States, 217 U.S. 349 (1910).

   In a recent decision, the Arizona Supreme Court ruled that absent specific statutory authority, a trial judge had no jurisdiction to order that a couple convicted of child abuse submit to sterilization as a condition of receiving a lesser sentence. Smith v. Superior Ct., 39 Cr. L. 2484 (9/11/86). Buck v. Bell, 274 U.S. 200 (1927) was distinguished in that the Court upheld involuntary sterilization of institutionalized "mental defectives" as a means to prevent the birth of defective children and not as an aspect of punishment. The genetic premises of *Buck* and its dubious position of "population purity" are not endorsed here. *Buck* is mentioned only by way of contrast with the *Smith* problem.
4. Blackstone informs us:

   Rape was punished by the Saxon laws . . . with death. . . . But this was afterwards thought too hard: and in its stead another severe, but not capital, punishment was inflicted by William the Conqueror; viz, castration and loss of eyes; which continued till after Bracton wrote, in the reign of Henry the Third, "In the 3 Edw. I. [1275] by the statute Westm. 1.c.13. the punishment of rape was much mitigated: the offence [sic] itself being reduced to a trespass, if not prosecuted by the women within forty days, and subjecting the offender only to two years imprisonment, and a fine at the king's will. But, this lenity being productive of the most terrible consequences, it was in ten years afterwards, 13 Edw. I. found necessary to make the offence [sic] of rape felony, by statute Westm. 2.c.34. And by statute 18 Eliz. c.7. it is made felony without benefit of clergy."

   4 W. Blackstone, *Commentaries*, 211-12 (1st ed. 1769).
5. As we shall see subsequently, there are considerations of the constitutional right to privacy, the First Amendment (e.g., the ability to form and express ideas), and the fundamental due process rights to marry and procreate.
6. In Bell v. Wolfish, 441 U.S. 520, 537-38 (1979), the Court indicated that absent a showing of an expressed intent to punish, a particular jail condition or restriction which is reasonably related to a legitimate government purpose does not, without more, amount to punishment. Under *Bell*, to decide if a measure is punishment, then, one must determine the government's intent, the measure's purpose, and the extent of any excessiveness in the measure and its announced purpose.

   Bell arose in the context of pre-trial detainee claims and in the framework of a constitutional rule prohibiting the infliction of any punishment prior to trial or conviction. Whether the subjective approach announced in *Bell* is wholly apt in the "treatment v. punishment" debate (as opposed to the "security vs. punishment" debate) remains speculative.

   See also Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973), which is discussed in some detail below.
7. Comment, 30 Loy. L. Rev., at 389.
8. See Heim, *Sexual Behavior of Castrated Sex Offenders*, 10 Arch. Sex. Behav. 11 (1981).

   Castration has been far more popular in Europe than in the United States. Heim and Hursch, *Castration for Sex Offenders: Treatment or Punishment? A Review and Critique of Recent European Literature*, 8 Arch. Sex. Behav. 281, 297 (1979) reviewed the European literature on surgical castration, including some startling claims to success in the prevention of recidivism, and they raise major questions about methodology and actual achievements.
9. This is precisely what a South Carolina trial judge recently attempted in a widely publicized rape case. See *Time Magazine*, December 12, 1983, p. 70.
10. Whether such a consent should be permitted is yet another question and is discussed below.
11. See Comment, *The Use of Depo-Provera™ for Treating Male Sex Offenders: A Review of the Constitutional and Medical Issues*, 16 U. Tol. L. Rev. 181 (1984) (hereinafter referred to as "The use of Depo-Provera™"). The author holds a graduate degree in chemistry as well as a law degree.
12. Ibid., at 198-99.
13. Ibid., at 205.
14. Id. The use of Depo-Provera™ in prison would be less concerned with short-term control than with achieving long-term cure.
15. Id.
16. 352 N.W.2d 310 (Mich. Ct. App. 1984). At 353 N.W.2d 463 (Mich. 1984), the Michigan Supreme Court essentially upheld the intermediate appellate court except for its handling of the resentencing, a matter which is not of concern to us in this context.
17. 352 N.W.2d, at 313. The report of the case is replete with judges being disqualified, pleas for money from the defendant to support treatment programs, and errors in the sentencing process.
18. Id.
19. 352 N.W.2d, at 316. To reiterate, however, the grounds for holding submission to Depo-Provera™ as a probation condition illegal are far from clear. Every subsequent comment on the decision which this author has read is critical of the reasoning and result.
20. There is a report that Judge James A. Malkus of San Diego, California recently sentenced a sex offender to

treatment with Depo-Provera™, along with incarceration for four hours every Sunday, for a fixed number of years. This sentence allows monitoring and insures that the weekly injection of the drug occurs. See Comment, *Sexual Offenders and the Use of Depo-Provera™*, 22 San Diego L. Rev. 565, 585, n. 161 (1985).

The same article reports that between October 1982 and September 1983 about 3,000 prescriptions were written for Depo-Provera™ for the treatment of sexual deviation outside the criminal justice system. Ibid., at 570, n. 36.

21. Uphoff, Depo-Provera™ for the Sex Offender: A Defense Attorney's Perspective, 22 Crim. L. Bull. 430 (1986).
22. Ibid., at 438-439.
23. Ibid., at 443-44.
24. A much more complete discussion of this topic may be found in F. Cohen, *Sourcebook*, above, Chapter 18, note 1, at 84-90. A second edition of this work is scheduled for publication in late 1988 and will contain an even more exhaustive treatment of the topic.
25. See generally F.A. Rozovsky, *Consent to Treatment: A Practical Guide* (1984); *Informed Consent*, 1 Behav. Science & the Law 1, Autumn 1983.
26. See *Making Health Care Decisions: The Ethical and Legal Implications of Informed Consent in the Patient-Practitioner Relationship* 397 (President's Commission for the Study of Ethical Problems in Medicine and Behavioral Research, 1982).

Chapter 20: Confidentiality and Privilege

by Fred Cohen

Abstract

In this chapter, Mr. Cohen discusses the sensitive issue of confidentiality within the prison setting. The mental health professional working in a prison setting must balance his patient's right to confidentiality with the security of the institution. Certainly where questions of danger to self or others, escape, medical care, or transfers arise, then confidentiality should be waived. The offender should be informed of this prior to beginning treatment. A confidentiality decision which concerns all mental health practitioners regards their duty to inform when a patient makes a specific threat against another. However, there is no legal duty to report a past crime unless specified by state law.

Questions of when information gained by a mental health professional from an inmate-patient/client may or must be shared are among the most frequently asked and the most difficult to answer definitively. It is the prison or secure mental hospital setting which creates the often conflicting demands on the mental health specialist that give rise to much of the difficulty. There are questions of "split agency"—for example, court-ordered evaluation, jail, or prison screening—and there are questions of confusion of loyalties.[1] There are also questions related to duties owed to identifiable others who may be in danger from an inmate-patient and questions related to the general security and order of the facility.[2]

These complex issues and more will be analyzed in this chapter. However, a general solution to a great many, but certainly not all, of these problems can be suggested. The need for confidentiality and privilege, as a matter of law and professional ethics, rests on the individual's expectations of privacy and nondisclosure, and his recognition that the need for information required to provide needed treatment generally outweighs even compelling demands for disclosure.[3] Where the relationship with the inmate is for diagnosis/evaluation/classification, as opposed to treatment, the full impact of privilege and confidentiality does not apply.

The mental health professional or simply a counselor in a prison or mental hospital setting is well advised to disclose his/her agency to the individual before proceeding to disclose the purpose of the meeting, indicating the uses to which the information will or may be put, and indicating a willingness to answer questions as concretely as possible concerning the risks of disclosure.[4]

The principle of confidentiality of information obtained in the course of treatment is applicable in the prison or jail setting. Mental health professionals living under consent decrees are required to abide by the terms of the decree which may well vary from the prior statement of applicable law. Disclosure of the type recommended above is most appropriate when the inmate-clinician contact is not for treatment, but it may also apply during the course of treatment where certain categories of information, to be discussed shortly, are likely to be disclosed.[5]

The common law did not recognize the doctor-patient privilege, and it was not until 1828 that New York passed the first statute granting doctors the right to refuse to testify.[6] The late-arriving and narrow medical doctor-patient privilege has now been generally extended to psychotherapists and other mental health professionals.[7]

Recognizing that privilege and confidentiality generally apply in institutional settings and that these privacy safeguards are most clearly implicated during a treatment relationship, author Christine Boyle points out:

> It is suggested that there is a basic conflict here between the authoritative or controlling aspect of imprisonment, represented, in a very general way, by the custodial and administrative staff, and the need to rehabilitate, which is largely seen as the responsibility of the professional personnel. Because of this conflict, organization problems are bound to arise in an institution which must perform custodial as well as rehabilitative functions, since confidentiality may be seen as vital to the latter, but dysfunctional to the former.[8]

Legally safeguarded expectations of privacy in jail or prison are virtually nonexistent. In the context of freedom from unreasonable searches and seizures, claims that an inmate's cell is "home" and thus subject to some protections simply are not recognized.[9] On the other hand, the attorney-client relationship is vital to detainees and inmates, since they have little choice as to where to meet with counsel. Clearly the attorney-client privilege and the necessity for privacy attaches during attorney-client contacts in the facility.

The difficult problem for the clinician, then, is to balance the generally applicable principle of confidentiality in a treatment relationship with the countervailing demands of security: the security of specific individuals who may be in jeopardy and the general security of the institution.

Every jurisdiction should adopt a clear set of rules as to when confidentiality is inapplicable. This author suggests that mental health personnel be required to report to correctional personnel when an inmate is identified as:

- suicidal,
- homicidal,

- presenting a reasonably clear danger of injury to self or to others by virtue of conduct or oral statements,
- presenting a reasonably clear risk of escape, or the creation of internal disorder or riot,
- receiving psychotropic medication,
- requiring movement to a special unit for observation, evaluation or treatment of acute episodes, or
- requiring transfer to a treatment facility outside the prison or jail.[10]

Not according confidentiality to the categories listed above serves various purposes. The undoubted duty to preserve the life and health of inmates underpins the need to breach apparent confidences regarding suicide, homicide, or self-inflicted harm and harm to others. Riot or escape from prison are crimes and, as a general proposition, no privilege attaches to discussions of future criminality.[11]

Given the alterations in behavior that occur as a result of psychotropic medication, it is in the inmate's best interests that corrections staff be informed of their use. Finally, if there is a need for intra- or interinstitutional transfer, then it is perfectly obvious that corrections staff must know and likely assist.

What has come to be known as a *Tarasoff* situation calls for some elaboration. In *Tarasoff v. Regents of the University of California* (1976), a mental health outpatient carried out his intention to kill his former fiance, having previously confided his plan to his therapist. The decedent's parents sued for damages and the respected Supreme Court of California held that a psychotherapist owes a duty of reasonable care to identifiable third parties endangered by the therapist's patient.

The court held:

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.[12]

Professor David Wexler raises the question of just how the therapist may discharge the duty to warn, suggesting that alerting the would-be victim would be the standardized safe response.[13] In a prison or jail the standardized safe response would seem to call for alerting the appropriate security personnel and allowing them to take steps to protect the would-be victim.

A *Tarasoff* situation does not arise unless there is an identifiable victim. If a patient (or client) during treatment talks generally about murderous thoughts or hostility against authority, then clearly this is not a *Tarasoff* situation because there is no enforceable duty to an identifiable victim. Here, it seems, we enter the world of professional ethics and individual judgment.

One authority would solve the ethical question by treating such disclosures as generally confidential to the extent that the "public" is not imperiled. She states:

> Actually this . . . is not discrepant with the American Psychological Association's Ethical Standards of Psychologists, Principle 6, Section a (1972:3), which reads as follows: "Such information is not communicated to others unless certain important conditions are met:
> (a) information received in confidence is revealed only after most careful deliberation and when there is clear and imminent danger to an individual or to society, and then only to appropriate professional workers or public authorities."[14]

On the practical level, students of this problem indicate that with the exception of the probability of harm to the clinician or others, the decisions to be made are far from clear-cut. Quijano and Logsdon put it this way:

> It seems to be the general practice among correctional psychologists to inform their inmate clients—and the inmates must understand—that aside from plans to escape and/or harm themselves or others, the principle of confidentiality holds. Even in these two cases, the issue is not clear-cut.
>
> Special care must be exercised not to report just any talk about escape or violence to the security authorities. Only those threats whose probability of actual execution is reasonably high should be reported, and the only basis for that decision is historical data and the psychologist's best judgment. Unnecessary reports may harm not only the inmate client in question but also the correctional psychologist's credibility to both the inmate clientele and the administration. It is obvious that in the implementation of the principle of confidentiality many decisions will be "judgment calls," and prudence (whatever that means to the psychologist) is the guide.[15]

P. J. Lane admonishes the prison counselor or therapist to consider:

1. The role conflict in seeking to balance the therapeutic needs of the patient vis a vis the security and stability of the institution.
2. Inherent problems in accurately predicting dangerousness.
3. The impact of a breach of confidentiality on the relationship with the inmate.[16]

Where there is no identifiable intended victim and the therapist encounters "threats in the air," so to speak, the ques-

tion of disclosure becomes further complicated. Confidentiality in the treatment relationship should be the norm, with the therapist ultimately having to exercise his/her best judgment on the seriousness of the general threat. Therapists who reflexively reveal their patient's every threatening word surely compromise themselves professionally and will likely undermine their ability to help inmates.

Prior Offenses and the Treatment Relationship

A "reverse-*Tarasoff*" situation has been encountered by persons conducting sex treatment programs in institutional settings. During a group or individual treatment session an inmate-client/patient may disclose the commission of a past crime. Is there a duty on the clinician to report such a crime to the authorities? May such a report be made? Does the possible duty, or permissive right, to report vary with the discipline of the clinician? How much detail in the offense narrative is required before there is a problem?

In the first place, if the inmate's narrative is general with no identifiable detail, then the clinician may comfortably conclude there simply is no reporting problem. In effect, the clinician has not learned of a crime. The dilemma arises when there is rich detail as to victim identity, the nature of the offense, location, date, and time. Some clinicians have indicated that they will not allow the individual to go into great detail, while still encouraging honesty in the sessions. While that may be an effective ploy, it avoids the legal issues.

As a general proposition, there is no duty to report a crime unless specifically required by law.[17] Therefore, it could be said that if there is no duty to report a crime, this should preclude any issue of reporting with respect to a past crime which is revealed during a therapy or counseling session. In essence, this is true as to "duty." When considered in the light of the entire nature of the therapist-patient relationship, however, it is a bit too simplistic.

The relationship between patient and mental health professional (this includes psychiatrist, psychologist, psychiatric social worker, psychiatric nurse, mental health aide) is considered a fiduciary relationship.[18] As indicated earlier, the clinician has a duty to uphold the trust and confidence of the patient with respect to communications and do no harm to the patient. Although these principles originate in medical ethics, they are applicable to some extent to all statutorily encompassed mental health professions.[19]

Thus, while there may not be a duty to report, there is the possibility that neither confidentiality nor privilege will preclude the clinician from making the revelation. Clearly, if the clinician states at the outset that past crimes are not considered to be confidential matters, then the individual who discloses is at risk. Where a promise of confidentiality is made and where the disclosure is made within the confines of a privileged relationship, then the individual who is the privilege holder may assert the privilege and conceivably prevent testimony on the disputed subject.

Privilege is a matter of statute and varies from jurisdiction to jurisdiction[20] and from one mental health profession to another.[21] The privilege affects the one-on-one relationship and may be waived in the event of group or family therapy where there are more than two people in the room sharing the potentially privileged information, or when the patient offers his mental condition as an issue at trial.[22]

The privilege belongs to the patient and may be invoked to keep the therapist from testifying against the patient.[23] These rights are not absolute and must be balanced against other important rights.[24] If a past crime becomes an issue and the judge rules that there is a privilege, then the therapist will be precluded from testifying about what was learned during the course of treatment.[25]

Footnotes

1. These terms are taken from T.G. Gutheil & P.S. Applebaum, *Clinical Handbook of Psychiatry and the Law*, see above Chapter 19, note 30, p. 15 (1982). In general, this is an excellent resource for mental health professionals involved with the criminal justice system. One writer states:

   Those who have expressed concern about the divided loyalties of psychiatrists intimate that clarification and differentiation of the psychiatrist's professional role is most urgently required in institutional settings such as hospitals, prisons, schools, and the armed services.

   Merton, *Confidentiality and the "Dangerous" Patient: Implications of Tarasoff for Psychiatrists and Lawyers*, 31 Emory L.J. 263, 273 (1982).
2. This refers to the duty arising from the landmark decision in Tarasoff v. Regents of the University of California, 551 P.2d 334, 131 Cal. Rptr. 14.
3. The nature of privileges is unique.

   The purpose of ordinary rules of evidence is to promote the ascertainment of the truth. Another group of rules, however, is designed to permit the exclusion of evidence for reasons wholly unconnected with the ascertainment of the truth. These reasons are found in the desire to protect an interest or relationship. The term "privilege" is used broadly to describe such rules of exclusion. For relevant communications to be excluded by operation of a privilege, as Wigmore states:

   (1) The communications must originate in a *confidence* that they will not be disclosed;

   (2) This element of *confidentiality must be essential* to the full and satisfactory maintenance of the relation between the parties;

(3) The *relation* must be one which in the opinion of the community ought to be sedulously *fostered*;

(4) The *injury* that would inure to the relation by the disclosure of the communications must be *greater than the benefit* thereby gained for the correct disposal of litigation (citation omitted).

Graham, *Evidence and Trial Advocacy Workshop: Privileges— Their Nature and Operation*, 19 Crim. L. Bull. 442 (1983) (emphasis in original).

Privilege, more accurately termed testimonial privilege, is narrower than the right of confidentiality and applies in judicial or judicial-like settings.

4. As an example, "Mr. Jones, I am Mr. Smith, a psychologist employed by the Department of Corrections. I have been asked to meet with you and evaluate your present mental condition in order to help decide whether you should or should not be transferred to a mental hospital. Do you have any questions about who I am and what use may be made of what you say to me?"

   If the therapist is fairly certain that other uses will be made of this information, that, too, should be volunteered.

5. In Estelle v. Smith, 451 U.S. 454 (1981), the Supreme Court imported the Fifth Amendment's privilege against self-incrimination to the pretrial psychiatric evaluation of a person accused of capital murder, who was convicted and sentenced to death and who made no use of psychiatric testimony himself. Dr. Grigson gave lethal testimony on dangerousness at the penalty phase and his failure to provide a *Miranda*-type warning resulted in a denial of the condemned inmate's constitutional rights.

   This decision strives to limit itself to the unique penalty of death, although the same factors on the fairness of the type of disclosure recommended here seem applicable.

   Cf. Minnesota v. Murphy, 465 U.S. 420 (1984), upholding a probationer's confession to his probation officer absent *Miranda* warnings.

6. T.G. Gutheil & P. S. Applebaum, above Chapter 19, note 30, p. 10, n. 1. The authors state that nearly three-quarters of the states now have such statutes.

   For an interesting general discussion of privileges, see Saltzburg, *Privileges and Professionals: Lawyers and Psychiatrists*, 66 Va. L. Rev. 597 (1980).

7. See e.g. Ala. Code Sec. 34-26-2; Alaska R. of Evid., Rule 504; Ariz. Rev. Stat. Ann. Sec. 32-2085; Ark. Stat. Ann. Sec. 28-1001, Rule 503; Cal. Evid. Code Sec. 1010 et seq.; Colo. Rev. Stat. Sec. 13-90-107(g); Conn. Gen. Stat. Ann. Sec. 52-146c et seq. 1987 Supp.; Delaware Uniform Rules of Evid. Rule 503; Fla. Stat. Ann. Sec. 90-503; Ga. Code Ann. 24-92; Hawaii Rev. Stat. Tit. 33, ch. 626, Rule 504.1; Idaho Rule Evid. 503; Ill. Ann. Stat., ch. 110-8-802; Ind. Stat. Sec. 25-33-1-17; Ky. Rev. Stat. Sec. 421.215; La. Rev. Stat. Sec. 13:3734 (1987 Supp.); Me. Rules of Ev. 503; Md. Cts. & Jud. Proc. Code Sec. 9-109; Mass. Gen. Laws Ann., ch. 233, Sec. 20B; Mich. Comp. Laws Ann. Sec. 330.1750; Minn. Stat. Ann. Sec. 595.02; Miss. Code Sec. 73-31-29; Mo. Rev. Stat. Ann. Sec. 337.055 (1987 Supp.); Mont. Code Ann. Sec. 26-1-807; Neb. Rev. Stat. Sec. 27-504; Nev. Rev. Stat. Sec. 49.215 et seq.; N.H. Rev. Stat. Ann. Sec. 330-A.19; N.J. Stat. Ann. Sec. 45:14B-28; N.M. Rules of Evid. 504; N.Y. Civ. Prac. Law and Rules Sec. 4507; N.C. Gen. Stat. Sec. 8-53.3; N.D. Rules of Ev. 503; Okla. Stat. Ann. Tit. 12 Sec. 2503; Ore. Rev. Stat. Sec. 40.230; Tenn. Code Ann. Sec. 24-1-207; Utah Code Ann. Sec. 58-25-8; Vt. Stat. Ann. Tit. 12 Sec. 1612; Va. Code Sec. 8.01-400.2; Wash. Rev. Code Sec. 18.83.110; Wis. Stat. Ann. Sec. 905.04; Wyo. Stat. Ann. Sec. 33-27-103. See also D.C. Code Sec. 14-307.

   The foregoing enactments vary in scope and application and no attempt is made here to classify them or the decisions construing the provisions and their exceptions. See generally 44 A.L.R. 3d 24.

   For consideration of the privilege as applied to social workers, see 50 A.L.R. 3d 563.

   In New York, CPLR Sec. 4507 (McKinney Supp. 1983-84) psychologists are granted the privilege as follows:

   The confidential relations and communications between a psychologist and his client are placed on the same basis as those provided by law between attorney and client, and nothing in such article shall be construed to require any such privileged communications to be disclosed.

8. Boyle, *Confidentiality in Correctional Institutions*, 26 Canadian J. of Crim. & Corrections 26, 27 (1976).

9. See Hudson v. Palmer, 468 U.S. 517(1984), Black v. Rutherford, 468 U.S. 576 (1984). The term "expectations of privacy" is a legal term of art and goes beyond the hopes, desires, or even demands of inmates or detainees. It refers to those situations where the law finds the expectation "reasonable."

   In Katz v. United States, 389 U.S. 347, (1967), Justice Stewart rejected the notion of Fourth Amendment rights turning on whether or not the right is asserted in a "protected area." He noted that "the Fourth Amendment protects people, not places." Ibid., at 351.

   This analysis cannot be taken to mean that the place is unimportant in Fourth Amendment analysis. Indeed, it is difficult to imagine how an expectation of privacy can be judged as reasonable without some reference to the place involved.

   Although notions of privacy are at the core of the Fourth Amendment and search and seizure law, it should be plain that in the context of this discussion, the Fourth Amendment as such is peripheral.

   See J.J. Gobert & N.P. Cohen, *Rights of Prisoners* 176 (1981).

10. See Draft Minimum Standards (or the Delivery of Mental Health Services in New York City Correctional Facilities Sec. 7.2[a] [N.Y.C. Bd. of Correction, 1982]).

    The Standards for Health Services in Correctional Institutions promulgated by the American Public Health Association are more specific than most on this point but are still general.

    Full confidentiality of all information obtained in the course of treatment should be maintained at all times with the only exception being the normal legal and moral obligations to respond to a clear and present danger of grave injury to the self or others, and the single issue of escape. The mental health professional shall explain the confidential guarantee, including precise delineation of the limits. The prisoner who reveals information that falls outside the guarantee of confidentiality shall be told, prior to the disclosure, that such information will be disclosed, unless doing so will increase the likelihood of grave injury. IV (B) (3)
11. A.B.A., Standards for Criminal Justice, The Defense Function, 4-3.7(d) (1980).

    A lawyer may reveal the expressed intention of a client to commit a crime and the information necessary to prevent the crime; and the lawyer must do so if the contemplated crime is one which would seriously endanger the life or safety of any person or corrupt the processes of the courts and the lawyer believes such action on his or her part is necessary to prevent it.
12. 551 P.2d, 334, 340.
13. See Wexler, Mental Health Law: Major Issues 158 (1981). The reference, of course, is outside the prison or jail setting.
14. Kaslow, *Ethical Problems in Prison Psychology*, 7 Crim. Justice & Behavior 3, 4 (1980).
15. Quijano & Logsdon, *Some Issues in the Practice of Correctional Psychology in the Context of Security*, 9 Professional Psychology 228, 231 (1978).
16. P.J. Lane, *Prison Counseling and the Dilemma of Confidentiality in Conference on Corrections* (V.Fox, ed., 1978). The author concludes each decision is an individual one.
17. Physicians and psychotherapists, among others, must disclose information under compulsory reporting requirements in state or federal law, such as in child abuse reporting statutes that have been enacted in all 50 states and in states that require reporting of injuries that result from violent acts. In New York, N.Y. Soc. Serv. Law Sec. 413 (McKinney's Supp. 1987) requires physicians, psychologists, and mental health providers to report cases of suspected child abuse when they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child, or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian, custodian or other person legally responsible for such child comes before them in their professional or official capacity and states from personal knowledge or facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child.

    Not reporting a past crime is not considered compounding a crime in New York under N.Y. Penal Lw Sec. 215.45, nor is it considered a misprision of a felony under 18 U.S.C. Sec. 4 (1969). There must be knowledge and willful concealment of the offense. See United States v. Baez, 732 F.2d 780 (10th Cir. 1984).
18. R. Sadoff, *Legal Issues in the Care of Psychiatric Patients*, 3 (1982).
19. Id.
20. Ibid., at 6. See Lora v. Board of Education, 74 F.R.D. 565, (E.D.N.Y. 1977). "Privileges for information confided to a doctor were unknown to the common law . . .", p. 574.

    The physician-patient privilege has not been recognized in federal criminal trials. U.S. v. Meagher, 531 F.2d 752, 753 (5th Cir. 1976), cert. denied 429 U.S. 853 (1976). It is not found specifically in the Fed. R. of Crim. P. 26 nor in Fed. R. Evid. 501. Proposed Fed. R. Evid. 504, however, was adjudged an appropriate guide and standard for applying Fed. R. Evid. 501 to psychotherapist-patient privileges. 74 F.R.D., at 569.
21. See *Recent Developments: Waiving the Physician-Patient Privilege in Involuntary Commitment Proceedings in Washington*, 59 Wash. L. Rev. 103, 105, n. 11 (1983).

    See e.g., N.Y. Civ. Prac. Law Secs. 4504 (physician-patient privilege), 4507 (psychologist-patient privilege), and 4508 (social worker-patient privilege). People v. Wilkins, 65 N.Y.2d 172 (1985) held that the psychologist-patient privilege was broader than the doctor-patient privilege and equivalent to the attorney-client privilege. See also *Developments: Privileged Communications*, 98 Harv. L. Rev. 1451, 1540 (1985).
22. Sadoff, above Chapter 20, note 18, p. 7.
23. Id.
24. 74 R.F.D., at 567.
25. Sadoff, above Chapter 20, note 18, at 6-7.

Chapter 21: Liability and Negligent Release

by Fred Cohen

Abstract

In this chapter, Mr. Cohen considers the question that perhaps holds the most personal interest for individuals treating sex offenders. Will the therapist be held responsible if the client reoffends? Legal precedents have established that in the case of releasing an individual from prison, liability can only be established if there is gross negligence. This would include failing to inquire into an offender's situation or history and releasing an individual when there is absolutely no reason to believe that the person is no longer dangerous. Furthermore, other decisions have established that the plaintiff must prove that the acquisition of information would have resulted in a different decision from the one that was made without that information. In making release decisions, state employees are also granted immunity from liability under the federal tort rulings. However, liability may exist under the Federal Tort Claims Act if one provides professional care in a negligent manner. The author also examines the duty to warn as a basis for liability and its relation to negligent supervision. Adhering to responsible decision-making by following the information gathering-studying-sharing steps will go far to insulate professionals from liability.

Here the writer will address a question which is raised frequently by persons connected with the treatment of institutionalized sex offenders: what is the potential liability for participating in a decision that ultimately contributes to the release of a sex offender who reoffends? This question is characterized legally as one of potential liability for "negligent release." Negligent release claims often are joined with a challenge to the supervision employed or, more likely, the lack thereof; this necessitates adding at least a passing reference to "negligent supervision" later in this discussion.

At the outset, it should be established that this area of civil liability is complex, confusing, and evolving. There are basically three lines of cases to be dealt with:

(1) law suits brought in state court relying on state law;

(2) law suits brought in federal court based on the Federal Tort Claims Act; and,

(3) law suits brought in federal court under Sec. 1983 which involve a claimed loss of a federal constitutional right.

It is easier to give advice on how to avoid the prospect of liability than it is to give a succinct overview of the law.

As confusing and as inconsistent as the decided cases are, a few matters can be put to rest immediately. Suits on behalf of the victims of crimes challenging either the release decision, its component parts, or the manner of supervision usually do not succeed. State courts have been more receptive to such law suits than have the federal courts when presented with a civil rights action under Section 1983. Where liability is found and upheld, simple negligence generally will not suffice. Gross negligence or recklessness—conduct involving serious risk-taking and a high probability of harm—often will be required as a basis for the liability of governmental agencies, supervisors, and persons associated with the challenged decision or behavior.[1]

The cases also make plain that the longer the time lapse between release and the complaint, the dimmer the prospects for any recovery.[2] Turning that proposition around we can see that were an agency of government, or any individuals acting for the agency, held liable for harm which occurred years after release, then a release decision would be converted into an "insurance policy" with the public at large as beneficiaries.

While government certainly has the power to become a guarantor of results, no court has yet had the temerity to judicially impose it; and no legislature has bowed so low before victims' rights.[3]

The manner in which a decision to release is reached is far more likely to have legal significance than the ultimate correctness of the decision.[4] Although government will not guarantee results, it can guarantee adherence to certain minimal processes of rational decision-making which at least reduce the risk of error. The reported decisions are replete with instances of failure to collect relevant information, often in violation of statute; failure to make use of, or properly exchange, information which is available; failure to keep records; failure to engage in even minimal diagnostic efforts; failure to consult—and on and on.

Even these negligent omissions in a particular case may not create liability in a jurisdiction reasonably receptive to negligent release claims. For example, in *Grimm v. Arizona Board of Pardons & Parole* (1977),[5] a wrongful death and injury suit was brought against the defendants claiming they were grossly negligent and reckless in the release from prison of one Blazak. The parolee had a long record which included repeated violence and drug use. He had been hospitalized previously and there found to be psychotic and dangerous. While on parole Blazak killed one person and wounded another in a bar robbery.

The trial court dismissed the suit for damages, relying on a form of judicial immunity with which it cloaked the Board and its members. In an unusual ruling, the Arizona Supreme

Court reversed and held that total (or judicial) immunity was not required. The court went on to state:

> We hold that members of the State Board of Pardons and Paroles owe a duty to individual members of the general public when the Board decides to release on parole a prisoner with a history of violent and dangerous conduct toward his or her fellow human beings. The *standard of care* owed, however, *is* that of *avoiding grossly negligent or reckless release* of a *highly dangerous* prisoner. If the history of an applicant for parole shows a great danger of violence to other humans, the members of the Board are under *a duty to inquire further* before releasing the prisoner. With medical and psychological evaluations, plus day-to-day evaluations of the prison personnel, the Board should have access to sufficient information to make an informed decision. If the *entire record* of the prisoner reveals violent propensities and there is *absolutely no reasonable basis* for a belief that he has changed, then the decision to release the prisoner would be grossly negligent or reckless. . . . *[If] all the information* before the Board *negates* the probability of lawful conduct while on parole, the Board cannot ignore such evidence. We emphasize that *no liability* is to be imposed *when the evidence is conflicting* or contradictory, that is, when reasonable minds could differ. (emphasis added)[6]

The reader should note the terms emphasized above: *entire record*, *absolutely no reasonable basis*, and *no liability when evidence is conflicting*. From a plaintiff's point of view *Grimm*'s liberality is more apparent than real. Very few prison-parole records are without contradictions, and it is even more difficult to envision a record with absolutely no reasonable basis for taking the chances inherent in virtually every parole.

The issue of liability exposure needs to be taken one step further, even at this early stage of analysis. *Grimm* deals with the question of immunity from suit, that is, the extent to which a governmental agency or official may be sued. The immunity doctrine is an ancient one, going back to the early English concept that the King could do no wrong.[7] Today neither the federal government nor any state fully retains its inheritance of sovereign immunity, but neither has immunity been fully relinquished.[8]

Assuming a victim gets over any of the several immunity hurdles which are likely to be in place, other formidable obstacles await him. *Santangelo v. New York* (1980) is a good example of such an obstacle.[9] That decision grapples with a rape victim's efforts to collect damages based on a claim that her assailant was negligently placed on temporary release by New York's Department of Correctional Services. The court found that prior to the decision to confer what was virtually unsupervised release, there had been only the barest form of inquiry, with no tests or evaluations administered.

The problem for the victim was that while she could prove these omissions, she could not demonstrate that more adequate procedures, for example, consultation with supervisory officers or obtaining a psychiatric evaluation, would have resulted in a different decision. There was no evidence in the record of an overt propensity to commit rape and thus no trigger for a specific inquiry into that possibility. Thus, the plaintiff in *Santangelo* foundered not on immunity but on her inability to show a breach of duty. Liability does not result from being wrong where, as demonstrated here, reasonable minds could differ.[10]

With *Grimm* as an example of a loosening of immunity accompanied by a strict standard of liability and *Santangelo* as an example of the difficulty of showing an actionable breach of duty, we begin to see that legal doctrine and evidentiary requirements present serious problems for a plaintiff. Indeed, "negligent release or supervision" is a misnomer; "reckless release or supervision" seems a more accurate term.

There are major program and policy implications associated with this area of law. In preparing this chapter, the author asked a number of treatment program people what they regarded as the most important legal problems they faced in dealing with sex offenders. Liability invariably was among the top three or four problems.[11]

The reality as well as the perception of legal requirements will likely have a significant impact on policy and its implementation. At the practical level, as one astute attorney informed this author, once there is a dent in the liability armor, the perception of liability and recovery may outdistance reality. Plaintiffs typically are entirely innocent and seriously injured. The state has a "deep pocket" and a most unsympathetic defendant as a "partner." As any lawyer knows, this becomes the friendly turf for negotiated settlements.[12]

The possibility of civil liability in this area, however, should not and need not produce debilitating caution. Given a set of problems and offenders as complex and intractable as many sex offenses and sex offenders, action and risk-taking clearly should be preferred to inaction and excessive caution.

The threat of a lawsuit for informed, good-faith decisions should be neither a stop sign nor even a yield sign. Rather, when the risks may be high—as with the release of a chronic sex offender, or the undertaking of a promising treatment program with aversive measures—risk-taking should be the preferred option, with the law providing a framework for action, not a barrier. Surely the decisions in *Grimm* and *Santangelo* should not be viewed as supportive of excessive caution.[13]

The Supreme Court's decision in *Martinez v. California* (1980) is basic to an understanding of this topic.[14] This case arose out of a murder of a 15-year-old girl by a parolee. The parolee earlier had been convicted of attempted rape and then committed to a state hospital under California's (then) Men-

tally Disordered Sex Offender Law. Not being amenable to treatment, he was sentenced to 1 to 20 years imprisonment with a recommendation he not be paroled.

Nonetheless, five years later parole authorities released him although fully informed of his history, propensities, and the likelihood he would commit another violent crime. The parole authorities failed to observe certain unspecified formalities.[15] The release decision was characterized as negligent and reckless, wanton and malicious. However, relying on California's statutory grant of absolute immunity to public officials, the state trial judge, in effect, dismissed the complaint.

The Court characterized *Martinez* as presenting two problems: whether the Fourteenth Amendment invalidated the California immunity statute, and whether California officials also were immune from suit under the Federal Civil Rights Act, 42 U.S.C., Sec. 1983.[16]

The Court determined that the California immunity statute deprived the decedent's survivors of neither due process nor property.[17] The law obviously did not authorize nor immunize the killing of any human being. What it did was provide a defense to liability which is not the equivalent of taking something of constitutional value from possible victims.

> At most, the availability of such a defense may have encouraged members of the parole board to take somewhat greater risks of recidivism in exercising their authority to release prisoners than they otherwise might. But the basic risk that repeat offenses may occur is always present in any parole system.[18]

The deprivation of property claim was disposed of by the Court's reaffirmation of the State's strong interest in fashioning its own tort law, an interest that prevails unless there is an effort to elude liability to citizens for state action that is wholly irrational and arbitrary. The State's purpose appears to be the fostering of parole release decisions unfettered by fear of liability. This, held the Court, is entirely reasonable.

Having upheld California's immunity law, the Court turned to the Sec. 1983 claim. Under Sec. 1983 the first question is not necessarily immunity but whether any federal right has been taken and, if so, whether the taking was of a constitutional dimension.[19]

The Fourteenth Amendment, of course, provides assurance that life will not be taken by the State without due process of law. This victim lost her life due to the actions of a parolee some five months after release. The parolee was not an agent of the State and the parole authority was not aware that the decedent was in any special danger. That is, the danger was to the general public and that, in a word, does not create any Sec. 1983 liability.[20]

From our standpoint, the most important aspect of *Martinez* is that it upholds the constitutionality of a state law granting absolute immunity to public employees making parole-type release decisions. This, of course, does not mandate, nor directly encourage, such immunity.[21]

Subsequent to *Martinez*, the Court decided two cases that will importantly affect Sec. 1983 suits. In *Daniels v. Williams* (1986)[22] and *Davidson v. Cannon* (1986),[23] the Court unambiguously removed negligence from the ambit of liability under Sec. 1983. In *Daniels*, which involved injuries suffered by a jail inmate who slipped on a pillow negligently left on some stairs by a correctional officer, the Court held:

> Where a government official's act causing injury to life, liberty, or property is merely negligent, "no procedure for compensation is constitutionally required."[24]

In *Williams*, one inmate was seriously injured by another. The injured inmate based his claim on procedural due process, arguing that State officials were negligent in failing to protect him and by denying him an opportunity to sue in State court.[25] Despite the serious injuries, despite the inmate's abortive efforts to obtain protection from prison officials, and despite having no remedy in State court, the Court reiterated its view in *Daniels* that negligence alone will not support a Sec. 1983 claim.

By narrowing the basis for a federal tort action, the Court will have encouraged either more damage claims to be brought in State courts or a change in the way federal plaintiffs plead their cause. That is, future plaintiffs may simply embellish their complaints with terms like "recklessness," "deliberate indifference," and "wanton and malicious." Indeed, in *Williams* such an approach would not have been frivolous.

When going into State court with a claim for damages based on a claim of "negligent or reckless release," a litigant will encounter the issues raised at the outset of this section: State immunity and, where suit is permitted, the tasks of proving that the injury complained of resulted from the breach of a duty owed the victim. *Grimm* and *Santangelo* were mentioned earlier to introduce these points and here we shall add a bit more substance to that earlier discussion.

Let us now assume that a given jurisdiction, federal or state, has waived total immunity from tort liability. What are the major legal and practice issues that need to be considered? To answer these questions, we begin with a somewhat detailed analysis of *Payton v. United States* (1982),[26] a suit brought under the Federal Tort Claims Act (FTCA) which is also representative of similar cases brought into the State courts.[27]

A parolee from federal custody murdered three women and in the process raped and hideously mutilated the bodies. The suit on behalf of Ms. Payton was brought under the FTCA and alleged a number of acts of negligence by federal authorities. The central issue on appeal from the district court's dismissal of the action was stated to be: whether the alleged conduct by personnel of the United States Board of Parole and the United States Bureau of Prisons comes within the

FTCA or is exempt as a discretionary function pursuant to 28 U.S.C. Sec. 2680(a).

The key phrase in the issues statement is "discretionary function" and it is one that requires initial explanation. The FTCA authorizes suits for money damages against the United States for personal injury or death caused by the tortious actions of government employees acting within the scope of their employment and under circumstances where a private person would be liable. [28 U.S.C. Sec. 1346(b)] Specifically exempt from jurisdiction are claims based upon the exercise by a government agency or employee of a "discretionary function or duty."[28] [28 U.S.C. Sec. 2680(a)]

Discretionary function is not defined in the Act and has been a source of judicial consternation and confusion in the 36-year life of the FTCA. But at the outset we can safely state that decisions that are made at the policy-planning level, as opposed to the operational level, are most clearly exempt under the Act. Parenthetically, this exemption is not an issue of constitutional dimension. It is strictly a matter of statutory interpretation within the framework of an Act that, among other things, is a waiver of sovereign immunity.[29]

The nature of a discretionary act giving exemption from liability and a nondiscretionary (at times called "ministerial") act which is subject to liability may be more easily understood if we turn to the specific claims and findings in *Payton*.

In the first count of the complaint the United States was alleged to be liable for Ms. Payton's death because the parole board negligently released a person known to be a dangerous psychotic. The court stated:

> We read the statute to state that if the initial request for parole, whether submitted by the prison bureaucracy or by the prisoner himself, shows a reasonable probability that the prisoner is capable of living in society without violating the laws or endangering the public welfare, then the parole board may, in its discretion, release the prisoner on parole. The decision to release the prisoner on parole must necessarily entail an evaluation by the parole board of the prisoner's records. Thus, the parole board's final decision that the prisoner is worthy to live in society as a free person is not different from the decision to release him on parole. The statute clearly describes this as a discretionary function.[30]

In determining that the parole release decision was wholly discretionary and thus could not be the basis of an action under the FTCA, the Fifth Circuit did not also hold that all steps in the decision-making process could be ignored with impunity.[31] Before turning to a discussion of what some of those steps might be, let us briefly note the court's treatment of two earlier decisions on which plaintiffs have relied heavily.

In *Fair v. United States* (1956),[32] a seriously mentally disturbed Air Force captain killed a student nurse he had threatened earlier. Prior to the homicide, "[a] cursory psychiatric examination was made of [the officer] and he was released."[33]

In the view of this author, the *Fair* court allowed the FTCA suit because it determined there was inadequate diagnosis and, more centrally, a failure to notify the detective agency guarding the nurse of the release, as government representatives had promised. In *Payton*, the court stated: "Thus, the [*Fair*] court did not base its decision on the 'negligent release' of the officer, but rather on his 'negligent medical treatment' which encompassed the decision to release him from the hospital."[34]

This author finds virtually no support for this reading of *Fair*, although for these purposes this is not a debate that needs to be entered. It must be stressed only that the *Payton* decision unequivocally characterizes parole release as a discretionary decision exempted from FTCA coverage. If the release decision is based on prior negligent medical treatment, however, then the lack of adequate care may not be discretionary and liability is possible.

The other decision on which the *Payton* plaintiffs relied is *Underwood v. United States* (1966),[35] which involves a mentally disturbed airman released from hospitalization who then killed his wife with a military weapon. *Underwood* does seem to be utilized properly in *Payton* in that the key liability factor was the failure of the initial physician to provide his replacement with vital information concerning the airman's mental state. This information presumably might well have led to a more circumspect decision.

Thus, *Fair* and *Underwood* may be viewed as a combination of failure to adequately diagnose, failure to warn as promised (which is not based on a judicially imposed duty to warn third parties),[36] and failure to share diagnostic material. These decisional steps (or omissions) are treated as nondiscretionary and thus within the FTCA, whereas the actual release decision is treated as discretionary and exempt.

Returning to *Payton*, the court rejected liability claims based on a failure to supervise or to provide continued care and failure to acquire certain records showing the parolee to be homicidal. These activities, along with the release decision itself, were viewed as discretionary. The court did accept claims based on a failure of the Bureau of Prisons to supply the board with records showing the parolee's dangerousness [18 U.S.C. Sec. 4208(c)], failure to examine and report on the inmate so that a decision could be made by the Attorney General on whether to seek hospitalization for the remainder of his prison term [18 U.S.C. Sec. 4241] and, finally, the negligent rendering of psychiatric care while the parolee was in prison.[37]

Two of these counts characterized as nondiscretionary functions were based on explicit and mandatory statutory language, as cited in the above text. The final count, negligent care, is

based on the general proposition that, while psychiatric care may not always be required for inmates, once undertaken it cannot be done negligently.

The upshot of a case like *Payton*, as well as its ancestors and progeny, is the judicial creation of very fine distinctions between the steps in a decision process and the decision itself. As was noted earlier, the key to successfully working within this area of law—as opposed to a complete understanding of the doctrinal subtleties—is the necessity of adherence to the legally required steps in the decision-making process as supplemented by adherence to one's professional norms. A clinician does not have to be right but does have to acquire and share relevant information, faithfully keep promises about warnings, and provide care in accordance with professional norms.[38]

As the court stated in *Lipari v. Sears, Roebuck & Co.* (1980):

> It may be difficult for medical professionals to predict whether a particular mental patient may pose a danger to himself or others. This factor alone, however, does not justify banning recovery in all situations. The standard of care for health professionals adequately takes into account the difficult nature of the problems facing psychotherapists. . . . Under this standard a therapist who uses the proper psychiatric procedures is not negligent even if his diagnosis may have been incorrect.[39]

In *Fair*, a failure to warn as promised formed a significant part of the court's rationale in creating a basis for liability. It was suggested that a duty to warn created by a nonmandatory promise to do so is distinguishable from the *Tarasoff*-like, judicially created duty to warn identifiable victims.[40]

The limits of *Tarasoff* may be illustrated by another California decision, one that has proven to be highly controversial. *Thompson v. County of Alameda* (1980) involved the release of a violent youth to his mother.[41] The County knew of the youth's violent propensities regarding children and that the youth had indicated that if released he would kill an unspecified youngster in his neighborhood. Within 24 hours of release, he assaulted and murdered the plaintiff's son.[42]

A majority of the then-sitting California Supreme Court—a court favorable to plaintiffs—first disposed of the easier points: as a parole decision, the release is wholly immunized under California law, and selection of a proper custodian for a minor is inherently a discretionary decision and is also exempt from liability.[43]

The most troublesome aspect of the case is a claim of liability based on the failure to warn local police and neighborhood parents.[44] Distinguishing *Tarasoff*, the court determined that the County had no special relationship with the particular plaintiffs nor did the defendant place this particular decedent into a foreseeably dangerous situation.[45] *Tarasoff* was described as involving a foreseeable victim (versus neighborhood children) and a special relationship (the therapist-patient extending also to known third parties).[46]

The court declined to impose liability for failure to warn police, neighbors, the mother of the assailant, or other children. Perhaps the most crucial points were the absence of specific threats to specific victims and a sense of futility in judicially calling for some sort of generalized neighborhood alarm.[47]

Justice Torbriner filed a vigorous dissent based on *Tarasoff* principles and a belief that the failure to warn the custodian-mother that her son had threatened to kill a neighborhood child could be the proximate cause of the death.[48]

Using *Thompson* as a point of departure, a phenomenon related to the issues just discussed that puts an even greater focus on liability will be discussed. Suppose that authorities place a youth with homicidal tendencies and a background of violence and cruelty into a foster mother's home and fail to inform the woman of these facts? Or suppose that a probationer with a history of sexual abuse of children is allowed to rent a room in a home with young children and participate in a work release program in proximity to young children, without notice to the respective parents?

Liability has—and seemingly should have—attached in both situations. The first situation involved the creation of a special relationship between the ward and the foster parent, and a clear duty to warn of a foreseeable peril not readily discoverable by those at risk. The second situation may be characterized as negligent supervision with the possible addition of liability which flows from the violation of judicially imposed probation conditions which prohibited contact with children under the age of fifteen.[49]

To summarize this section and also provide some guidance to clinicians and others working with sex offenders, the author wishes to reemphasize the critical need to know and follow legally mandated steps in the decision-making process. Adherence to those information gathering-studying-sharing steps will go a long way toward insulating from liability what turns out to be an erroneous decision (or misplaced trust).

In addition, courts will be importantly influenced by the capacity of a clinician to control an inmate or a patient. In *Semler v. Psychiatric Institute* (1976), there was contravention of a court order regarding the issuance of release passes and the placement of a patient on an outpatient basis without prior judicial approval.[50] The hospital was liable in tort for a death caused by the patient based on a special relationship between the hospital and the patient and the consequent duty of the hospital to maintain custody of the patient until there was a judicial order.[51]

This type of negligence is often referred to as negligence per se, that is, the violation of the court's orders obviates the need to prove that release was otherwise improper. Perhaps of more interest is the fact that "the degree and manner of a therapist's control over a patient is often a key factor in negligent release cases."[52]

In a prison setting, clinical and program staff will have little to do with the actual release of an inmate. More likely, the role will be that of providing diagnosis and treatment along with release or custody recommendations. Within the facility itself, clinical and program staff are likely to play key roles in the level and nature of the confinement ordered for an inmate. As has been shown, a basis for liability may be found where a law mandates a report and it is not developed, or where important diagnostic material exists and is not shared as legally mandated.

Where release of a sex offender is anticipated and promises have been made concerning notification, it is imperative that those promises be kept. If, for example, a child molester is released and placed in proximity to young people, or if a rapist is offered a job in a women's dormitory, that is recklessness of the most culpable sort and a certain invitation to liability.

It is difficult to imagine that the *Tarasoff* problems will often be confronted in the context of a prison program. If an inmate is currently making specific threats about an identifiable victim in the community, it is unlikely that any sort of discretionary release would occur.[53] Where an inmate is about to "max out" and staff believes that person remains dangerous, then there may be an interesting question on a possible duty to seek civil commitment.[54]

Footnotes

1. R.V. del Carmen, *Potential Liabilities of Probation and Parole Officers* 89 (National Institute of Corrections, Rev'd. ed., 1985) (hereinafter referred to as "Potential Liabilities").

   The statement in the text, of course, is general. The State of Washington, for example, may be unique in its liability exposure and consequent frequent settlements since the decision in Peterson v. State, 100 Wash. 2d 421, 429, 671 P.2d 230 (1938). *Peterson* allowed a motorist, who was injured by a pot-smoking former state hospital patient, to sue successfully, based on the State's duty to take reasonable precautions to protect *anyone* who might be endangered by the patient's drug-related mental problems. The State's duty included seeking an additional commitment.
2. See e.g., Leverett v. State, 399 NE2d. 106 (Ohio Ct. App. 1978), holding that injury caused within three months of an alleged negligent release from a state hospital was a question for the jury whereas an earlier decision was reaffirmed holding that a two-year gap was too long as a matter of law.
3. A number of jurisdictions have enacted victim compensation legislation which is on a no-fault recovery basis but quite limited in the amount recoverable. New York's highly structured law is representative.

   N.Y. Exec. Law Sec. 631 (McKinney 1982, and Supp. 1987).
4. Part of the explanation for this position lies in the vagaries of predicting future criminality. See generally, *Dangerous Behavior: A Problem in Law and Mental Health* (1978).
5. 564 P.2d 1227 (Ariz. 1977).
6. 564 P.2d, at 1234. See also Ryan v. Arizona, 656 P.2d 597 (Ariz. 1982), a suit to recover damages for injuries inflicted by a youth who escaped from custody and shot the plaintiff, where it was held that the State will be subject to the same tort law as private citizens with liability preferred to immunity.
7. See C.D. Robinson, *Legal Rights, Duties, and Liabilities of Criminal Justice Personnel: History and Analysis*, Ch. 5 (1984). This is an excellent work to consult generally on liability for various criminal justice personnel.
8. "Potential Liabilities," p. 33, above, Chapter 21, note 1.
9. 426 N.Y.S. 2d 931 (N.Y. Ct. Cl., 1980).
10. Ibid., at 935.
11. The author has lectured several times at special issue seminars conducted by the National Institute of Corrections on the subject of this chapter. The clinicians and program personnel attending these sessions invariably viewed liability for their decisions as a major problem.
12. Letter from William C. Collins, correctional law specialist in Olympia, Washington, to Fred Cohen, April 7, 1987.
13. Hopefully, such decisions also may not read as inviting the slipshod and informationally deficient decisions encountered there.

    The author is aware that the text is based on legal analysis alone, whereas political realities create powerful pressures to resist even modestly risky offenders and especially so for certain sex offenders.
14. 444 U.S. 277 (1980).
15. Ibid., at 556.
16. The California courts accepted jurisdiction of the federal claim. Although it is not a common practice to bring this federal claim into state court, the court raised no objection to it although it is plain that the Sec. 1983 claim is governed by federal law. See 44 U.S., at 282-83, nn. 6-7.
17. Ibid., at 281.
18. Ibid. The quoted text is, of course, consistent with the author's earlier caution against excessive caution.
19. Ibid., at 283.
20. Ibid., at 285. The Court reserved decision on whether another set of facts might create liability for a life taken in connection with a parole release decision.

    Failure to supervise adequately was raised in *Martinez* but not pursued.
21. Readers will have to consult the law of their particular jurisdiction to know whether or not they come under absolute or qualified immunity.

22. 106 S.Ct. 662 (1986).
23. Ibid., at 668.
24. Ibid., at 666.
25. A New Jersey statute exempted public entities and employees from liability for injuries inflicted on one prisoner by another.
26. 679 F.2d 475 (5th Cir. 1982), on rehearing *en banc*; reviewing and affirming in part, 636 F.2d 132 (5th Cir. 1981).
27. See e.g., Lloyd v. State, 251 N.W.2d 551, (Iowa 1977) involving a claim under the state torts claims act.
28. 679 F.2d, at 478. The district court dismissed the complaint solely because it believed it lacked jurisdiction under the FTCA.
29. See Dalehite v. United States, 346 U.S. 15 (1953), the first important interpretation of the FTCA by the Supreme Court.

    As a practical matter, liability in any jurisdiction is not likely to come from a decision to initiate a program, but from operational decisions in its implementation.
30. 679 F.2d, at 480.

    In Greenholtz v. Inmates of Nebraska Penal & Correctional Complex, 442 U.S. 1 (1979), the Court determined that an inmate had no federal constitutional liberty interest in the parole decision for purposes of obtaining even rudimentary procedural due process. If, however, a particular state used mandatory language in its parole statute, such as, "shall release . . . unless," then a state-created liberty interest is involved and minimal due process is thereby mandated.

    The great majority of jurisdictions use language of the sort used in the federal law and thus escape due process obligations and also minimize their liability exposure.
31. 679 F.2d, at 481.
32. 234 F.2d 288 (5th Cir. 1956).
33. Ibid., at 290.
34. 679 F.2d, at 481.
35. 356 F.2d 92 (5th Cir. 1966).

    That is, this is not kin to Tarasoff v. Board of Regents, 551 P.2d 334 (Cal. 1976), which turned on a clinician's duty to warn identifiable third parties and, most important, did not involve a custodial patient.
36. 679 F.2d, at 481, accurately describes *Underwood*.
37. 679 F.2d, at 482-83.
38. The latter statement should not be confused with the less demanding "deliberate indifference" standard which applies when the cruel and unusual punishment provision of the Eighth Amendment is invoked as the constitutional norm in a prison treatment situation.

    In Sellers v. Thompson, 452 So.2d 460 (Alabama 1980), a suit was brought against the state parole board for releasing one Jones without a psychiatric report whereby the parolee then murdered the plaintiff's husband. The Alabama law on point used apparently mandatory language, "shall obtain," concerning the missing report but the Alabama Supreme Court disagreed. The Court decided that the legislature would not have intended that result and it read *Payton* as a failure to provide existing records vis a vis failure (as here) to develop one initially.
39. 497 F.Supp. 185, 192 (D. Neb. 1980).
40. See above Chapter 6, note 35. See also Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 Harv. L. Rev. 358 (1976).
41. 614 P.2d 728 (Cal. 1980). Given the existence of absolute immunity by the State, the County became a more accessible defendant.
42. Ibid., at 738 (Tobriner, J. dissenting), gives a succinct factual summary.
43. Ibid., at 731. In Washington, the *Peterson* decision, above Chapter 21, note 1, did not require a specific foreseeable victim.
44. 614 P.2d, at 732.
45. Ibid., at 733. This is a highly debatable conclusion on these facts.
46. See Fleming & Maxiou, *The Patient or His Victim: The Therapist's Dilemma*, 62 Calif. L. Rev. 1025, 1030-31 (1974), predating *Tarasoff* and arguing that there was even then enough authority to conclude that by entering into a doctor-patient relationship, a therapist is sufficiently involved to assume responsibility for the patient and also for the safety of any third party known to be threatened by the patient. The authors extruded this position from the then firmer base of control of dangerous persons in actual detention.
47. The Cal. Penal Code, Sec. 290 required that certain sex offenders notify the police of their presence in the community. This section became inoperative after January 1, 1988, although there is a new duty on Youth Authority wards to register.
48. 614 P.2d, at 738-42 (Tobriner, J., dissenting).
49. The first situation is Johnson v. State, 947 P.2d 352 (Cal. 1968). The second situation is Aceredo v. Pim County Adult Probation Dept., 690 P.2d 38 (1984).

    In Eiseman v. New York, No. 189, slip op. (Ct. of Apls. July 9, 1987), the decision focused on the duty of the State and a college when an ex-felon with a history of drug abuse and criminal conduct is conditionally released from prison, is accepted into a college program and thereafter rapes and murders a fellow student. While the case has many interesting facets, of particular interest here is the conceded failure of a prison physician to accurately complete the prisoner's medical history as an aspect of the college's admission requirements.

    If this had been done, the prisoner-applicant's history of drug abuse and suicide attempts would have been disclosed. The court determined that the doctor's duty was to the applicant and other persons who might reason-

ably rely on the doctor for this service to his patient. There was no duty to the unknown students who would not know of this material in any event. The medical data was not part of the college admission criteria and was used for other post-admission purposes and, thus, there also was no breach of duty to the college.

50. 538 F.2d 121 (4th Cir.) cert. denied. 429 U.S. 827 (1976).

    See *Aceredo*, above note 49, for a similar disregard of judicial orders.

    There may be a problem of previously made threats or ambiguous threats. The more ancient or nonspecific the threat, however, the less basis there is for liability.

51. 538 F.2d, at 125.

52. Note *Psychiatrists' Liability to Third Parties for Harmful Acts Committed by Dangerous Patients*, 64 N. Car. L. Rev. 1534, 1538 (1986) analyzing Pangburn v. Saad, 326 S.E.2d 365 (N.C. App. 1985), sustaining liability for wrongful release of a patient.

53. If the threats are directed at a fellow inmate, that is another problem.

54. No such case has been uncovered.

    For more detailed coverage of the legal issues discussed in this section, readers are advised to consult the following American Law Report Annotations wherein all reported cases within the annotation title are collected, analyzed, and updated:

    a) Immunity of Public Officer from Liability for Injuries Caused by Negligently Released Individual, 5 A.L.R. 4th 773.
    b) Liability of Governmental Officer or Entity for Failure to Warn or Notify of Release of Potentially Dangerous Individual from Custody, 12 A.L.R. 4th 723.
    c) Governmental Tort Liability for Injuries Caused by Negligently Released Individual, 6 A.L.R. 4th 1155.
    d) Probation Officers' Liability for Negligent Supervision of Probationer, 44 A.L.R. 4th 638.

Chapter 22: Duty to Protect

by Fred Cohen

Abstract

In this brief chapter, Mr. Cohen explores the issue of the duty to protect. It is important to distinguish a duty to protect from a duty to treat. Certain sex offenders by virtue of their offense and certain inmates by virtue of their sexual preference may be said to represent high-risk categories. Prison officials should be alert to their security needs and make available safe environments. In most prisons, sex offenders are at risk from the general population due to the nature of their crime. Prison authorities have the duty to provide protection to offenders who request it and to mandate it when the authorities believe that a threat exists for a specific individual. Confidentiality must be maintained, particularly regarding sex offender treatment.

It is well accepted that "a prison inmate has a constitutional right to be protected from the constant threat of violence and from physical assault by other inmates."[1] The fact, however, that a person convicted of crime may also be a member of a group that is particularly at risk in prison will not exempt such person from a prison sentence. For example, in a New York case, two defendants argued that their homosexual orientation and physical appearance would likely subject them to physical and sexual abuse in prison and they argued that they should be exempt from incarceration.[2] The court could find no cases exempting homosexuals from confinement:

> In short, there is no support in the law for defendants' contentions that an increased possibility of homosexual rape in prison constitutionally prohibits incarceration. Even granting that the defendants here may be at a relative disadvantage because of their size, inexperience, youth, or sexual preference, none of these factors entitles them to such special consideration from the court. Many prisoners are younger or in worse physical condition.[3]

In a recent California case, a trial judge indicated that he was granting probation, in lieu of an otherwise likely prison term, because the defendant was "blonde and slender, which would make him the target of sexual abuse in a state prison."[4] The State successfully sought a writ of mandate arguing that the trial judge rendered an impermissible disposition.[5]

The reviewing court found that there had been no showing of impermissible risk to the defendant nor that the Department of Corrections could not afford him reasonable protection.[6] Thus, we can establish that one's sexual orientation or crime of conviction is unlikely to be a bar to imprisonment. Both factors, however, should alert to the need for special protection during confinement.

In *Zatler v. Wainwright* (1986), a former inmate brought a civil rights action against Florida prison officials based on his having been forcibly raped by inmates on eight occasions at six different institutions.[7] As a young, white, slightly built homosexual, Zatler claimed he was obviously at risk and that inadequate protection was afforded him.[8]

In order for Zatler to have succeeded against Secretary Wainwright, he had to show that any alleged failures to adopt adequate policies for inmate protection were a breach of Wainwright's duty and evidenced a reckless disregard or deliberate indifference to the inmate's constitutional rights.[9]

Wainwright was able to show a general policy that allowed inmates who needed protection to request it and be placed in protective custody. In addition, he showed that Zatler was placed in such custody every time he asked and was released only at his own request.[10]

Zatler's point, accepted by Judge Clark in dissent, was that prison officials discouraged such requests by maintaining harsh conditions in protective confinement. But Zatler did not claim that the conditions themselves constituted cruel and unusual punishment which led, in part, to his losing the case.[11] In a word, the court found that Wainwright was not guilty of a reckless disregard of Zatler's rights to be free of violence. Obviously, then, when an inmate can prove multiple rapes in multiple facilities in the same jurisdiction and still not win his case, further claims will be greatly deterred.

Despite the difficulty an inmate will have in succeeding on a constitutional claim, prison officials still must be alert to the sex offender who enters the system. There should be readily available special protective environments or transitional care type placements for these "at risk" inmates. Clearly, protective custody must be available when requested, and it may be insisted upon when prison officials independently determine that an individual is in imminent danger of sexual attack. In those jurisdictions where protective custody space is at a premium, it is imperative that additional "safe space" be created or that an "at risk" inmate be allowed to lock-in his cell as a temporary measure.

Obviously, prison officials should not act in a way to create or heighten the risk for a sex offender. In one recent case, a prison counselor apparently posted a list of sex offenders in connection with a treatment program.[12] It should have been clear that the list would get around the prison, and while the federal judge declined to take action, finding that the plaintiff was in protective custody, he cautioned prison officials about their duty to safeguard an inmate's personal safety.

Prison officials, well aware of the risk to certain sex offenders, must be especially cautious about safeguarding this type of information. Where treatment programs exist, the programs should be offered in such a way that other inmates will not know of the nature of the group or individual treatment activity. Inmates in the group are not likely to give themselves away, so cautionary measures need to be directed at others.

As a final note, in this brief chapter we have looked only at an inmate's claim to protection due to his sex offense or sexual orientation. The prison owes "at risk" inmates special protection, but this of course is not treatment. Protection may be a form of quarantine but is not any type of positive intervention aimed at change or symptom relief.

Obviously, protection can be more, and as a matter of policy, conditions should not be so bad as to discourage use of protective confinement. We should not confuse protective measures for the sex offender, however, with treatment interventions for such offenders.

Footnotes

1. See Zatler v. Wainwright, 802 F.2d 397 (11th Cir. 1986) and cases cited therein.
2. People v. Fellman, 405 N.Y.S.2d. 210 (N.Y. Sup. Ct. 1978).
3. 405 N.Y.S.2d, at 212.
4. People v. Superior Court, 230 Cal. Rptr. 890, 894 (1986). The trial judge also indicated that he relied on a lack of a substantial prior record and the fact that the defendant's distinctive surname is the same as a local District Attorney with a hard-liner reputation.
5. Ibid., at 896. One technique, used with success in some prison systems, is to place a sex offender in a closely observed dormitory setting during initial reception and classification. This allows prison officials to determine how the inmate behaves, whether he is at risk and, if so, how the risk is handled, and it is a good check on who knows what about the inmate and the offense.
6. Ibid., at 897.
7. 802 F.2d, at 398. Except for state immunity issues, the same claim could be brought as a tort with a lower negligence burden.
8. Ibid.
9. Ibid., at 402.
10. Ibid.
11. Ibid., at 403 (Clark, J., dissenting).
12. Hollie v. Manville, No. 485-376, (S.D.Ga., May 2, 1986).

The only remote caveat to this position is when the photographs used to create arousal also involve the communal protective interests for the young. The photographs of concern are of value only to the extent that, in a controlled situation, the offender experiences pleasure followed by something painful or disgusting. This is somewhat different than an historical study of erotica or the depiction of masturbatory techniques in a medical textbook. The basic rationale, however, of exempting from criminal punishment the legitimate and controlled use of sexually explicit material remains intact.

In *New York v. Ferber* (1982), the Supreme Court upheld a New York law which criminalizes the use of children in a "sexual performance."[6] Sexual performance includes films and is not limited to obscene material. In the face of a strong First Amendment challenge, the Court reasoned that a State's interest in safeguarding minors is compelling.[7]

> The value of permitting live performances and photographic reproductions of children engaged in lewd sexual conduct is exceedingly modest if not *de minimis*. We consider it unlikely that visual depictions of children performing sexual acts or lewdly exhibiting genitals would often constitute an important and necessary part of a literary performance or scientific or educational work.[8]

Justice O'Connor, concurring, wrote to emphasize that the Court did not hold that New York (and the 20 or so states with similar laws) must except material with serious literary, scientific or education value from the statute.[9] The Justice also wrote that clinical pictures of adolescent sexuality might not involve the type of exploitative abuse targeted by the New York law.[10]

In our situation, there is no question about legitimately prosecuting those who originally took, distributed, or exhibited the photographs. Indeed, criminal proceedings will already have occurred (or the prosecution not pursued for a variety of reasons) before the photographs are available in a treatment program. There simply can be no serious question of commercial exploitation, and where the programs involved represent a decent chance for altering deviant behavior, then any conceivable interest of the state in prosecuting is outweighed by the value of the programs.[11]

Turning to the second question, a possible violation of the as-yet-undefined rights of the juvenile depicted in the photograph, this analysis is much more tentative and the conclusions reached, more speculative. First, no precise civil or criminal case on point has been uncovered. Second, in seeking guidance from others, including the legal advisor for the National Institute of Health, the question presented was deemed novel.[12]

If we assume that there are no statutory requirements that the police destroy such photographs—and therefore do not establish a reference point for the creation of a tort on behalf of the subject—then we must look to the tort of invasion of privacy for an answer.[13]

The relatively new tort of invasion of privacy, first enunciated in 1890, is now recognized in almost every jurisdiction in the United States which has considered the question.[14] The Restatement of Torts,[15] widely emulated in this area, sets forth the following general principles:

1. One who invades the right of privacy of another is subject to liability for the resulting harm to the interests of the other.
2. The right of privacy is invaded by:
   a. unreasonable intrusion upon the seclusion of another, or
   b. appropriation of the other's name or likeness, or
   c. unreasonable publicity given to the other's private life, or
   d. publicity that unreasonably places the other in a false light before the public.

These principles which focus on the revelation of private matters to the public, including the publication of photographs, however, seem inapplicable to the use of photographs in a bona fide treatment program.[16]

While most states have codified the right to privacy,[17] all of the states provide protection only in instances where a person's name, portrait or picture is used for advertising or for trade purposes, without first obtaining the person's consent.[18] These specific statutory privacy measures, however, do not provide relief for the juveniles in the photographs under this analysis simply because there is no publication of their photograph in an advertising or commercial sense.

Many states require that photographs and fingerprints be returned to an accused person upon termination of criminal actions in favor of the accused.[19] There appears to be no analogous requirement to provide for the destruction of obscene materials depicting juveniles which were confiscated by police.[20] If there were, this would create a type of privacy interest for those pictured in the photographs.

Looking at the problem from another angle, if one views the minors depicted in the photographs as victims of a sex crime, they may well be covered under the statutory provisions of some states which seek to protect the privacy of sex crime victims.[21]

Unfortunately, a very circuitous method of analysis must be utilized in order to arrive at any present statutory protection. For example, under New York Civil Rights Law, Sec. 50-b, the identity of any sex offense victim under the age of 18 shall be kept confidential unless otherwise specified by the statute. The designated sex offenses are described in Article 130 of the New York Penal Law and include, among others, sodomy. Obscenity is defined in Penal Law Sec. 235.00.

Chapter 23: Therapeutic Uses of Sexually Explicit Photographs

by Fred Cohen

Abstract

In this chapter, the author explores the use of sexually explicit materials in the behavioral treatment of sex offenders. The courts have ruled that such material is not obscene when used by professionals in a recognized treatment program. However, since these materials were produced as pornography involving real victims who, in the case of children, were being sexually exploited, do these victims have the right to avoid the further invasion of their privacy by insisting that these materials be destroyed when they are no longer needed by the courts? Furthermore, should this be done routinely, even when the victim is never identified? These questions have never been raised in the courts. Computer-created composite pictures can now be produced. In this author's opinion, auditory tapes are more effective and avoid the issue entirely.

Clinicians and others involved with certain aversive treatment techniques have raised two separate yet interrelated questions concerning the use of sexually explicit photographs of young persons. The first question is whether or not the users might be guilty of criminal conduct in the possession and "exhibition" of putatively obscene material. The second and more difficult question relates to whether the subjects in the photographs might suffer legally cognizable harm and possibly collect monetary damages for the unauthorized use of the photographs in question.

Before turning to these two questions, let the author briefly and in oversimplified fashion relate how photographs are often obtained and used. Law enforcement agencies frequently confiscate photographs depicting sexual activity by young persons. While such material quite often is destroyed when it has outlived its evidentiary life, law enforcement agencies may make this material available to persons involved in legitimate sex offender treatment programs.

For example, if the program focuses on homosexual pedophiles, then the offender will be shown a variety of sexually explicit photographs of young males, and when the offender-subject's sexual arousal reaches a given point, a negative stimulus, for example, a putrid smell, will be applied to create negative reinforcement of the fantasy and ultimately the behavior sought to be changed.

Discussions with persons in conducting these behavior modification programs revealed unanimous agreement that if the photographs are obviously touched-up in ways to hide the identity of the youth, then the arousal factor is compromised. New techniques, however, are now available through the use of ordinary home computers which allow photographs to be altered so perfectly that composites may be created with no predictable loss of the power to arouse the offender.[1] Ultimately, this may be the best solution to the second question, but the legal issues involved will be reviewed before that solution is proposed.

Sexually explicit material which may otherwise be obscene and which is distributed to scholars and educators and, in the view of this author, for use in bona fide treatment programs is not subject to criminal prosecution. At the practical level, it seems highly unlikely that material obtained from a local law enforcement agency is later going to be the subject of criminal prosecution. This would be especially true if the user took the additional prudent step of informing the local prosecutor of the arrangement and the uses made of the photographs.

Let's assume the worst case analysis where some irate citizen learns of the arrangement and publicly denounces such a program. What then? As early as 1957, the courts began to deal with similar problems. In *United States v. 31 Photographs* (1957),[2] the government attempted to block the importation of obscene material to be used for scholarly purposes by the Kinsey Institute. The federal court was able to avoid the First Amendment constitutional question by finding that, where otherwise obscene material is imported for the sole use of qualified staff or scholars and held under security conditions, then there is lacking in the material an appeal to prurient interest, a sine qua non for a finding of obscenity.[3]

This federal court, in effect, determined that material is variably obscene, and when otherwise obscene material is used for legitimate scholarly or educational purposes, it loses its obscene quality while retaining its sexual explicitness.

A case which is closer to the problem at issue arose in California in 1962. In *People v. Marler* (1962),[4] there was a prosecution involving the use of admittedly obscene films for experimental treatment purposes on hospitalized sex offenders. On appeal the case presented somewhat subtle legal questions concerning the trial judge's instructions. The appellate court, however, pointed out that admittedly obscene material when measured by the "average person" test may lawfully be distributed when in good faith it is to be used exclusively within a professional group pursuing legitimate professional purposes, where the material is germane to those purposes, and where it is not likely to fall into the hands of others.[5] Very clearly, a bona fide sex offender treatment program, created and staffed by professional persons who are pursuing a generally recognized form of treatment, fits the "scientific" exception to any possible charge of distribution or possession of obscene material.

The only remote caveat to this position is when the photographs used to create arousal also involve the communal protective interests for the young. The photographs of concern are of value only to the extent that, in a controlled situation, the offender experiences pleasure followed by something painful or disgusting. This is somewhat different than an historical study of erotica or the depiction of masturbatory techniques in a medical textbook. The basic rationale, however, of exempting from criminal punishment the legitimate and controlled use of sexually explicit material remains intact.

In *New York v. Ferber* (1982), the Supreme Court upheld a New York law which criminalizes the use of children in a "sexual performance."[6] Sexual performance includes films and is not limited to obscene material. In the face of a strong First Amendment challenge, the Court reasoned that a State's interest in safeguarding minors is compelling.[7]

> The value of permitting live performances and photographic reproductions of children engaged in lewd sexual conduct is exceedingly modest if not *de minimis*. We consider it unlikely that visual depictions of children performing sexual acts or lewdly exhibiting genitals would often constitute an important and necessary part of a literary performance or scientific or educational work.[8]

Justice O'Connor, concurring, wrote to emphasize that the Court did not hold that New York (and the 20 or so states with similar laws) must except material with serious literary, scientific or education value from the statute.[9] The Justice also wrote that clinical pictures of adolescent sexuality might not involve the type of exploitative abuse targeted by the New York law.[10]

In our situation, there is no question about legitimately prosecuting those who originally took, distributed, or exhibited the photographs. Indeed, criminal proceedings will already have occurred (or the prosecution not pursued for a variety of reasons) before the photographs are available in a treatment program. There simply can be no serious question of commercial exploitation, and where the programs involved represent a decent chance for altering deviant behavior, then any conceivable interest of the state in prosecuting is outweighed by the value of the programs.[11]

Turning to the second question, a possible violation of the as-yet-undefined rights of the juvenile depicted in the photograph, this analysis is much more tentative and the conclusions reached, more speculative. First, no precise civil or criminal case on point has been uncovered. Second, in seeking guidance from others, including the legal advisor for the National Institute of Health, the question presented was deemed novel.[12]

If we assume that there are no statutory requirements that the police destroy such photographs—and therefore do not establish a reference point for the creation of a tort on behalf of the subject—then we must look to the tort of invasion of privacy for an answer.[13]

The relatively new tort of invasion of privacy, first enunciated in 1890, is now recognized in almost every jurisdiction in the United States which has considered the question.[14] The Restatement of Torts,[15] widely emulated in this area, sets forth the following general principles:

1. One who invades the right of privacy of another is subject to liability for the resulting harm to the interests of the other.
2. The right of privacy is invaded by:
   a. unreasonable intrusion upon the seclusion of another, or
   b. appropriation of the other's name or likeness, or
   c. unreasonable publicity given to the other's private life, or
   d. publicity that unreasonably places the other in a false light before the public.

These principles which focus on the revelation of private matters to the public, including the publication of photographs, however, seem inapplicable to the use of photographs in a bona fide treatment program.[16]

While most states have codified the right to privacy,[17] all of the states provide protection only in instances where a person's name, portrait or picture is used for advertising or for trade purposes, without first obtaining the person's consent.[18] These specific statutory privacy measures, however, do not provide relief for the juveniles in the photographs under this analysis simply because there is no publication of their photograph in an advertising or commercial sense.

Many states require that photographs and fingerprints be returned to an accused person upon termination of criminal actions in favor of the accused.[19] There appears to be no analogous requirement to provide for the destruction of obscene materials depicting juveniles which were confiscated by police.[20] If there were, this would create a type of privacy interest for those pictured in the photographs.

Looking at the problem from another angle, if one views the minors depicted in the photographs as victims of a sex crime, they may well be covered under the statutory provisions of some states which seek to protect the privacy of sex crime victims.[21]

Unfortunately, a very circuitous method of analysis must be utilized in order to arrive at any present statutory protection. For example, under New York Civil Rights Law, Sec. 50-b, the identity of any sex offense victim under the age of 18 shall be kept confidential unless otherwise specified by the statute. The designated sex offenses are described in Article 130 of the New York Penal Law and include, among others, sodomy. Obscenity is defined in Penal Law Sec. 235.00.

It states in Sec. 235.00(1)(b): ". . . any material or performance is obscene if it depicts or describes in a patently offensive manner, actual or simulated: sexual intercourse, sodomy, sexual beastiality, masturbation, sadism, masochism, excretion or lewd exhibitions of the genitals . . ."[22] Furthermore, Sec. 235.00(7) states that sodomy means any of the types of sexual conduct defined in Penal Law Sec. 130.00, under which sodomy is defined as a sex offense. Therefore, it may be concluded that a child photographed while engaging in sodomy, actual or simulated, is a victim of a sex offense under Penal Law Sec. 130.00, and such a photograph identifying that child is warranted protection under Civil Rights Law Sec. 50-b.

If one were to consider the applicability of the Federal Civil Rights Act, 42 U.S.C. 1983.25, the requisite state action would be present in the manner in which the photographs were obtained and most certainly in their use in state facilities by state employees. The question, however, for any prospective litigant would be the establishment of the deprivation of "rights, privileges, or immunities secured by the Constitution and laws of the United States."[23]

Although the Court has recognized a constitutional right to privacy, that right has been narrowly confined to the protection of a woman's right to choose between pregnancy and abortion.[24] Indeed, very recently the Court has signaled strongly its reluctance to expand constitutional notions of privacy.[25]

Aside from possible legal sources of protection of privacy or the vindication of invasions thereof, the ethical codes of the medical and psychological professions indicate that the privacy of these children should be protected.[26] Indeed, some therapists have strong religious or moral objections to the use of such photographs. For them, the prospect of litigation is not the issue.

For those without such objections, we are led to conclude that there is no clear answer to the question. Obtaining a written release hardly seems feasible since the users will rarely, if ever, know the subject's identity. On the other hand, the likelihood is slight that a parent or child will actually learn of the use, or in any direct way be harmed by such use.[27]

Returning to a theme raised earlier, the simplest, most economic solution protective of the youngsters and still consonant with treatment needs is to alter the photographs. Computers can scan original photographs, translate images into a pattern of binary numbers, and then produce precisely the composite picture desired by the treatment specialists.[28] Apparently, the majority of images seen in advertising today are not "real." They are computer composites which are completely undetectable as such. The author urges the investigation and adoption of this technique instead of running the risk, however slight, of causing further injury to a young person who already has been victimized.

Footnotes

1. See Ditlea, *Digital Disinformation — Artificial Intelligence*, 9 Omni 26 (Feb. 1987) which describes exactly how this process is completed. This issue will be discussed again below.
2. 156 F. Supp. 350 (S.D.N.Y. 1957).
3. Ibid., at 358.
4. 18 Cal. Rptr. 923 (Cal. App. 1962).
5. Ibid.
6. 458 U.S. 747 (1982).
7. Ibid., at 756-57.
8. Ibid., at 762.
9. Ibid., at 774.
10. Ibid.
11. It is true that one of the evils of child pornography is that the pictures are a permanent record of the earlier exploitation. There is no doubt in the author's mind that the pictures can be, and in most instances should be, destroyed. That is not the problem, however, which the text addresses.

    See also People v. Wrench, 371 N.Y.S.2d 833 (Dist. Ct. Suff. Co. 1975); State v. Piepenburg, 602 P.2d 702 (Utah, 1979), both involving statutory defenses to a charge of possession of obscene materials. The statutes in question are derived from the Model Penal Code, Sec. 251.4(3) providing for the "scientific" exception.

    The statutes of the reader's jurisdiction should be consulted for a similar defense should a question arise.
12. Mr. Robert Lanman did indicate that in the Health and Human Service Regulations, at 45 C.F.R. Sec. 46.102(f), the definition of research on human subjects does not include a child in a photograph, the child not being the subject of the program.
13. It is not clear whether a law enforcement agency must destroy pornographic or obscene pictures that have been confiscated. N.Y. Penal Law Sec. 400.05 (McKinney's 1980) provides for the destruction of weapons and dangerous instruments, appliances and substances. There is no specific statute regarding the destruction of pornographic materials. A member of the New York State Police indicated that there are New York State Police internal practices which regulate the destruction and preservation of confiscated pornographic materials.

    Statutes in other states handle this topic differently. See, e.g., Conn. Gen. Stat. Ann. Sec. 53a-205 (West 1985) (specifically discusses destruction of obscene materials); Mass. Ann. Laws Ch 276 Sec. 3 (Michiee/Law. Co-op. 1980) (disposition of all property seized); N.J. Stat. Ann. Sec. 2C:64-1, 6 (West 1982) (disposition of any illegal property).
14. See Restatement (Second) of Torts, Sec. 652A, Comment A (1965).
15. Ibid.

16. The four sections of the Restatement noted in the text do not cover the facts of our problem. Comment C to this same section of the Restatement, however, indicates that "nothing in this Chapter is intended to exclude the possibility of future developments in the tort law of privacy."

    Restatement (Second of Torts, Sec. 652A, comment C (1965).
17. See below Chapter 23, note 18.
18. See, E.G., N.Y. Civil Rights Law Sec's 50, 51 (McKinney's 1976).
19. See, e.g., N.Y. Crim. Proc. Law Sec. 160.50 (McKinney's Supp. 1987); Eddy v. Moore, 487 P.2d 211 (Wash. 1971).
20. See above Chapter 23, note 13, the Massachusetts statute.
21. See, e.g., N.Y. Civ. Rights Law Sec. 50-b (McKinney's Supp. 1987). While child pornography is not one of the four sex offenses defined in N.Y. Penal Law Sec. 130, child pornography is described in N.Y. Penal Law Sec. 263.00. Specifically, Sec. 263.00(3) describes the sexual conduct which may be involved in the photographs or other materials. Some are identical to the acts and offenses described in N.Y. Penal Law Sec. 130. Therefore, it may be said that these minors, if such acts are involved in the photographs, are the victims of a sex offense in New York and that these identifying photographs are private and should not be disclosed to anyone unless such action satisfies certain statutory elements not relevant here.

    Very clearly, there is no issue here of the subject having consented to the photographs and therefore somehow waiving future objections. Consent, even if the youth is old enough to give valid consent, is no defense to the offense (and would not be valid either as a civil waiver).
22. New York Penal Law Sec. 235.00(1)(b).
23. See C.D. Robinson, *Legal Rights, Duties, and Liabilities of Criminal Justice Personnel: History and Analysis*, 97 (1984).
24. See Griswold v. Connecticut, 381 U.S. 479 (1965); Roe v. Wade, 410 U.S. 113 (1973). Also see Note, *Developments in the Law — The Constitution and the Family*, 93 Harv. L. Rev. 1156 (1980).
25. See Bowers v. Hardwick, 106 S. Ct. 2841 (1986).
26. Even when preparing a training videotape on psychotherapy, a clinician is urged to protect the identity of persons other than the patient under American Medical Association Principles of Ethics, Section 4. Therefore, one may ask, why should they not attempt to protect the privacy and identity of the juvenile in the photograph that the clinician may be using. See American Psychiatric Association, *Opinions of the Ethics Committee on the Principles of Medical Ethics* 21-22 (1983).
27. One problem was raised at the NIC special issue seminars. Suppose an offender in a treatment program is released and either stalks or stumbles upon a youngster whose picture was used in treatment and suppose further that the offender sexually molests the youngster. Could it be said that the use of the picture caused the new offense? Is the state liable if only simple negligence is made out?

    A successful law suit on these facts would be improbable but not impossible.
28. See Ditlea, above Chapter 23, note 1.

Part Six:
Annotated Bibliography

Abel, G.G., Blanchard, E.B., & Becker, J.V. (1978). An integrated treatment program for rapists. In R. Rada (Ed.), *Clinical aspects of the rapist*. New York: Grune & Stratton.

A good rationale for the use of behavioral techniques to alter sexual arousal patterns. Also argues for a comprehensive approach to treatment with attention given to social skills and anger management.

Abel, G.G., Becker, J.V., Murphy, W.D., & Flanagan, B. (1981). Identifying dangerous child molesters. In R. Stuart (Ed.) *Violent behaviors: Social learning approaches to prediction, management and treatment*. New York: Brunner/ Mazel.

A very practical and clear article on performing and analyzing physiological assessments.

Amir, M. (1971). *Patterns in forcible rape*. Chicago: University of Chicago Press.

An interesting sociological and criminological analysis of sexual assault. Statistics are now out of date, but analysis of "culture of violence" represents a relevant perspective.

Barlow, D.H. (1974). The treatment of sexual deviation: Toward a comprehensive behavioral approach. In K.S. Calhoun, H.E. Adams & K.M. Mitchell (Eds.), *Innovative treatment methods in psychopathology*. New York: Wiley.

Introduces the idea that simply modifying sexual arousal is insufficient as a treatment approach to sexual aggression and diversity and stresses that other skill deficits, such as social skills deficits or impulse and anger control problems, must also be addressed.

Barlow, D.H., & Abel, G.G. (1981). Recent developments in assessment and treatment of paraphilias and gender-identity disorder. In W.E. Craighead, A.E. Kazdin & M.J. Mahoney (Eds.), *Behavior modification: Principles, issues and applications* (2nd ed.). Boston: Houghton Mifflin.

Another rationale for and overview of behavioral assessment and treatment procedures.

Brownell, K.D., Hayes, S.C., & Barlow, D.H. (1977). Patterns of appropriate and deviant sexual arousal: The behavioral treatment of multiple sexual deviations. *Journal of Consulting and Clinical Psychology, 45*, 1144-1155.

A case study of the use of behavioral procedures to modify multiple sexual deviations in a single individual.

Brownmiller, S. (1975). *Against our will: Men, women and rape*. New York: Simon and Schuster.

A provocative view of sexual assault based on a radical feminist perspective.

Burgess, A., & Holmstrom, L. (1974). *Rape: Victims of crisis*. Bowie, MD: Robert J. Brady Co.

Summation of views of authors who were among the first to focus professional attention on the rape victim and her treatment.

Carnes, P. (1983). *Out of the shadows*. Minneapolis, MN: CompCare Publications.

Carnes provides a compelling description of the phenomenology of the sexual offender. Men who have sexually abused others consider the depiction of the compulsive aspect of sexual offenses contained in this book to be an accurate portrayal of their experience.

Chaney, E.F., O'Leary, M.R., & Marlatt, G.A. (1978). Skill training with alcoholics. *J. Consulting and Clinical Psychology*, 46:1092-1104.

This publication introduces an assessment technique known as the Situational Competency Test, initially used to evaluate coping skills of substance abusers. It has been revised for use with sex offenders, and it appears to those using the Relapse Prevention theory that response latency, blocking, and elaboration details may be related to an increased likelihood of relapse.

Conrad, S.R., & Wincze, J.P. (1976). Orgasmic reconditioning: A controlled study of its effect upon the sexual arousal of adult male homosexuals. *Behavior Therapy, 7*, 155-166.

A well controlled outcome study of the effects of orgasmic reconditioning in which the authors conclude that, by itself, the procedure is suspect.

Cook, M., & Howell, K. (1981). *Adult sexual interests in children*. London: Academic Press.

Interesting overview of pedophilia which includes articles on theory, treatment and sociological implications.

Finkelhor, D. (1984). *Child sexual abuse: New theory and research*. New York: The Free Press, a division of MacMillan, Inc.

Highly readable report of a new theory based on an extensive study with implications for treatment and prevention.

Foote, W.E., & Laws, D.R. (1981). A daily alteration procedure for orgasmic reconditioning with a pedophile. *Journal of Behavioral Therapy and Experimental Psychiatry, 12*, 267-273.

A good description of the fantasy alteration procedure for altering sexual arousal.

Fortune, M. (1983). *Sexual violence*. New York: Pilgrims.

An outstanding analysis from a pastoral counseling perspective. Includes theory and suggestions for counseling victims, families and offenders.

Freeman-Longo, R., & Wall, R. (1986). Changing a lifetime of sexual crime. *Psychology Today*. 20:58-62.

Describes therapeutic interventions that are employed in a sex offender treatment program at Oregon State Hospital. The efficacy of therapy in diminishing the relapse rates of sexual offenders is discussed.

Freud, S. (1919). A child is being beaten: A contribution to the study of the origin of sexual perversions. In S. Freud (Ed.) *Collected papers, Vol. 2*. London: International Universities Press.

Historically interesting psychoanalytic study.

Gebhard, P., Gangnon, J., Pomeroy, W., & Christenson, C. (1964). *Sex offenders: An analysis of types*. New York: Harper & Row.

Historically interesting analysis of typologies.

Gil, E. (1983). *Outgrowing the pain*. Walnut Creek, CA: Launch Press.

A book for and about adults abused as children. Easy reading materials, appropriate for offenders to read.

Greer, J. (1983). *The sexual aggressor*. New York: Van Nostrand & Rhinehold.

Extremely interesting collection of articles focused on therapeutic interventions with highly specific directions on setting up and conducting physiological assessments.

Groth, A.N. (1979). *Men who rape: The psychology of an offender*. New York: Plenum Press.

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Guttmacher, M.S. (1951). *Sexual offenses: Problem, causes and prevention*. New York: Norton.

Historically interesting analysis.

Justice, B., & Justice, R. (1979). *The broken taboo*. NY: Human Sciences Press.

An excellent analysis of incest, with an interesting classification of offenders. Deals at length with family dynamics.

Karpman, B. (1954). *The sexual offender and his offenses: Etiology, pathology and treatment*. New York: Julian Press.

A radical book for its time in terms of advocating treatment. Includes a useful, lengthy social history interview.

Kelly, R.J. (1982). Behavioral reorientation of pedophiliacs: Can it be done? *Clinical Psychology Review, 2*(3), 287-408.

A review of 32 studies since 1960 using a variety of behavioral procedures to alter sexual arousal in pedophiles which concludes that, despite some methodological issues, behavioral procedures seem to be effective.

Kilman, P.R., Sabalis, R.F., Gearing, M.L., Bukstel, L.H., & Scovern, A.W. (1982). The treatment of paraphilias: A review of the outcome research. *Journal of Sex Research, 18*(3), 193-252.

A methodological evaluation of studies involving the treatment of multiple and singular sexual paraphilias in which issues in treatment planning are discussed.

Knopp, F.H. (1984). *Retraining adult sex offenders: Models and methods*. Syracuse: Safer Society Press.

An extremely useful review of model treatment programs. The index contains a collection of forms and treatment suggestions which are invaluable to the clinician.

Langevin, R. (1983). *Sexual strands: Understanding and treating sexual anomalies in men*. Hillsdale, NJ: Lawrence Erlbaum Associates.

Provides a highly documented analysis of the men who engage in sexual abuse, an excellent reference for anyone who wishes to gain greater understanding of men who abuse.

Lanyon, R.I. (1986). Theory and treatment in child molestation. *Journal of Consulting and Clinical Psychology, 54*(2), 176-182.

A more recent review of theory and treatment in child molestation which revises Groth's fixated-regressed typology.

Laws, D.R., & O'Neil, J.A. (1981). Variations on masturbatory conditioning. *Behavioral Psychotherapy, 9*, 111-136.

Reviews orgasmic reconditioning literature and suggests alternatives, including the daily fantasy alteration method.

Laws, D.R., Meyer, J., & Holmen, M.L. (1978). Reduction of sadistic sexual arousal by olfactory aversion: A case study. *Behavior Research and Therapy, 16*, 281-285.

A case study showing the effects of olfactory aversion to reduce sadistic sexual fantasies.

Maletzsky, B.M. (1974). "Assisted" covert sensitization in the treatment of exhibitionism. *Journal of Consulting and Clinical Psychology, 42*, 34-40.

Introduces the rationale and procedures of assisted covert sensitization.

Marlatt, G.A., & Gordon, J. (1980). Determinants of relapse: Implications for the maintenance of change. In P.O. Davidson & S. M. Davidson (Eds.) *Behavioral medicine: Changing health lifestyles*. New York: Brunner/Mazel.

Concept of Relapse Prevention created by G.A. Marlatt for use with substance abusers. This chapter discusses factors that precipitate reoffenses in a variety of compulsive behavioral disorders. On the basis of the identified risk factors, appropriate treatment interventions are proposed.

Marlatt, G.A., & Gordon, J.R. (1985). *Relapse Prevention*. New York: Guilford Press.

In the most comprehensive work concerning Relapse Prevention, Marlatt and Gordon present the theoretical basis of their model for maintaining behavioral change. Assessment and treatment techniques are covered generally. Chapters are dedicated to specific behavioral disorders such as alcohol, overeating, and gambling.

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Pithers, W.D., Buell, M.M., Kashima, K., Cumming, G.F., & Beal, L.S. (1987). Precursors to sexual aggression. Paper presented at the Association for the Behavioral Treatment of Sexual Abusers. Newport, OR.

Events preceding commission of sexual offenses are reported in this paper. In addition to analyzing precursors to sexual aggression, the authors examine the effectiveness of Relapse Prevention in assisting parole and probation supervision of sex offenders.

Pithers, W.D., Kashima, K., Cumming, G.F., Beal, L.S., & Buell, M.M. (1987). Relapse prevention of sexual aggression. Paper presented at the New York Academy of Sciences, New York City.

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Presents the first comprehensive coverage of the modification of Relapse Prevention for sexual offenders.

Quinsey, V.L., & Marshall, W.L. (1983). Procedures for reducing inappropriate sexual arousal. In J.G. Geer & I.R. Stuart (Eds.), *The sexual aggressor: Current perspectives on treatment*. New York: Van Nostrand Reinhold.

An excellent review of a variety of procedures for treating the sex offender, which deals with the issues in practical as well as theoretical terms.

Salter, A. (1987). *Treatment of child sexual abuse*. Beverly Hills, CA: Sage Press.

In this excellent volume, Dr. Salter reviews literature concerning the incidence of child sexual abuse, reviews changes in philosophy about child sexual victimization, and discusses assessment and treatment techniques for victims and offenders. In appendices, the author provides copies of questionnaires commonly used in evaluation of offenders.

Schrenck-Notzing, A. (1895). *The use of hypnosis in psychopathia sexualis*. New York: Institute for Research in Hypnosis Publication Society and Julian Press.

Probably the first article published on treating the paraphiliac.

Sturgeon, V.H., & Taylor, J. (1980). Report of a five-year follow-up study of mentally disordered sex offenders released from Atascadero State Hospital in 1973. *Criminal Justice Journal*. 4:31-63.

Recidivism rates of offenders released from treatment at California's Atascadero State Hospital, or without treatment from California's prisons, are compared. Data presented by offender subtype. Generally, untreated offenders manifested twice the recidivism rate of men who had participated in treatment. As with any research project, methodological shortcomings impair the conclusiveness of the findings.

Stoller, R.J. (1975). *Perversion: The erotic form of hatred*. New York: Random House.

An interesting Jungian analysis of the problem.

Yochelson, S., & Samenow, S. (1976). *The criminal personality. Vol. 1: A profile for change*. New York: Jason Aronson.

Introduces a new approach to the treatment of individuals who engage in repetitive criminal acts. Rather than blaming sociological or familial factors, authors propose that criminals engage in "thinking errors" that enable them to justify abuse of others. Primary thinking errors of criminals are then delineated. Methods for assisting offenders in altering their thinking patterns are briefly discussed.

Part Seven: Glossary

Abreactive: The release of emotional tension through some type of therapeutic process, usually relating to the repression of a traumatic experience.

Abstinence Violation Effect: In Relapse Prevention theory, the diminishing of self-esteem and change in self-definition which come about when an individual begins the relapse process.

Addictive: A behavior to which a person becomes so habituated that cessation causes severe physical or emotional reaction.

Akathisia: Extrapyramidal side effect of certain psychotropic medications, distinguished by severe muscular rigidity.

Anectine™: Trade name for succinylcholine chloride, a drug which has been used in aversive conditioning techniques.

Antiandrogenous: Medications which lessen the production of androgen, the male sex hormone.

Anticholinergic: Pertaining to, acting as, or caused by a cholinergic blocking agent.

Apparently Irrelevant Decisions: In Relapse Prevention theory, the decisions which an offender makes which bring him into High Risk Situations.

Apomorphine: An alkaloid derived from morphine and used as an emetic. Has been used in aversive conditioning techniques.

Assertiveness: To behave in a manner which is affirmative and confident in order to meet one's needs.

Aversive: A conditioning technique which pairs a stimulus with a distasteful or repugnant reinforcement; also referred to as "counterconditioning."

Bestiality: A sexual deviation in which an individual derives primary gratification from sexual contact with animals.

Bibliotherapy: A therapeutic technique in which the client is assigned books related to his/her disorder to read and discuss.

Castration: The removal of the testes.

Catharsis: A therapeutic process usually related to psychoanalysis that releases pent-up emotions.

Cognitive Distortion: In Relapse Prevention theory, the use of thinking errors or rationalizations to justify sexually deviant behavior.

Compulsive: A behavior which an individual feels compelled to perform.

Confrontational: A style of therapy which stresses openness, honesty and direct challenge to psychological defenses.

Contingencies: Events, rewards or reinforcers which are dependent upon the fulfillment of certain conditions.

Depo-Provera™: Trade name for medroxyprogesterone acetate, occasionally used in sex offender treatment.

Desensitization: A behavioral technique involving the process of making a client less sensitive to or physiologically reactive to an external stimulus. Covert desensitization is a process in which sex offenders learn to match deviant sexual fantasies with negative images to reduce sexual arousal.

Deviancy: Any condition which departs from the norm; sexual deviancy is sexual behavior which is either illegal or against social mores in relation to the nature of the act or certain characteristics of the victim.

Deviant cycle: The identified set of precursors which precede deviant behavior.

Didactic: Therapeutic techniques which utilize teaching or lecture methods.

Disinhibitors: Internal and external stimuli which may serve to release certain types of physical, psychological or behavioral reactions.

Disinhibitory: The process of releasing certain physical, psychological or behavioral reactions.

DSM-III and DSM-III, Revised: The *Diagnostic and Statistical Manual* of the American Psychiatric Association is the official handbook for diagnosing and classifying mental illness.

Dyskinesia: Any abnormal or disordered movement, particularly affecting the extrapyramidal system, such as with phenothiazine intoxication.

Dystonia: Disorder of or lack of tonicity.

Emetic: Medication which induces vomiting.

Eugenics: The science of improving a species through the study of genetics.

Exhibitionism: A sexual deviation in which an individual gains sexual gratification from exposing his genitals to strangers.

Evisceration: The process of disemboweling.

Fellatio: Oral stimulation of the male genitalia.

Fixated pedophile: An individual who has an exclusive sexual preference for children.

Fixation: An arrest of development at an earlier stage of life, usually caused by some sort of trauma.

Forensic: Pertaining to or connected with the criminal justice system, as in forensic psychology, which is the study of criminal behavior.

Frottage: Indecent liberties.

Frotteur: An individual who gains sexual gratification from illicitly touching others.

FTCA: Federal Tort Claims Act.

High-Risk Situations: In Relapse Prevention theory, a set of circumstances which threaten the individual's sense of self-control and thus increase the risk of relapse.

Hysteria: A mental state characterized by emotional outbursts, as well as a variety of other psychiatric symptoms.

Iatrogenic: A disorder which is caused by a treatment technique.

Imagery: The use of mental images in a variety of therapeutic techniques, including behavioral conditioning and relaxation techniques.

Impotence: The sexual dysfunction in males which impairs erectile capacity.

Incest: Sexual activity between individuals who are so closely related that marriage is forbidden.

Inhibitors: Internal or external stimuli which may produce inhibition of certain physical, psychological or behavioral reactions.

Inhibitory: The process of blocking or holding back of physical, psychological or behavioral reactions.

Inoculation: To build up immunity to a disease or condition by exposing the client to small forms of the disease; e.g., stress inoculation is a form of stress management which teaches the client to cope with small amounts of stress so that he can utilize the technique to cope with larger amounts of stress.

Ipecac: A drug made from the roots of South American rubraceous plants which induces vomiting.

Intrusiveness: The degree to which a treatment technique invades one's emotional or physical self.

In vivo: A conditioning technique in which an individual practices a behavior in as realistic a setting as possible and is given appropriate reinforcement, either positive or negative.

JCAH: Joint Commission on the Accreditation of Hospitals is an organization which evaluates and accredits hospitals.

Lascivious: Relating to lewdness, expressing lust.

Lack of Coping Response: In Relapse Prevention theory, the failure to deal with a lapse in a constructive manner.

Lobotomy: The surgical alteration of a part of the brain, usually the frontal lobe, to alter behavior.

Malingering: To fake an illness in order to gain some benefit.

Masochism: A sexual deviation in which a person derives gratification from having pain inflicted on himself/herself.

MDSO: Mentally Disordered Sex Offender.

Milieu Therapy: Any therapeutic technique which attempts to mold all aspects of the environment so that they support and reinforce the recovery process.

Neuroleptic: Pertaining to actions of a drug that overall result in improvement of patients with mental disorders.

Paraphilias: Sexual deviations.

Penile Plethysmograph: A device used to measure penile erection in response to various sexual arousal stimuli.

Phenothiazines: Major tranquilizers usually used in the treatment of psychoses.

Pre-assault cycle: The pattern of behaviors which precede deviant behavior.

Preferential pedophile: An individual who has an exclusive sexual attraction to children.

Problem of Immediate Gratification: In Relapse Prevention theory, the stage in the relapse cycle when the offender remembers the positive outcomes of his sexually deviant behavior and forgets the negative ones.

Prognosis: The probable course of a disease or condition.

Prolixin™: Trade name for fluphenazine hydrochloride, a phenothiazine derivative used in the treatment of psychotic disorders.

Prurient: Related to lasciviousness or lust.

Psycho-Educational: A technique which utilizes a didactic approach, including lectures and homework assignments, to teach coping skills.

Psychometrics: The process of using psychological tests to evaluate mental and personality traits and processes.

Psychosis: A severe form of mental illness characterized by impaired reality testing, disordered thought processes, hallucinations, and delusions.

Refractory: A condition which resists an ordinary course of treatment.

Regressed pedophile: An individual who deviates from a pattern of normal sexual adjustment and molests a child or children, usually during a period of stress.

Relapse Prevention: A method for enhancing behavioral self-management and external supervision of the sexual aggressor.

Religiosity: The quality of being religious, especially excessively or ostentatiously religious.

Repression: The rejection from conscious awareness of disagreeable thoughts, feelings or memories.

Rorschach Inkblot Test: A projective test which measures psychological dynamics through the interpretation of responses to a set of inkblots.

Sadism: A sexual deviation in which sexual pleasure is derived from the infliction of pain.

SAR (Sexual Attitude Readjustment): Experiential workshops which examine sexual attitudes through discussions and the use of sexually explicit films.

Satiation: A behavioral technique in which an attraction to a certain activity is diminished by systematically engaging in it to excess, e.g., masturbatory satiation.

SDPA: Sexually Dangerous Persons Act.

Self-centeredness: The quality of being engrossed with one's self.

Self-esteem: Respect for one's self.

Sensitization: A behavioral technique in which an individual is made to react in a highly sensitive way to a stimulus usually in which a negative response is created.

Sexaholics Anonymous (SA)/Sex Addicts Anonymous (SAA): Self-help groups modeled after Alcoholics Anonymous, which use Patrick Carnes' addiction theory of sexual deviation to treat individuals with a variety of sexually compulsive behaviors.

Sexualize: To endow an object or situation with sexual qualities.

Situational pedophile: An individual who, during periods of stress, seeks sexual gratification from children.

Sodomy: Usually refers to anal intercourse; may be used in legal terminology to refer to a variety of sexual acts other than adult heterosexual intercourse.

Succinylcholine: See Anectine™.

Thematic Apperception Test: A projective test in which the personality is evaluated through analyses of stories told about a set of pictures.

Thorazine™: Brand of chlorpromazine, a phenothiazine used in the treatment of psychotic disorders.

Transference: A psychoanalytic term referring to the shifting of one emotion from one person to another, such as from a patient to a therapist.

Triage: To make an initial assessment of the seriousness of a condition.

Valeric acid: An acid derived from the valerian root which has a particularly pungent odor and is used in aversive olfactory conditioning.

Victimization: The process of being made a victim of a destructive or injurious action.

Voyeurism: A sexual deviation in which a person derives gratification from secretly watching sexual activity.

Zoophilia: The condition in which an individual gains sexual satisfaction from sexual contact with animals.

Part Eight: Appendices

Appendix A
PSYCHOLOGICAL EVALUATION

NAME: Mr. A **AGE:** 36 **REFERRAL SOURCE:** Veterans Administration Hospital

REASON FOR REFERRAL: Psychological evaluation relevant for the assessment of sexual deviance

ASSESSMENT PROCEDURE: Psychological interviews, administration of Minnesota Multiphasic Personality Inventory (MMPI) and Thematic Apperception Test (TAT), psychophysiological assessment of sexual responsivity

BACKGROUND INFORMATION: Mr. A, a 36-year-old service-connected veteran, was referred by the Veterans Administration Hospital to the Sex Offender Research and Treatment (S.O.R.T.) Program. Mr. A was referred to the S.O.R.T. Program for psychological evaluation relevant for the assessment of sexual deviance. Mr. A apparently reported deviant sexual urges and insinuated deviant sexual behavior to the psychiatric staff at the VA Hospital.

Mr. A presented himself in a well-groomed, neat, casual fashion for each interview and testing session involved in the assessment procedure. He was generally cooperative during the assessment procedure, but he also appeared to be quite suspicious. He raised some concerns at the outset of the assessment procedure. He wanted to know what the limits of confidentiality were. These limits were explained to him. Also, he wanted a copy of the state laws regarding the release of information. These requests were granted him.

After having his initial concerns about confidentiality and the release of information addressed, Mr. A said he was seeking treatment for deviant sexual urges. Mr. A reported deviant sexual urges directed toward his 2-year-old daughter and 4-year-old son. He stated that he's watched these urges evolve and that he's seeking treatment to prevent himself from acting on these urges. When asked outright by the examiner whether he currently was sexually molesting his children, Mr. A replied that admitting to this would be tantamount to turning himself in and that "the logical answer is 'no'."

Overall, Mr. A manifested a rather restricted range of affective expression during the assessment procedure. From his verbal behavior during the assessment procedure, it appeared that Mr. A uses a very intellectualized coping style. At points during the assessment procedure when Mr. A related some of the more painful, difficult events of his life, however, he appeared to be on the verge of crying. Other impressions concerning Mr. A's behavior during the assessment procedure were that his speech tends to be circumstantial, he rather easily loses his train of thought, he sometimes uses rather peculiar, idiosyncratic expressions, and his style of thinking sometimes appears very unusual.

BRIEF HISTORY: Mr. A was born on June 15, 1948. He is part Choctaw Indian. His father died when he was two; his mother, a teacher, lives in Oklahoma. Mr. A has two older brothers. As a child, Mr. A said he was a quiet, introverted loner. He described his home environment as disciplined but noted that he was not physically abused as a child.

Mr. A said that he was an average student throughout his school years. He attended college on and off between 1967 and 1983; during this interval, he changed his major area of study several times. He received a bachelor's degree in computer science from Southeastern Oklahoma State University in 1983.

Mr. A served in the Army from 1967 until 1972. He said that he considered himself a conscientious objector at the time he was drafted. While in the Army, Mr. A worked as a finance clerk. Though he was stationed in Vietnam for a portion of his time in the Army, he said he experienced no frontline or combat duty.

Concerning his marital history, Mr. A has been married twice to the same woman. Their first marriage began in 1973 and ended in divorce in 1977. Mr. A noted the following factors as contributing to their divorce in 1977. He said his wife was unready and unprepared for marriage; there was frequent interference by his mother-in-law; he was often experiencing considerable physical pain; and he was very independent. During this first marriage, Mr. A and his wife lived in Albuquerque. After their divorce in 1977, Mr. A moved back to MacAllister, Oklahoma to live with his mother. While they were divorced, however, Mr. A and his wife maintained contact. In 1978, they were remarried and lived in Oklahoma. In 1980, Mr. A and his wife had a son. This same year, Mr. A faced accusations raised by the State of Oklahoma of child neglect and/or physical abuse. These accusations apparently stemmed from an incident during which Mr. A slapped his young son in public.

Perhaps contributing to these accusations were some unusual childrearing practices mentioned by Mr. A. For example, he said that his infant son seemed to be disturbed by bright lights, so Mr. A kept the infant blindfolded or covered up. Eventually, after a period during which Mr. A's son was placed in the custody of Mr. A's mother, the accusations were dropped. Around 1981, Mr. A said his wife overdosed on Dilantin, which she was apparently taking because of a history of epileptic seizures. Though Mr. A said his wife has a history of suicidal ideation, it is not clear whether or not this overdose was intentional. Mr. A said his wife hasn't been the same since the overdose: she experiences loss of equilibrium, her eyes flutter up and down, and her handwriting is poor. Mr. A noted, however, that his wife apparently didn't suffer any intellectual deterioration as a result of the overdose. In 1982, Mr. A and his wife had their second child, a daughter. After Mr. A received his college degree in 1983, he and his family moved back to Albuquerque, where he obtained employment as a computer programmer and is still employed.

Mr. A briefly discussed his current marital situation, which sounded rather unpleasant. He and his wife are presently experiencing financial problems, which Mr. A seemingly attributes to his wife's spending habits. He said his household is often untidy because his wife fails to keep up with the housework. The sexual aspect of their marriage is apparently poor, with Mr. A and his wife having sexual intercourse approximately once per month. Mr. A noted that he sometimes seeks sexual relationships with other women because he isn't satisfied sexually by his wife. Concerning the children, Mr. A said his wife has difficulty managing them while he is away. He attributed this to his wife's failure to use discipline. Mr. A described himself as the disciplinarian of the family and said that he sometimes gets "too aggressive" when disciplining his children. As a sort of summary statement about his marital/home situation, Mr. A said he felt like he just lived there.

Mr. A related several things about his medical history and current physical condition. At the age of four, he was struck by an automobile and lost consciousness. He additionally reported a history of duodenal ulcers and prostatitis. Mr. A reported several unusual current physical complaints. He said he is frequently in pain and that the pain is related to weather conditions. Specifically, he reported feeling generally uncomfortable, light-sensitive, and "sunburned" all over when there is a local high-pressure system. Mr. A's comments about how the weather determines his physical condition led the present examiner to suspect that Mr. A suffers from somatic delusions and possibly somatic hallucinations. It should be noted here that Mr. A said he has been previously diagnosed by VA psychiatrists as having a neurotic disorder with hypochondriacal features. This diagnosis is apparently the basis for his service-connected disability compensation.

In regard to his psychological history, Mr. A reported the following information. He described himself as introverted and introspective. He said he experiences some social anxiety, but in a special sense—Mr. A said he feels his actions are often at odds with the rest of society and that this gets him into trouble. Mr. A reported that he experienced "nervous breakdowns" between 1972 and 1977, which he ascribed to difficulties he had in dealing with the Veterans Administration. Mr. A said he felt the VA had twisted regulations and improperly treated him when he was seeking help for his physical and psychological complaints in the 1970's. Mr. A said he withdrew socially and felt irritable, tense, depressed, and demoralized during these nervous breakdowns. Additionally, Mr. A mentioned that he'd been diagnosed as having paranoid schizophrenia around 1976. The circumstances around this diagnosis are unclear, but it appears that he received the diagnosis from a psychiatrist at the VA Hospital in Albuquerque. Mr. A said he was placed on some medications, which he believed were minor tranquilizers, around the time this diagnosis was made. However, he said he discontinued these medications because they were ineffective in alleviating his physical complaints. Mr. A reported that in 1977, he sought psychological treatment at a mental health agency in Oklahoma. He said the personnel at this facility told him he was a "threat" and insisted that he take medications, apparently major tranquilizers. Mr. A took these medications for a time but discontinued them because he felt they were interfering with his functioning. Finally, it should be noted that Mr. A reported no history of suicidal ideation or attempts. Mr. A noted no current suicidal ideation or plans.

Mr. A mentioned several significant facts regarding his sexual history. He reported being sexually molested around the age of 16 by a dentist. Also, around this age he became involved in homosexual activity. He said there were several isolated episodes of homosexual activity and one relatively prolonged homosexual relationship with a neighbor two years younger than he. Mr. A said that around 1972 he began to feel deviant sexual urges, which he apparently believes were the result of a "brainwashing" process he underwent in Army basic training. At that time, he had urges to rape adult women. He described how he had made plans to rape women on the university campus, but he indicated that he'd never taken action on these plans. In 1976, Mr. A was charged with indecent exposure by a female neighbor. The charges were later dropped, but Mr. A admitted to the present examiner that he, in fact, had exposed himself and masturbated while visible to the neighbor woman. Significantly, Mr. A also reported a history of pedophilic activity. Several years ago, he said, on two separate occasions he had fondled 6- to 9-year-old girls while bus riding. Additionally, he noted two other incidents in which he had

fondled or engaged in mutual masturbation with an 11-year-old girl and a 12-year-old girl. About his pedophilic activity, Mr. A said he felt it was precipitated by stress and an inability to satisfy his sexual drive. He also said that his deviant sexual urges seem to be worse in the spring because spring is the "mating season for people."

TEST RESULTS:

TAT. Mr. A's TAT responses included several elements which may be indicative of serious psychological difficulty. Some of his TAT responses were loosely and vaguely constructed; some contained peculiar, idiosyncratic expressions. Mr. A seemed to try approaching the TAT stimuli in a very intellectualized manner. He was occasionally confused by affect-laden TAT stimuli and sometimes he would not speculate about the emotions portrayed in the TAT stimuli. Prominent themes in Mr. A's TAT responses were psychological distress, grief, hostility and interpersonal conflict, and sex.

MMPI. Mr. A's MMPI suggested that he responded frankly to the test items. Furthermore, his MMPI profile was a valid one. Mr. A's MMPI was indicative of an anxious, depressed individual whose coping resources are limited. Individuals with MMPI profiles like Mr. A's are typically described as being impulsive, unpredictable, nonconforming, socially isolated, marginally adjusted, resentful of authority, and distrustful. Furthermore, MMPI profiles like Mr. A's are fairly typical among individuals manifesting sexually deviant behavior as well as paranoid schizophrenia, schizoid personality disorder, paranoid disorders, or antisocial personality disorder. Given the particular configuration of Mr. A's MMPI profile, the likelihood of psychosis and bizarre symptomatology, including paranoid suspiciousness, is relatively high.

Psychophysiological Assessment of Sexual Responsivity. The psychophysiological assessment of sexual responsivity, conducted with a penile plethysmograph, consisted of the following: (1) measurement of Mr. A's erection responses to heterosexual, homosexual, female pedophilic, and male pedophilic slides, and (2) measurement of Mr. A's erection responses to audiotapes describing heterosexual, nonviolent female pedophilic, and violent female pedophilic activities. Mr. A was given instructions either to enhance or suppress sexual arousal during the slide and audiotape presentations. Additionally, he was asked to give a verbal rating of his degree of full erection after each stimulus presentation.

The results of the first part of the assessment indicated that Mr. A became moderately to strongly aroused by heterosexual slides; moderately sexually aroused to homosexual and female pedophilic slides; and only slightly sexually aroused to the male pedophilic slides. Mr. A's ratings of degree of erection correlated highly with the actual measured values. Finally, Mr. A appeared to have some capability, though sporadic, to suppress his sexual arousal during the slide presentations.

The results of the second part of the assessment indicated that Mr. A became strongly sexually aroused to audiotapes describing both nonviolent and violent pedophilic activity. He manifested moderate sexual arousal to the audiotape describing heterosexual activity. Again, Mr. A's ratings of degree of full erection correlated highly with the actual measured values and he manifested a sporadic capability to suppress his sexual arousal.

SUMMARY AND CONCLUSIONS: Mr. A, though presently functioning at a marginal level, seems to be having increasing difficulty coping.

At the moment, it appears as if he is keeping himself relatively psychologically intact through his intellect.

Mr. A reported the following: (1) a history of deviant rape and pedophilic urges; (2) a history of pedophilic behavior with young females; (3) previous exhibitionistic sexually deviant behavior; and (4) current deviant sexual urges directed toward his 2-year-old daughter and 4-year-old son. The interview material and test results suggest that Mr. A may be psychotic, perhaps paranoid schizophrenic. Mr. A appears to manifest somatic delusions and possibly somatic hallucinations, suspiciousness, unusual thinking, circumstantial speech, and easy distractibility. The psychophysiological assessment indicates that Mr. A becomes sexually aroused by deviant female pedophilic stimuli and that his ability to suppress his sexual arousal is sporadic. Given the previous information and lacking any form of therapeutic intervention, Mr. A is at high risk for engaging in deviant pedophilic behavior.

Several factors suggest that Mr. A's children may be currently experiencing neglect and/or physical and sexual abuse. First, Mr. A was reluctant to discuss his current situation until the limits of confidentiality were clearly demarcated. While he has apparently insinuated that he may be engaging in deviant sexual behavior, he realizes that an admission of this would be tantamount to turning himself in. Second, Mr. A said he has previously faced accusations of neglect and physical abuse; he also admitted to being "too aggressive" sometimes when he disciplines his children. Third, neither Mr. A nor his wife appear to be emotionally stable. Fourth, from the way Mr. A described his home, the home environment of his children may

be inadequate. Fifth, Mr. A described some very peculiar childrearing practices, and the likelihood exists that he may be currently using some unusual practices in raising his children.

The recommendations that can be made regarding treatment for Mr. A include the following. Mr. A is seen as being at very high risk for sexual acting-out and probably should be hospitalized and placed on antipsychotic medications. We consider him too disturbed to be seen on an outpatient basis. Behavior modification techniques can be implemented to attempt to reduce his deviant sexual arousal. One anticipated difficulty in treating Mr. A is that he may not comply with a therapeutic regimen.

Appendix B
Minnesota Transitional Sex Offenders Program
TSOP ORIENTATION

The TSOP Orientation Phase is an intensive, four-week therapeutic-educational approach to working with sex offenders. The aim is to open them up, get them talking about and begin treatment of their sexually abusive behavior. Educational material is presented in a variety of mediums on five basic topics.

The model is adaptable to an inpatient or outpatient setting, in a prison, in the community, in a mental hospital or in a day or evening treatment program. The basic idea is to present the material to known sexual offenders, discuss it, and have them apply it to themselves, their crimes and their life situation. The discussion is best accomplished in a small group of seven to nine sex offenders with one or two skilled therapists who are able to deal with the sexual abuse realistically and yet in a way that is supportive to the offender's growth and change.

During the four weeks, the offender will write a thirty-page autobiography and complete several written assignments. The counselor will review the assignments with him either individually or in a small group discussion. Some group discussions will intensely focus on the offender's known sexual assaults. Specific use is made in group of the victim's statements about the assaults as they come from the Pre-Sentence Investigation or Police Reports. Attention in these groups is directed towards labeling the emotional state of the offender and his reasoning that allowed him to justify the assaults at the time he did them. The groups should also be supportive of the man taking full responsibility and openly saying what he did in his sexual assault.

Overcoming denial is unquestionably the hardest and most important part of the treatment process so most of the materials and approaches are aimed at this problem.

There are also a number of written exercises that the offender completes on the reading material. This is in the form of short essay-type answers to written questions. Some of these questions are attached. The questions are designed to focus the man's attention on important points in the written articles and to get him to think about and apply these ideas to himself. The major topics and materials used are listed and described below:

SEXUAL ADDICTION

The main material used here is a book by Pat Carnes entitled *Out of the Shadows*, (formerly *The Sexual Addiction*) published by CompCare Publications, Minneapolis, MN.

The men read chapters 1, 2, 3, 5 & 6:

Chapter 1 The Addiction Cycle
Chapter 2 Levels of Addiction
Chapter 3 The Family and the Addict's World
Chapter 5 The Belief System
Chapter 6 Twelve Steps to Recovery

This material describes in simple terms from the offender's perspective the feelings, impulses and behaviors involved in a sexual addiction cycle. The material is applicable to both child molesters and rapists although it often angers the rapists who are more likely to deny the sexual problems in their behavior.

It gives specific examples of how a preoccupation with sexuality manifests itself in seemingly benign activities, such as pornography, prostitutes, fetishes, peeping or promiscuity. The book shows how these preoccupations can progress to more serious sexual assaults which then bring people into trouble with the law. It also touches on the impact the sexual addiction has on the family and on the steps to recovery which are similar to the AA Steps of Recovery. This is helpful in laying down a philosophy of treatment which involves a lifetime of involvement, if necessary, in a support group after "formal treatment" is completed. Support groups for sexual addicts and/or sex offenders are becoming more and more common in all parts of the country. They are free, run by the men themselves who have finished treatment and often are a valuable adjunct to the therapy process.

We also use a videotape of the Phil Donahue Show in which an addict, his wife, and Pat Carnes discuss sexual addiction and treatment of the problem.

The book and the videotapes present examples of other men and women who have had sexual addiction problems and have learned to control them and stay out of trouble. It gives a hopeful message about the possibilities of being honest with yourself and learning to trust other people.

It is important to review with a counselor written answers the offenders put together. This can be done in a small group discussion, two chapters at a time, by having each man read his answers to the group and in some cases discuss their ideas. This helps them to see similarities between themselves and others, and they do not feel so strange or so alone with their problems. For some settings it is helpful to put this material on video- or audiotape and have the men listen to it. Many men who are illiterate are able to understand the ideas and concepts and apply them to themselves. They can audiotape their answers if they can't write or someone else can write for them.

TYPOLOGY OF OFFENDERS

Sexual Assault of Children and Adolescents, by Ann Wolbert Burgess and A. Nicholas Groth, published in 1978 by Lexington Books, D.C. Heath and Company, Lexington, Massachusetts. Chapter 1.

Men Who Rape, the Psychology of the Offender, by A. Nicholas Groth. Plenum Press, New York, 1979. They read Chapters 1, 2, and 3.

Film: "Acquaintance Rape," from MTI Teleprograms, 108 Wilmot Road, Deerfield, IL 60015; 800/323-5776.

"Incest: The Hidden Crime"—The Media Guild, 118 South Acacia Ave., Box 881, Solano Beach, CA 92075; 714/755-9191.

These readings describe the typology of offenders who assault children and the typology of rapists. It gives case histories and examples and explains the difference between a fixated and a regressed child molester. The chapter talks about the characteristics, problems and feelings of men involved in these kinds of assaults and some of the incidents that preceded or triggered assaults on children, as well as background factors in their lives which predisposed them to develop patterns of assault against children.

The readings on the rapists describe the typology of anger, power and sadistic rapists. The patterns in these types are different and the men usually are able to see themselves in these patterns and case histories. Again questions are answered in writing and then discussed in a group with a counselor. We have found it useful in our therapy groups to mix child offenders and adult sexual offenders. The groups which are heterogeneous as to types of sex offenders function better. It is valuable then to have the men understand all of the different types of sex offenders and the different backgrounds they come from.

"The Acquaintance Rape" films are four eight-minute films dealing with sex role stereotypes, teenage sexuality and miscommunication in dating situations which then lead to sexual assault. These films are excellent for viewing and then group discussion on: What is a rape? Why does it happen? Where are the misunderstandings?

The film, "Incest: The Hidden Crime," shows interviews with family members, how each person felt and what was done once the veil of secrecy was lifted. This gives a good overview of the impact of incest on a family and opens the men up for discussion of their own families and their situation.

These films and others we use carry a heavy emotional impact. They do open the men up, and their ideas and feelings need to be discussed and talked about within a safe and supportive group following the viewing of the films. It teaches the clients to talk about issues and feelings they have long kept hidden. Offenders model the people in the films and books who are talking about sexual abuse, and they experience great relief when they can disclose things they have never told anyone before. The advantage of a group is that they also find out others have hidden similar or worse problems and others feel terrible about their behavior. The shared feelings bond the groups together and prepare them to work in treatment together.

VICTIMIZATION

Films: "The Last Taboo"—MTI Teleprogram
"Shattered"—MTI Teleprograms
"Incest: The Victim Nobody Believes" — MTI Teleprograms
"Not Only Strangers"—Centron Films, 1621 W. 9th, Box 687, Lawrence, KS 66044; 913/843-0400.

Anyone working with this population knows that it is easy for offenders to minimize their actions or the impact their anger has on others or how afraid their families are of them. Rapists fail to understand the long-range impact of a rape on the victim and others.

The films listed above and others are available to help the offenders better understand and feel the impact of their actions on others. These were originally used to sensitize offenders to the feelings of their victims.

We have found the more powerful impact of these films is that the offenders, often for the first time, open up on and identify victimization in their own lives. These are the most powerful and sensitive films we use, and it is important to have a good therapeutic experience following the showing of these films. Like any victim of physical or sexual assault, they need to talk through their experiences of victimization and express anger at their offenders and then resolve or let go of their bitterness. For some we have found this to be a fairly lengthy process. Very often there is obvious connection between what they did in their crimes and what happened to them as victims.

SEXUAL INFORMATION

Films: "A Family Talks About Sex," "The Masturbatory Story." (Unfortunately, these films are no longer available.)

Article: "Orgasmic Reconditioning: Changing Sexual Object Choice Through Controlling Masturbation Fantasies," by John N. Marquis in *J. Behavioral Therapy and Exp. Psychiat., Vol I,* pp. 263-271, Peragmon Press, 1970.

Just talking about sexual issues, ideas and feelings is a large barrier for most sex offenders and many counselors, as far as that goes. Using the explicit words: intercourse, oral sex, anal sex, masturbation, penis, or vagina, is not easy at first. We have found movies again to be helpful in starting this process and opening the clients up for discussion. In this section, we try to present sexuality in a positive or at least neutral light. The movies and readings are meant to openly acknowledge the existence and power of sexuality in their

lives and the need to come to terms with it within themselves. Many of the preceding sections have emphasized the harmful aspects of sexuality, and this needs to be moderated. Neither of these movies is explicit. They do not show nudity or sexual acts.

The movie, "A Family Talks About Sex," shows scenes of families with children from pre-school years through college age discussing sexual questions and issues with their parents. Most of the offenders will, in discussion, reflect on their own childhood and what they were taught about sexuality and how this has influenced them as adults. Most express great concern that they were never able to talk about their sexuality with their parents. In doing this, they open themselves up to discuss their sexuality now in treatment.

The one topic that has proved hardest to approach and talk about with clients and other helping professionals is that of masturbation. It is easier to discuss rape or incest than masturbation. "The Masturbatory Story" deals with the topic in a light, humorous sort of way. It tells of how a young man discovers that earlier injunctions about "blindness" and "insanity" are not true and that masturbation can be a good thing. Especially for a restricted or incarcerated population, it is important to recognize from the start that masturbation is going on regularly and it makes a great deal of difference as to what they are masturbating to.

The article, "Orgasmic Reconditioning," is a bit technical in the beginning and hard for most of them to follow, but it eventually describes a method for changing deviant sexual fantasies to more appropriate sexual fantasies. Many hardened sex offenders are unable to be aroused or ejaculate except to deviant fantasies. Although they may know that this is unhealthy and amounts to practicing for their next crime, they do not know what to do to change their fantasies and arousal pattern. The article explains clearly a process for changing it and gives 11 case histories of clients who applied the method and changed their sexual patterns into a healthier direction. This article should be read, questions answered in a written form and then discussed in a group. Men in our treatment program have said repeatedly that they wish they had known of this when they first came to prison; it would have saved them years of unhealthy practices. It is likely that a large range of men, not just sex offenders, would appreciate knowing more about this and would use the information on reconditioning constructively, with or without help from a counselor.

PSYCHOLOGICAL TESTS

1. CAQII
2. 16PF, FORM C
3. MAT

Available from IPAT, Inc., P.O. Box 188, Champaign, IL 61820; phone: 800/225-4728

4. MSI

Available from Multiphasic Sex Inventory, Nichols and Molinder, 437 Bowes Drive, Tacoma, WA 98466; phone 206/565-4539

5. Hostility-Guilt

Available from Hostility-Guilt Inventory, A.H. Buss and A. Durkee, "An Inventory for Assessing Different Kinds of Hostility," *J. of Consulting Psychology, 21*, 1957, 343-349.

These five psychological tests are used at entrance to the program and after ten months of treatment, when they are getting ready to leave the program. At intake they are taken one-a-day so as not to tire the man out or diminish their effectiveness. Psychological tests should not be used except under the supervision of a trained psychologist but, with this consultation, they can be a useful tool to motivate and direct the client in treatment. Before he takes the test, he is told that a counselor will go over the results with him. He will be shown how he scored in comparison to others, the norms. Sometimes review of testing is just as effective in a small group as individually. Especially if he lives with others who have begun to learn what his behavior is like, they can point out to him what they see socially, behaviorally in his behavior and how this relates to what the test is indicating.

This kind of open approach to psychological testing decreases the mysticism and paranoia about the tests and increases their cooperativeness and interest in the tests. We have had men ask to take the tests at various points to see how they are doing as a check on their progress in therapy. If the counselors or therapists review the testing with their clients, the counselors make better use of the tests also.

The 16PF is a factor analytically derived test which shows how the individual scores on 16 personality variables which are named in straightforward, understandable language. The variables are presented as continuums from shy and inhibited to venturesome and socially bold, or introverted versus extroverted. The continuums are presented as ten scores, from 1 to 10, indicating where the individual falls compared to the sample which standardized the test. This is an easily understandable way to present and discuss normal personality factors. Reviewing testing often helps crystalize needed changes that can become goals for treatment.

Form C of the 16PF is used because the language is at a simpler 10th grade level, which more offenders are better able to understand. This is a well standardized and developed test. More information on it is available from the IPAT Company.

The CAQ Part II is an extension of the 16PF to cover clinical or psychiatric problems. It also reports scales on a continuum of 1 to 10, measuring depression, psychosis, schizophrenia, and neurotic symptoms. It is helpful for detecting mental illness when this is also present and may point to a need for psychotropic medications which would help control psychiatric symptoms to the point where the man can participate in treatment.

The Multiphasic Sex Inventory is a 300-item true/false test developed on sex offenders. It covers all kinds of sexual behaviors such as homosexuality, voyeurism, fetishes, sexual functioning problems, cruising, child abuse, and rape. It is only as accurate as the man will make it. There are several validity scales which compare his answers with his known criminal history. The main advantage of the test is that it systematically asks about areas a counselor might not think of or might be unaware of. It is helpful to go over specific items with the man and ask about new information which he may choose to disclose on the test.

The Motivational Analysis Test is given every three months in the program, and the results are reviewed with the offender in his therapy group. This is a very fluid test which measures changing emotional states in ten areas of motivational drive. Is he more interested in a career or materialistic things? Or living up to his conscience or sexual drive? How are these motivational patterns changing during treatment? The test taps both conscious and unconscious drive states and shows where there might be a conflict between them. The fear scale is particularly useful in indicating a potential for violence. More information is available through the IPAT Corporation.

The Hostility-Guilt Inventory measures the way in which the man expresses his anger; is it verbal or physical? Is it direct or passive, as in sarcasm or ridicule? It is useful in pointing out areas that need to change in treatment.

SUMMARY

Some samples of questions on the reading assignments are attached, as well as an outline for an autobiography. The life story should be started a week or two into the Orientation Phase. There will be more depth and more disclosure if they have first seen some films and done some discussing of the material. They need to know they are in an environment that is safe for disclosing painful, shameful material and that they will be supported for doing this.

Real change in behavior takes more than 30 days and more than just opening up and discussing sexual abuse. The Orientation Phase should be followed by therapy, group or individual, once to three times a week for a year or so. This material is only meant as a beginning for change. It should help pinpoint the specific areas of behavior that need to change to stop the sexual assaults.

If there are questions or you would like more information, call or write:

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Out of the Shadows

Read Introduction and Chapter 1

1. Give an example of a "dramatic moment" for a sexual addict. Was it for you?
2. What are some of the myths which allow the addict to repeat his/her behavior?
3. Name and describe four parts of the addictive cycle. Use yourself as an example. How did you experience each of these stages?
4. Is it possible to have more than one addiction? How do they reinforce each other? What other related addictions have you had?
5. "Recovery from addiction is the reversal of alienation." What is meant by that? What are you doing today to reverse the alienation?

Read Chapter 2

1. When is sexual behavior a binge? How do you know when it crosses the line and becomes a compulsive addiction?
2. Give examples of sexual behavior at each of the three levels of addiction.
3. What is Corollary I? Do you believe it is true? Why?
4. How does sexual behavior between the levels reinforce one another? Give an example.
5. The driving force from each cycle of addiction comes from what?

Read Chapter 3

1. Do you think the Cermak family is very different from most families where incest has occurred? Why or why not?
2. Why has it been helpful to include family members in treatment? In what other fields of treatment has this shown positive results?
3. How do families teach the core belief: "I am basically a bad and unworthy person?" What is the worst threat for a child?
4. How and why do addicts learn not to count on other relationships?
5. How is the fusion between sex and nurturing cemented?
6. Fill out the abuse check list for yourself.

Read Chapter 5

1. What is the key factor in our socialization process that trains men to be rapists?
2. The most effective therapists were those who were able to help their clients do what?
3. How do these beliefs contribute to sex offenses: I must have sex and I am powerless to influence my relationships? Are these beliefs true?
4. What are the beliefs you have had about women and sex? Share these in your group. What others can you think of in your group?
5. What beliefs did the children have about sexuality? How did they learn them?
6. What is the task for the addict in the recovery process?

Rape: Myths and Realities

1. Give several reasons why the public stereotypes men who rape. Do you consider this true today? Why?
2. What is the common misconception in the stereotypes and popular notions in viewing the sexual offender? What, in fact, do clinical studies reveal concerning this misconception?

3. There are three basic ways in which a person gains sexual access to another individual. Name them and give a definition of each. Which ways are familiar to your experience?
4. Why does the author state some offenders are very likely to become repetitive offenders? What do you feel can be done to avoid this happening?
5. State two examples of myths that persist concerning victims. What do you feel should be done to change this situation?
6. What does the author mean by "external objects" and what does this have to do with the behavior of the offender?

Psychodynamics of Rape (Questionnaire)

1. What are the main parts of rape? Is rape the first thought of your sexual desire?
2. Describe the two main approaches used by the anger rapist. What is anger rape?
3. Describe what happens in the development of anger rape. Of the many upsetting events that were pointed out in the articles as to what happens before most assaults, which if any can you relate to your offense? Explain.
4. Why is it important when working with the victim of an anger rape to help them understand and know the underlying reasons of such an offense?
5. The power rapist aim is to capture and control his victim. Describe the three ways the author suggests he may do this. Do any of these fit your offense? Explain.
6. Is the power rapist offense done with a desire for sexual gratification? In this type of rape, is this the offender's first or only offense?

Clinical Aspects of Rape (Questionnaire)

1. What is primary impotency? What is secondary impotency? Which is common during rape?
2. Explain the difference between premature ejaculation and spontaneous ejaculation. What is ejaculatory incompetence?

Article by Marquis

1. What is the physical sign during masturbation that occurs four seconds before ejaculation that means an orgasm is inevitable? Will switching fantasies at this point stop ejaculation?
2. In the method of treating deviant arousal, what is the first step?
3. Would you consider it important with Case One that he learn through masturbation to couple sexuality and tenderness and respect? Why? How had sex conditioned to a "bad girl" messed up his life?
4. Which of these cases did you find most interesting? Why?

AUTOBIOGRAPHY OUTLINE

A. EARLY CHILDHOOD (0-6 YEARS)

1. Where did you live? What kind of work did your mother and father do? How did they feel about their work?
2. What was the religious and ethnic background of your family?
3. Who named you? Why was your name chosen?
4. What is your earliest memory? What are the feelings connected to it?
5. What was it like being a small child in your home? Who was special to you, who cared the most about you?
6. Give the names and birthdates of other children in the family in which you grew up:
   a. How did you get along with them?
   b. What was your place in the family?
   c. How did the parents treat each of the children?
7. Who disciplined you?
   a. How did they do it?
   b. Why did they do it?
   c. How did you feel about the discipline you received?
8. Were there any health problems in your family? Any deaths?
9. Did your family attend church or Sunday School? How often? Did parents attend? What church? How important was religion in the family?
10. How did your family show feelings toward each other? a. Anger? b. Love? c. Closeness? d. Fear?
11. How did your parents get along with each other? What did they enjoy together? What did they fight about? How did they fight? What effect did their relationship have on you then and now?

B. SCHOOL ACTIVITIES (6-19 years)

1. How did you feel when you started school? What was good about school? What was bad about it?
2. Who were your friends at school? What did you do with them? What games or hobbies did you enjoy with other children during grade school years?
3. How did the teachers treat you?
4. Did you enjoy schoolwork? Was any of it hard for you? What subjects?
5. What did your parents want for you in school? Did they want you to do well in sports, schoolwork, or religion?
6. Were there changes in your living arrangements or family during high school years? Financial changes? Deaths? Moves?
7. Did your feelings about school or achievements in school change in your high school years?
8. What friends and/or activities were you involved with during high school years?
9. What kind of future job dreams or plans did you think about in your high school years? What were your goals?

C. SEXUAL DEVELOPMENT

1. When you were very young, what did your parents teach you about sex?

2. When did you start to masturbate? What did your parents tell you about it? What were your feelings about masturbating?
3. Did you have sexual contact with other family members? Who? When?
4. What was your first sexual experience you remember as a child? What were your feelings then?

Adolescence

5. How did you feel about the changes in your body as a teenager?
6. How often did you have sexual feelings and thoughts about sex as a teenager?
7. When did you start to date?
8. When did you start to have sexual contact with others? Male or female?
9. What did you think was the expected sexual behavior of men during your teenage years?
10. What did you think was the expected sexual behavior of women during your teenage years?
11. Who scared or humiliated you sexually? How? When?
12. What was your father's sexual behavior like? How did you feel about it?
13. What was your mother's sexual behavior like? How did you feel about it?
14. What has your sexual behavior been as an adult? When and why have you been involved in sexual relations with other people?
15. How often do you masturbate now? To what thoughts or fantasies do you usually masturbate?
16. Do you sometimes have different kinds of fantasies that you masturbate to? When and what kinds of thoughts or fantasies?

D. ADULTHOOD

1. What schooling or training were you involved in beyond high school? How did you like it and how did you do in it?
2. What kinds of jobs have you had? For how long? How did you like them?
3. When did you get romantically involved with someone for the first time? How did you meet? What was attractive about the person to you? How long did it last? When and how did it end?
4. How many serious relationships did you have before you married? How long did they last? When did they break up?
5. What first attracted you to your wife? Why did you decide to marry? How did the relationship change after you were married?
6. What were the good parts of your marriage? What were the troubles in the marriage?
7. When did you have children? How many? (Names and ages) How did they affect the marriage?
8. Did you or your wife have other sexual relationships? Why? When?
9. Did the marriage end? When? Why?

REPEAT 5, 6, 7, 8 AND 9 FOR ANY OTHER MARRIAGES YOU MAY HAVE HAD.

E. BEHAVIOR THAT BROUGHT YOU INTO TROUBLE WITH THE LAW

1. When and how did you first get involved with the law? What happened?
2. What other things have you been arrested for? When? What happened?
3. Have you served time in other institutions? How long? Where? For what?

4. What was the situation leading up to your most recent sex offense? What was going on in your life? How were you feeling?
5. What was the specific incident that seemed to trigger your sexually assaultive behavior?
6. What did you say and do to your victim? How did you feel about him/her at the time?
7. What did you feel about the victim and yourself after the crime? What did you say to them?
8. What other similar crimes have you been involved with and for how long?
9. Which drugs or chemicals have you abused? For how long? Do you still use or plan on using?

F. TREATMENT

1. What other treatment have you or your family been involved in? For what kinds of problems?
2. What helps you the most in treatment?
3. What do you wish you had done differently? How could you have gotten more from the treatment?
4. What is the most important thing you need now in this treatment? How can we help you get it?

List on a separate piece of paper a minimum of four (4) specific goals that you want to work on in treatment. Consider which part of yourself you need to change that caused your crime. Consider your own goals for the future.

Appendix C
EVALUATION SCHEMES

Evaluation Variables	Types of Measures
I. Pre-Treatment Characteristics	General Demographic Data Offense Characteristics Victim Characteristics Criminal History Attitude to Treatment Education Vocational Substance Abuse Intellectual Measure Social Skill/Adjustment Psychiatric Diagnosis Predictor Equation Questionnaire (Laws, 1984)
II. Service Delivery System	A. Survey of Identification/ Engagement into Treatment Efforts for Sex Offenders in General Population. B. 1. Client Interview 2. Moos Environmental Scales 3. Staff Interview
III. In-Treatment Change	Pre/Post-Tests each Module, e.g., Situational Competency Test Sex Knowledge Inventory Bem Sex Role Inventory Interpersonal Behavior Survey Attitude to Women Scale Novaco Anger Inventory Mosher Sex Guilt Scale Becker Cognition Scale Goal Attainment Scale MMPI CPI Sexual Arousal Patterns
IV. Follow-Up Outcome	General Demographic Data Type of Discharge from Treatment Level of Supervision Type of Legal Contact Type of Arrest Type of Conviction Relative Adjustment Scale (Seiter) Self-Report: Crimes Self-Report: Fantasy Activity

Appendix D
SUGGESTED SENTENCING CONDITIONS FOR SEX OFFENDERS
General Conditions for All Sex Offenders

1. Individual assumes responsibility for paying counseling costs for victims.
2. ALL SEX OFFENDERS—classified as Level 2 supervision, no less than one time per month contact with parole and probation officer.
3. Individual must successfully enroll, participate in and complete a treatment program for sex offenders approved by parole and probation officer.
4. Not possess any type of deadly weapon.
5. Submit to polygraph examination to determine involvement in sexual criminal activity or compliance with parole and probation conditions. These examinations would be periodic, upon parole and probation officer's request.
6. Maintain full-time school and/or employment, as approved by parole and probation officer.
7. Individual should not associate with ex-felons.

Community

1. Not driving alone at night or key times when he would offend. Keep detailed driving log, including time, place and miles.
2. Drive at night only with parole and probation officer's permission and specific destination.
3. No picking up hitchhikers.
4. Not driving with single female unless for a specific reason, e.g., pre-arranged date (usually for rapist).
5. Use of curfew when necessary.

Contact with Children

1. A) No socialization with individuals under the age of 16 in work or social situations unless accompanied by an approved, responsible adult who is aware of the individual's sexual deviancy; or

   B) No contact with males or females under the age of 18.
2. No contact with victim unless approved by victim's therapist and offender's therapist and visits are supervised.
3. Individual will not frequent places where children congregate, i.e., parks, playgrounds, schools, etc.
4. Not live in an apartment complex which allows children or neighborhoods with large numbers of children or neighborhoods near schools, parks, playgrounds, etc. Parole and probation officer must approve residence.
5. No involvement with women who have children without approval of parole and probation officer and therapist.

Conditions Addressing Possible Pre-Assault Behaviors

1. Individual should not view TV shows or motion pictures which are geared towards offender's modus operandi, act as stimulus for offender's deviant cycle, or act as stimulus to arouse offender in deviant fashion, e.g., pedophiles not viewing shows whose primary character is a child.
2. Individual not engage in use of pornography, erotica, or frequent adult book stores, sex shops, topless bars, massage parlors, etc.
3. Individual should not use illegal substances; individual with known alcohol problems not to use alcoholic beverages.
4. Individuals with history of alcohol problems not to frequent bars, taverns and businesses whose primary function is to serve alcoholic beverages.
5. Individual not to associate with alcohol and drug users/ abusers.
6. Individual maintain use of prescribed medications.

7. Any offender with a substance abuse problem will attend and successfully complete a drug and/or alcohol treatment program.

Conditions for Low-Functioning Offenders

1. Attend once a week a verifiable social activity (club, church, etc.).
2. Attend counseling (especially important is relationship counseling).
3. Keep budget of money earned and spent.
4. Keep log of daily activities.

APPENDIX E
TREATMENT LEVEL DESCRIPTIONS
CFFPP Sex Offender Treatment Program

Level 1:

1. You are maintaining good personal hygiene. This means:
   a) Shower, using soap, and shampoo hair at least five times weekly.
   b) Brush teeth daily.
   c) Comb and brush hair daily and get a trim when barber comes, as needed.
   d) Change clothes, top to bottom, after shower; wear socks and slippers or shoes at all times.
   e) Wash clothes after two changes of dirty clothes have accumulated.
   f) Change linen weekly.

   These are responsibilities to yourself and to others, and you may be reminded one time before this is seen as a problem behavior.
2. You are dressing appropriately for all situations. This includes clean pants, shirt, socks and shoes. A coat is to be worn if the weather warrants it. You are to be sleeping in proper sleeping attire.
3. You are keeping your room clean. This includes:
   a) Bed neatly made with fresh linen weekly (more often if necessary).
   b) Nothing under your bed (this is part of the fire code).
   c) Locker cleaned inside and out. Top neatly arranged (not cluttered).
   d) Window sills clean and dusted.
   e) Floors swept daily; mopped weekly.
4. You are assisting in ward clean-up with willingness, without complaining, and doing a thorough job.
5. You are to attend all assigned ward programs and activities (this includes group) without being disruptive. You are expected to be on time, attend group consistently, listen to discussion and express opinions if called on. Schedules are posted on the Bulletin Board. You are to be clean and dressed appropriately for group.
6. Complete first draft of the sexual acting-out scenario on one of each type of sexual crimes. This is to be a complete, specific description of the offense, including, but not limited to:
   1) What were you doing before the offense?
   2) What happened during the offense?
   3) What were you thinking before, during and after the offense?
   4) What were you feeling before, during and after the offense? and,
   5) What did the victim do or say?
7. Regardless of the type of crime, complete the first draft of your clarification letter to the victim(s). (This is to be done even if there is no intent to send the letter.)
8. When the first drafts of the acting-out scenarios and the clarification letter have been completed and approved, you will begin attending Sex Offender Group (SOG). You are to discuss with the group your crime relative to:
   a) Your feelings towards the person/persons involved then and now.
   b) Your attitude and thinking at the time of the crime and any changes since.
   c) How your behavior led to the crime.
   d) Demonstrate insight into the impact on the victim.

9. Read and report on at least one library book. (The book and the report must be approved by the Case Monitor. The report must apply the information in the book to your own personal situation.)
10. Complete mini-module on Thinking Errors.
11. If there are significant others (spouse, girl friend, parents, etc.) involved in your life, set up a time for an initial interview with staff.
12. Each month, identify a behavior you need to change. (This could include one of the general treatment level requirements or specific ones designed for you.) With your Case Monitor, Behavioral Therapist or Group Leader, develop a contract for change. Present contract to Family Group. You should review your progress each week with your Case Monitor, Behavioral Therapist or group.
13. Participate meaningfully in assigned Activity Therapy assignments, groups, modules and activities. This includes being prepared and on time, actively participating and accepting and giving feedback on behaviors and attitudes.
14. You are completing on time and accepting feedback on any additional assignments given you from your groups, Case Monitor, Behavioral Therapist, Activity Therapist, educational module facilitators or other staff members.

During Levels 1, 2 and 3, you must read either *Father-Daughter Incest* or *Hidden Victims* or *Men Who Rape,* in addition to *Inner Child of the Past.*

Level 2:

1. You are to participate meaningfully in prescribed treatment programs. You are expected to pay attention, interact appropriately, contribute appropriate comments voluntarily twice each group meeting, follow directions and clean up after groups without reminders.
2. Begin writing the first draft of your autobiography.
3. You are accepting the responsibility of group wake-up person or assume other responsibility as assigned.
4. Sign in and out each time you leave the ward for groups or walks. Show your name, destination, time left.
5. You are to be on time for medication without reminders.
6. Complete the clarification letter to the satisfaction of the SOG.
7. Begin keeping a daily thinking, feeling and/or fantasy log as assigned. Turn the log in to the Case Monitor or Behavioral Therapist as requested, on time and without reminders.
8. Read and report on at least one more book per Case Monitor or Behavioral Technician.
9. Complete sexual acting-out scenarios per Behavior Therapist.
10. Participate satisfactorily in any behavioral treatment per Behavior Therapist.
11. Successfully complete module on difference between assertiveness and aggressiveness, and giving and receiving feedback.
12. Hold first session between staff and significant other(s).
13. You are to maintain all Level 1 responsibilities without reminders from staff or group members.

Level 3:

1. You are to sponsor a new resident into your group. You need to be available to help new people prepare for group (remind of grooming, time, dress, etc.). You are demonstrating your awareness of routine in group activities and are actively involved.
2. You are to serve on the Ward Council as elected or assume other responsibilities as assigned or elected.
3. You are demonstrating realistic improvement in giving and receiving feedback. You are showing yourself to be an increasingly responsible and mature human being. In group, you share your feelings and thoughts on topics being discussed. You accept responsibility for your own behavior without excuses and appropriately assist others through support and confrontation. Give and receive feedback in group; contribute several times each meeting.

4. You are expected to know security procedures for your ward and all areas which you travel in. You are expected to demonstrate a positive attitude towards security at all times.
5. You are showing self-direction concerning leisure time.
6. Successfully complete Thinking Errors and Anger Management modules when offered.
7. Begin to identify and write out danger cycle thinking and behavior patterns per Case Monitor and Behavior Therapist.
8. You are presenting the first draft of your autobiography to SOG and are accepting feedback regarding more details needed.
9. Read and report on at least two more books per Case Monitor or Behavior Therapist.
10. Interview with staff and significant other(s) dealing with past responsibility of all parties.
11. You are aware of your fiscal responsibilities and are demonstrating mature money management.
12. You are maintaining all responsibilities from previous levels without reminders from staff or group members.

Level 4:

1. In group, you are continuing to play a leadership role and are available to facilitate group members having difficulty. This includes sharing yourself honestly and openly, participating in nearly all discussions in group, model assertiveness in group and bring up relevant issues in group without prompting.
2. You are to present the final draft of your autobiography to group and accept feedback on it.
3. You are continuing to assume leadership roles on the ward. This includes appropriate role-modeling behavior and a positive attitude toward treatment.
4. Complete and present to SOG your danger cycle thinking and behavior patterns.
5. Successfully complete Problem-Solving Module.
6. If substance abuse or dependency has played a part in your antisocial behavior, you will begin attending a community-based AA or NA group.
7. Read and report on at least two books per Case Monitor or Behavior Therapist.
8. At least one more session between staff and significant other(s) is to be held.
9. You are maintaining all responsibilities from previous levels without reminders from staff or group members.

Level 5:

1. You continue to participate openly and actively in group. Take a leadership role in group, giving and receiving feedback, supporting and confronting, facilitating discussion. Lead group when assigned.
2. You will begin attending Transition Group and openly and honestly discuss fears, frustrations and problems dealing with community transition and living.
3. You are developing a transition plan. Your very detailed plans should involve the following:
   a) Housing
   b) Household budget
   c) Mental health, medical and dental aftercare
   d) Probation/parole supervision
   e) Employment
   f) Relationship with family
   g) Leisure time activities
   h) Support groups, both therapeutic and recreational
   i) In the transition planning, thoroughly list all danger cycle thinking and behaviors, and specifically what you intend to do to identify and stop that cycle. Include a specific, continuing self-administered behavioral treatment plan when in the community.

4. Participate in Victim Awareness Program (as available).
5. Participate in a structured empathy assignment.
6. Demonstrate less than 20% arousal to all deviant material in two successive assessments.
7. Demonstrate consistent, adequate response to stress, pressure and frustration.
8. Demonstrate appropriate assertiveness behavior with persons in authority.
9. At least two more sessions with staff and significant other(s) dealing with danger cycle thinking and behavior patterns.
10. Read and report on at least two more books per Case Monitor.
11. You are demonstrating effective time management, prioritizing and problem-solving skills in most aspects of ward and community behavior.
12. You are maintaining all responsibilities from previous levels without reminders from staff or group members.

Level 6:

1. You are continuing to participate in group and are acting as a proper role model.
2. You are now participating appropriately and responsibly in all relevant aspects of community transition.
3. At least one session with the staff and significant other(s) dealing with responsibilities of all parties upon discharge.
4. Complete discharge evaluation, including final Minnesota Multiphasic Personality Inventory (MMPI).
5. You are maintaining all responsibilities from previous levels without reminders from staff or group members.

(FPP6)

Appendix F
MODEL PROGRAMS WITHIN CORRECTIONS

Although the treatment of this population remains at an early developmental stage as a technique and continues to be highly controversial, a number of states have been active in the field for many years and have devoted substantial resources to the development of innovative programs. The type of program developed may depend upon the type of physical facilities available, the characteristics of the prison population, the department's classification system, and the state statutes.

Whether the program will be housed in a maximum, medium, or minimum security prison will impact the type of treatment offered. State laws may limit sex offender's participation in community release programs. This presents a major obstacle as these individuals are particularly in need of transitional programs.

If the individual corrections department decides to segregate sex offenders or to offer a segregated treatment program, there may be both positive and negative repercussions. Segregation is probably the most economical approach as establishing physiological assessment laboratories at a number of institutions could be quite costly. At a segregated program, the entire staff can be specially trained. Correctional officers involved with this population can serve as part of the therapeutic team. The professional staff can devote their full energies to this particular problem. Segregated programs can provide a therapeutic atmosphere. Residents need not be concerned about hiding their crimes or about ridicule or physical assault upon revelation. However, segregated programs may be limited in the range of rehabilitative programs they can offer. The stigma of participating in such a program may be so severe that participants must remain in the program regardless of their adjustment or else serve their time in protective custody. Creative efforts will be needed to overcome these problems and fund suitable alternatives.

Corrections departments are faced with other problems in establishing treatment programs. If the state has indeterminate sentencing, sex offenders will view participation in therapy as a prerequisite to parole. Their participation will be based much more on an interest in gaining their freedom than in treating their problem. They may become quite involved in manipulating the staff and presenting the image of the "ideal patient," as the issue of "freedom" is paramount. Treatment will never succeed with all patients, and inevitably some individuals will leave a treatment program and commit another sex offense. If the media picks up on this, the treatment program may be blamed for recommending release. It is, therefore, imperative that treatment personnel refrain from advocating the parole of participants. Completion of treatment may be rigidly and objectively defined and parole boards continuously cautioned that completion of treatment does not guarantee success in the community. Outside consultants may be used to evaluate treatment progress and parole readiness. While indeterminate sentences have their own set of problems, they also provide the opportunity to keep incarcerated those individuals who are obviously dangerous. They also serve initially to motivate individuals who can respond well to treatment. They may provide more control and more leverage for encouraging appropriate behavior.

Determinate sentencing automatically screens out individuals who see treatment as the path to release because the individual serving a determinate sentence knows he will be released at a specific time, often depending upon accrual of "good time." Treatment programs should be quite cautious about awarding good time for participation as this usually leads to the same manipulation associated with the indeterminate sentence but without the controls. When time is up for this individual, he is released regardless of his potential dangerousness. Since treatment is time-based rather than criteria-based, the failure rate is probably higher. While there is not presently any formal research to confirm this, it would not be unrealistic to assume that a program whose participants must successfully complete a course of treatment would do better than one where some patients complete 100%, some 50%, and some 25% of that program.

There are numerous problems inherent in trying to treat any type of problem in prison, particularly the problems associated with sex offenses. Faye Honey Knopp, in *Retraining Adult Sex Offenders* (1984), points to the attitudes of secrecy, defensiveness, and denial which the prison value system encourages. Idle time to engage in and reinforce deviant attitudes and fantasies is a problem. Expressing emotions or admitting problems is perceived as a weakness. The individual is exposed to a variety of problems which he may not have entered prison with but may have acquired—drug abuse, alcoholism, criminal thought patterns, bitterness and anger towards the system. Prisons encourage dependency, while treatment focuses on responsibility. Prisons often isolate men from women, while treatment tries to facilitate more appropriate interaction with women. Prisons encourage distrust, while treatment encourages trust.

With these inherent problems, one might be tempted to completely abandon the idea of treating the sex offender. However, Freeman-Longo (1986) states that 80% of untreated incarcerated sex offenders recidivate, while the figure is reversed for treated offenders. Mental hospitals may not be able to accommodate sex offenders for either the length of time or at the level of security that the crime warrants. Judges may

resent being placed in the position of having to choose between treatment and incarceration. The community may perceive commitment to a hospital program as the exoneration of the offender. Corrections departments, however, are obligated to respond to all of these situations.

A number of states are involved in sex offender treatment in one way or another, either in prisons or in mental hospitals. However, for a substantial number of offenders, no treatment at all is available. While much more research is needed, there are treatment modalities with demonstrated effectiveness. It remains for individual states to commit the personnel and resources to establishing and supporting sex offender programs. There is also a need for cooperation and communication between established programs to continue to advance techniques in this field.

ALASKA

Fairbanks Treatment Associates offers sex offender treatment to about 40 offenders incarcerated at Fairbanks Correctional Center in an inpatient program and approximately 60 nonincarcerated offenders, some in a halfway house and the remainder in the community. While treatment is offered to a full range of sexual problems and crimes, sadistic offenders or those involved in victim deaths have—to this point—not been accepted. Treatment is offered over a two-year period and includes group therapy based on a structured cognitive-behavioral approach. The program utilizes family reunification therapy where appropriate, as well as some individual therapy. The plethysmograph is used in assessment and treatment.

This program has been in operation approximately two and a half years; no recidivism data is available.

ARIZONA

Arizona offers sex offender treatment in two settings. At the Arizona State Penitentiary at Florence, the Sex Offender Treatment Program operates on a contract with the Youth Services Bureau and treats about 80 sex offenders. These clients are all classified as minimum security and participate in a variety of psycho-educational classes and therapeutic groups. This program can be completed in 18 months and presently reports a recidivism rate of 7%.

Another program for medium security sex offenders is offered at the correctional facility at Tucson, where a staff psychologist conducts individual and group therapy for about 35 clients.

COLORADO

The Colorado Department of Corrections has its Sex Offender Treatment Program in Canon City, with about 162 offenders being treated at the present time. Offering treatment for all types of sex crimes, the program is cognitive behavioral in orientation and divided into two phases. Phase I is a discussion and education group, primarily didactic, lasting 11 months. Phase II, also for a period of 11 months, is a confrontive interactional group, utilizing journal-keeping.

All sex offenders paroled to the Denver or Northeast Parole Regions are placed on specialized supervision, regardless of prior participation in the Sex Offender Treatment Program. Parole officers working with these parolees receive specialized training and work in close cooperation with treatment programs and law enforcement.

No recidivism rates have been determined as yet.

CONNECTICUT

The Sex Offenders Program, Connecticut Correctional Institute in Somers, operates with a nonsegregated group of sex offenders in a maximum security prison. Approximately 150 patients are treated by a staff of 2 professionals and approximately 14 volunteers and trainees. The program includes individual therapy and/or participation in one of nine therapy groups, which may focus on basic group issues, personal victimization, or combatting sexual assault. Psycho-educational components include sex education, understanding sexual assault, victim personalization, interpersonal relations, anger management, and Parents Anonymous groups. Behavioral techniques are not ulilized.

This program reports a 6% recidivism rate.

FLORIDA

The Dr. Geraldine Boozer Rehabilitation Program for Sex Offenders at the South Florida State Hospital in Hollywood, FL is a residential, comprehensive, self-help, therapeutic program operating in its present form since 1972. It is one of the oldest programs of its type in the country.

Offenders are admitted to the program on a voluntary basis from the Department of Corrections. The program operates on a peer-directed, self-help model. The therapeutic core of the program is the "home group" which meets four times a week for an hour. Each group has two peers who function as group leaders; they are selected from the more experienced, more responsible members of the program. They consult regularly with the program clinical psychologist and program director. Numerous other groups are also available, as are chapters of Narcotics Anonymous and AA.

Recreational therapy is available, as well as an educational program for those wishing to pursue further education. For those who have been in the program at least a year, there are special off-the-ward, staff-supervised, therapeutic work assignments.

This program reports a recidivism rate of 7% for those who have successfully completed the program.

ILLINOIS

The STOP program, operating since 1977, is located in Menard, IL, at the Menard Psychiatric Center, a maximum security facility providing services to adult male felons in the

Illinois Department of Corrections. This program treats adult males civilly committed under Illinois' statues as Sexually Dangerous Persons, as well as felons incarcerated in the Department of Corrections volunteering for treatment. Those civilly committed remain in the program until they are determined by the committing circuit court to be no longer sexually dangerous. Volunteer felons participating are either transferred to another correctional facility on completion of the program or released into the community on completion of their sentence.

Currently 41 Sexually Dangerous Persons and 15 volunteers from the Department of Corrections are participating in STOP. Group therapy, with a strong didactic component focused on relationship issues, is the primary treatment modality.

Average length of stay is about five years. Current recidivism rate is 11%.

KANSAS

Sex offender treatment is provided by the Mental Health Unit at the Kansas State Penitentiary in Lansing. At the present time, there are about 25 participants. All types of sex crimes are treated with both individual and group therapy. The program is in two phases, with the initial phase involving written assignments, with feedback to the client given in written evaluations; individual therapy is also utilized. The second phase consists of group therapy, utilizing cognitive restructuring, assertive training, values clarification, role playing, biofeedback, and empathy enhancement.

A study is currently underway to establish the recidivism rate.

KENTUCKY

The 1986 Session of the Kentucky General Assembly passed landmark legislation designed to address the specific mental health treatment needs of the convicted sexual offender. House Bill 535 requires successful completion of a sex offender treatment program for certain specific sex offenders in order to be eligible for parole consideration. The program includes the following components in both institutional and community environments: diagnostic services; assessment and evaluation; and treatment services, including individual, group, and marital/ family therapy, and psycho-educational modules, addressing the specific problems of the sexual offender. Maintaining acceptable behavior, rather than purporting to "cure," is much more feasible when treating the sexual offender.

Continuity between the institution and the community is vital to the success of most released offenders. Likewise, those persons being treated in the free world must have the necessary resources and support available to prevent them from falling again.

MAINE

The Maine State Prison Sex Offender Project began in January, 1981 and has a primary goal of the reduction of sexual assault through management and treatment of offenders. Related goals include community education and consultation to mental health and criminal justice systems' personnel.

Treatment is provided in a maximum-security correctional institution, with follow-up referral to available community programs on release from prison. At the present time, approximately 157 (or 32%) of those incarcerated are identified as sex offenders. Treatment is voluntary; currently 32 offenders (or 20% of the sex offender population) are in treatment.

Offenders participate in a four-month educational class on sexual assault prior to participation in group therapy. Child molesters and rapists participate in separate groups. In addition to group therapy, treatment modules are offered in sex education, skill building in anger management, assertiveness training, and social skills, as well as individual therapy to begin resolution of personal victimization issues, and family/couples therapy. Referrals for substance abuse education and counseling and/or medical referral for antiandrogenic therapy can also be provided.

Average length of stay is two to three years, although there are some offenders still in the program, which began in 1981. Currently, eighteen individuals have completed at least two years of treatment and been released, with two having reoffended.

MASSACHUSETTS

The Massachusetts Treatment Center was established as a secure inpatient facility at Bridgewater in 1959 by Chapter 123A of the General Laws. This law provides for a civil commitment of One-Day-to-Life for persons who lack the power to control their sexual impulses and who are repetititive and/or violent in their sexual assaults. The program's task is to identify, via a 60-day observation, those individuals that may commit sexual attacks if they are released to society.

Once identified, the court may commit these individuals to the Treatment Center for treatment and rehabilitation. This commitment may extend beyond their criminal sentence up to the remainder of their life, if necessary. Approximately 260 patients are currently civilly committed as Sexually Dangerous Persons.

Based on an individual treatment plan, the patients participate in group, individual, and family/couples therapy. They learn individual management, relaxation skills, assertiveness training, and social skills. Behavioral techniques are utilized. General programs offer educational and vocational opportunities, as well as recreational and religious activities.

MINNESOTA

The Transitional Sex Offenders Program, Minnesota's Correctional Facility in Lino Lakes, is a unique pre-release pro-

gram for sex offenders. The men live in a therapeutic community housed in a cottage setting but are not segregated from the general population. Thirty residents receive treatment from three professionals. Newly transferred residents receive a 30-day orientation, during which time they are introduced to group therapy, write an autobiography, and read selected materials.

The ongoing therapy consists of core therapy groups which meet three times a week, couples groups, and educational groups which focus on assertiveness training, sex education, and sociosexual roles and stereotypes. Several unique programs supplement the basic therapy. Participants are urged to invite their entire extended family to a family group, which may clarify family interactions and help relatives understand the resident's problem. Sexual Attitude Reassessment (SAR) seminars, using sexually explicit films, help the offender deal with sexual attitudes and preconceptions. Initiation of a behavioral component is being considered.

Shortly prior to parole, the offender begins attending his outpatient group in Minneapolis. When released, he is transferred to one of several halfway houses. After this phase, he may continue in the outpatient group indefinitely.

This program reports a 3% recidivism rate.

MISSOURI

The Missouri Sexual Offender Program (MOSOP) was mandated by legislation in July 1980. It was one of the first to be mandated to operate within the Department of Corrections for the treatment of all persons convicted of sexual assault offenses.

There are currently 1398 sexual offenders with Missouri's Department of Corrections (12% of the prison population). All persons who are convicted of a sexual offense must successfully complete this program prior to release on parole.

The MOSOP offers cognitive behavioral therapy through both groups and individual modalities. The concentration of the group involves the skills of problem-solving, social skills, empathy, and assertion.

At this time, there are 354 sex offenders who have been released following completion of the program, with 5 sexual offense recidivists. This data covers the period from January, 1984 to the present.

MONTANA

Approximately ten years ago, Montana State Prison began treating sex offenders in a group format with ten offenders. Currently there are 212 inmates incarcerated specifically for sexual offenses. In August 1986 an innovative treatment structure was adopted. All therapy with sex offenders is now conducted exclusively in specialized Intensive Treatment Units (ITU's) within the general population. There are two ITU's currently in operation, one minimum-security and one high-security. Each unit is comprised of 12 offenders, a heterogeneous mixture of rapists and child molesters.

On initially entering the institution, if the offender admits responsbility for his crime and expresses a desire for treatment, he is accepted into the program. The offender receives two to three hours of structured group therapy per day, in addition to three hours of "community meeting," where he works with other offenders on individual and group therapy tasks. This program is a structured treatment regime where the individual completes a series of guided tasks as he progresses through the program. In addition to traditional group therapy, all members are required to complete a series of psycho-educational modules, addressing topics such as anger management, assertiveness training, stress management, addictive behaviors, family systems, human sexuality, offender dynamics, and cognitive restructuring. The program lasts between 24 and 48 months, with an average length of treatment being 36 months.

NEBRASKA

The Nebraska Department of Corrections offers the Inpatient Sex Offender Program at Lincoln Correctional Center. Thirty-three males convicted of adult rape, child molestation, exhibitionism, voyeurism, and other paraphilias are currently in the program. Group therapy is available through the core sex offender group. Anger skills, victim empathy, reoffense prevention, domestic violence, and human sexuality classes are also offered. Inmates may participate in other prison activities available to the general population, as well.

Recidivism rate is not known.

NEW JERSEY

In 1950 New Jersey enacted their sex offender statute which mandated that "repetitive and compulsive" sex offenders be placed in one of the state's mental hospitals. Later, still under the auspices of mental health, the group was housed in Rahway State Prison. In 1976 a separate facility, the Adult Diagnostic and Treatment Center, was built in Avenel, which now houses 300 sex offenders. All staff are specially trained to work with this population. Five part-time consultant psychiatrists, ten psychologists, five social workers, and sixteen paraprofessionals compose the treatment staff.

Individual, group, marital therapy, and behavioral techniques comprise the core of the program. Residents participate in sex education courses, social skills building, special topics groups, Alcoholics Anonymous, behavioral techniques, and relaxation therapy. The Re-education of Attitudes and Repressed Emotions (ROARE) technique, described in one of these chapters, is still available although used less frequently than it once was.Release from the program is contingent upon passing the scrutiny of the treatment staff, the superintendent, a special board with representatives from corrections, parole, mental health and the community, and the New Jer-

sey Parole Board. While on parole, the ex-offenders must participate in therapy and may do so at Avenel.

A recidivism rate of 14.8% is reported.

NEW MEXICO

The Sex Offenders Program at the Central New Mexico Correctional Facility in Los Lunas operates within a medium security prison with residents who live in the general population. About 60 men are served by 3 psychologists, 3 consultants who conduct the behavioral component of the program, and a volunteer therapist who works with rape victims and brings this experience into the sex offender groups.

The residents are introduced to the program through participation in a human relations class. This is the psychoeducational aspect of the therapy, which presents units on male awareness, sex education, social skills training, understanding sexual assault, assertiveness training, anger management, and stress management. At the conclusion of these classes, the participant is transferred to one of three therapy groups which focus on breaking down denial, dealing with guilt, understanding the dynamics behind deviant behavior including one's own victimization, and recognizing and controlling deviant fantasies. Sexual assault victims have participated in confrontation groups. Family groups focus on improving communication and, in the case of one group, understanding the dynamics of incest. The University of New Mexico's Sex Offender Program provides the behavioral component of the program, including plethysmograph assessment and monitoring and training in covert sensitization.

This treatment program reports an estimated recidivism rate of 10-15%.

SOUTH CAROLINA

This program, entitled the Comprehensive Sex Offender Treatment and Research Program (cSTAR), is managed from a central location, with services provided at ten institutions. There are over 1400 sex offenders in the South Carolina Department of Corrections, with approximately 300 involved in this program. Rape and child molestation are the two types of offenses treated at the present time.

The program is divided into four phases: Assessment, Orientation and Education, Primary Treatment, Maintenance, and Pre-Release. The first two phases are presently operational and the third phase is scheduled for implementation in 1988. During the first phase, each offender is given an MMPI and MSI, and a variety of education modules are presented over a 14-week period. During the second phase, group therapy sessions are conducted, centering on power, control, self-awareness, self-disclosure, anger/aggression, victim personalization, and other relevant issues.

SOUTH DAKOTA

The South Dakota sex offender treatment program started four years ago and is a three-phased program. Phase 1 occurs at the maximum security facility in Sioux Falls and is known as the Human Relations/Alternative Behavior Therapy Program. Phase 2 is carried out at the Springfield Correctional Facility, with Phase 3 taking place at the Yankton Detachment; both of these facilities are medium security. The latter two programs are known as the Advanced Human Relations Program.

Currently, approximately 40 inmates are being served in these three programs. All types of sex offenders are served on a voluntary basis after testing to determine amenability to treatment. The programs at all three facilities utilize psychoeducational, group counseling modalities.

As this is a relatively new program, no accurate statistics are available on recidivism.

TENNESSEE

The Tennessee Department of Corrections offers sex offender treatment at the Deberry Correctional Institute. Seventy-five males convicted of rape, child sexual abuse, and incest participate in an inpatient program. The treatment utilizes a therapeutic community approach. Psycho-educational modules include classes in the criminal personality, clinical goals, relaxation training, rational-emotive therapy, assertiveness training, anger management, and moral development. Group therapy is a vital part of the program. Participants write an autobiography and prepare at least 120 therapeutic talks, which are written accounts of therapeutic sessions between two participants. Relapse Prevention planning is conducted. The program utilizes a progressive level format and lasts a minimum of nine months.

No recidivism data is available at the present time.

UTAH

Project REVAMP is located at the Utah State Prison in Draper, Utah and currently treats approximately 60 residents. REVAMP is an acronym: Rape-Exhibitionism-Voyeurism-Autoeroticism-Molesters-Pedophiles, and "revamp" means to re-do or change completely.

This program began in 1979 and deals with adult offenders (rapists) and child offenders (molesters, pedophiles, and incest offenders); the program also works with voyeurs, exhibitionists, and individuals with fetishes. To be considered for inclusion in REVAMP, the sex offender must acknowledge commission of his offenses without attaching blame to some external factor, such as intoxication or victim provocation.

Several treatment modalities are employed including psychotherapy, primarily group, but individual and marriage/family therapy are also available. Educational courses are provided, including sex education, assertiveness training, parenting skills, social skills, communication skills, cognitive restructuring, victim empathy, etc.

Subjective evaluations are done approximately every two months and include rating by staff and the other group mem-

bers. Objective evaluations are done, using the penile plethysmograph as a measurement of sexual arousal.

No precise statistics have been gathered on recidivism rates.

VERMONT

A therapeutic community operated within a prison is represented by the Vermont Treatment Program for Sexual Aggressors at the Chittenden Correctional Facility. An extensive assessment is part of the admission criteria. One doctoral level psychologist with one part-time social worker and one part-time paraprofessional, plus psychology interns, comprise the staff. Treatment is tailored to the requirements of each individual and may include group and individual therapies, as well as behavioral techniques which utilize the plethysmograph and counterconditioning techniques.

In individual therapy, residents are taught to use covert sensitization and may utilize counterconditioning techniques. Victim confrontation may be handled by having a victim of sexual assault brought in to discuss the repercussions of the assault on her life. Group therapy focuses on developing general problem-solving techniques, recognizing emotional states, anger management, assertiveness training, social skills training, sex role clarification, and sex education. Family therapy is offered, as is treatment to deal with one's own victimization. Depo-Provera™ is also available under the supervision of a psychiatrist.

A unique component of this program is the extensive aftercare treatment provided. A recidivism rate of 4% is reported. (Also see Chapter 14, Relapse Prevention.)

VIRGINIA

In the early 1980's, three Virginia prisons began weekly group treatment for sex offenders. In 1984 a Sex Offender Programs Advisory Committee was formed and consisted of line staff representing youth, adult, parole and probation, as well as community agencies outside corrections. This committee assessed the state in terms of needs, numbers, and treatment resources and found great numbers of sex offenders and very limited treatment resources. In 1985 the Office of Coordinator of Sex Offender Programs was created to plan, develop and train staff in working with this population.

Through NIC resources, basic training has been given to approximately 300 staff, with advanced training to 40 staff, and resources provided for sex offender prevention, assessment, treatment and aftercare.

At the present time, staff in ten adult institutions (nine male, one female) have started groups specializing in sex offender treatment, providing basic level education and treatment for approximately 150 inmates. Over the next two to five years, sex offenders who have participated in these groups will begin to parole. It is critical now that an aftercare network be developed through parole services and into community mental health public and private agencies.

WISCONSIN

Wisconsin currently offers sex offender treatment at three institutions. Oakhill Correctional Institution, a minimum security prison, provides a 12-month group therapy treatment program for child molesters and child rapists. At present, the program consists of six specific modules, ranging from highly structured and didactic to highly unstructured and psychotherapeutic.

The Sexual Offender Treatment Program, which has been operating for about two years at Green Bay Correctional Institution, a maximum security facility, currently provides services to approximately 40 inmates. Primary mode of intervention is intensive process-oriented group psychotherapy, incorporating victim empathy, victimization issues, and interpersonal skills training. Program also includes a didactic presentation of the dynamics of sexual offenders and Relapse Prevention techniques. Individuals in treatment have been incarcerated for rape offenses, child molestation, and incest. Therapy groups are mixed. While all sex offenders are routinely screened for the program, only those who take responsibility for the offense, express internal distress, and are willing to commit to a minimum of one year of treatment are accepted.

The third program, located at Kettle Moraine Correctional Institution, has been developed for treatment of developmentally disabled sex offenders. Currently there are ten participants, presenting a number of disabilities (mental retardation, learning disabilities, and chronic mental illness), in addition to a need for treatment for sex offenses. The types of sex crimes treated here are offenses against children under the age of 16, including incest victims as well as nonfamily members.

In order to work effectively with this population, a variety of audiovisual materials has been used which take into account the learning style of the developmentally disabled. An important part of treatment involves a very structured segment on sex education which was developed for use with the mentally retarded.

WYOMING

Wyoming's sex offender treatment program, located at the Wyoming State Penitentiary at Rawlins, is conducted on three custody levels; inmates are referred through the classification process. Participation is voluntary, but noncompliance can affect Special Good Time earnings, lessen security considerations and possible parole termination. Inmates excluded include those who are inclined to breach confidentiality and inmates exhibiting obvious psychoses. Currently, there are 28 participants in maximum security, involved in groups dealing with molestation, rape, sexual addiction, Child Molesters Anonymous, and a mixed group. Thirty-two participants in medium security are in three groups. Forty-four participants in minimum security are in four groups. The program also includes 16 different psycho-educational modules.

Treatment offered is group and individual therapy. Groups meet on a bimonthly basis. Module completion is assessed on the basis of participant's mastery of information, attendance, and participation. Group placement is based upon crime dynamics and level of the inmate's current therapeutic progress. This allows those inmates who are sincere in their efforts to change to be separated from those participating for secondary gain.

Recidivism rate is unknown at this time.

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