HB

545

STATE OF ALASKA
THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

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Mary Van Nimwegen

H NESS 3/14/90

HOUSE COMMITTEE REPORT

(7)
Date Referred: February 12, 1990 FURTHER REFERRALS:
JUDICIARY

Date of Committee Action: 3/14/90

The HEALTH, EDUCATION, & SOCIAL SERVICES Committee considered: HB 545

HOUSE BILL NO. 545 SENTENCING/REHABILITATION/PAROLE

"An Act relating to sentencing practices and procedures; expanding the circumstances in which a sentence may require participation in an appropriate rehabilitation or treatment program; redefining eligibility for discretionary parole; adding a related mitigating factor in the determination of presumptive sentences; and providing for an effective date."

RECOMMENDATIONS:

[ ] be replaced with ______________ [ ] the same title [ ] a new title

[ ] have attached amendment(s)

[X] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the ______________ Committee

ADOPTS: ______________ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal impact ______

[ ] zero fiscal note ______

[ ] zero with analysis ______

APPROVES PREVIOUS: (Date/Dept)

[ ] fiscal note(s) ______

[ ] zero fiscal note(s) ______

[ ] zero fn/analysis ______

SIGNING DO PASS:

[signature]
[signature]
[signature]
[signature]

SIGNING:
(Check approp. column)

	Do Not Pass	No Rec	Amend

[signature]
Chairman's Signature

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907 465 [illegible]

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM March 10, 1990

SUBJECT: House Bill 545 -- sectional analysis

TO: Representative Niilo Koponen
ATTN: Drena McIntyre

FROM: Jack Chenoweth
Legislative Counsel

As the title notes, the measure is intended to modify current state sentencing practices and procedures, as follows:

-- the measure broadens the opportunity for the court to impose participation in a rehabilitation or treatment program as an element of its sentence;

-- it permits certain prisoners sentenced under presumptive sentences to be eligible for discretionary parole; and

-- it adds a factor to the list of mitigating factors that apply during a court's formulation of a sentence.

Each is more fully discussed in turn.

Bill section 1, reenacting AS 12.55.015(d), extends the court's authority to require participation in an appropriate training or rehabilitation program (1) as a condition of probation, (2) as a condition of suspended execution of sentence, or (3) as a condition of a suspended imposition of sentence. The re-enactment makes clear that, while time spent in participating in a rehabilitation or treatment program is to be counted as part of the defendant's sentence, that time does not reduce a mandatory minimum sentence imposed on the defendant.

Taken together, bill sections 2 and 4 permit a person who has been sentenced for a minimum term under a presumptive sentence and who has not been previously convicted of a felony eligible for consideration for discretionary parole during the minimum term by the state's Parole Board. The de-

fendant's eligibility would be gauged on the same basis as a prisoner not serving a minimum term applying under a presumptive sentence.

The change made by bill section 3 adds "[demonstrating] . . . a strong potential for successful rehabilitation" as a mitigating element that shall be considered by the court in setting a sentence.

Bill section 5 makes the provisions authorizing discretionary parole to certain prisoners under presumptive sentences retroactive to persons sentenced since January 1, 1980.

The bill is given an immediate effective date by bill section 6.

JBC:mi
wkmi6/053

STATE OF ALASKA
DEPARTMENT OF CORRECTIONS

STEVE COWPER, GOVERNOR

REPLY TO:

P.O. BOX T
JUNEAU, ALASKA 99811-2000
PHONE (907) 465-3376

March 13, 1990

The Honorable Niilo Koponen
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear ~~Representative~~ Koponen:

In response to your request, I have enclosed a copy of the chapter from Retraining Adult Sex Offenders: Methods and Models by Fay Honey Knopp that addresses the Oregon state program developed by Rob Freeman-Longo.

Mr. Freeman-Longo is currently under contract with our department to assist us in developing a more standardized approach to treating and managing sex offenders. As we discussed, I would be happy to arrange for Mr. Freeman-Longo to either meet with you or to address one of the legislative committees when he is in Juneau on April 2-3.

Please contact me so that we can make specific arrangements and provide you with any additional information you may need.

Sincerely,

Walter Majoros
Director, Statewide Programs

Enclosure
WM:lc
cc: Susan Humphrey-Barnett
Commissioner
Bill Parker, Special Assistant

RETRAINING ADULT SEX OFFENDERS:
METHODS & MODELS

By

Fay Honey Knopp

for

The Safer Society Program
of the
New York State Council of Churches

Order from:

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Shoreham Depot Road
Orwell, Vermont 05760

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THE SEX OFFENDER UNIT & THE SOCIAL SKILLS UNIT

OREGON STATE HOSPITAL
SALEM, OREGON

Multimodal evaluation and treatment programs for adult and for low-functioning sex offenders in a state hospital

CHAPTER 10
THE SEX OFFENDER UNIT & THE SOCIAL SKILLS UNIT
CORRECTIONAL TREATMENT PROGRAMS

Oregon State Hospital
2600 Center Street N.E.
Salem, Oregon 97310

The Sex Offender Unit (SOU) at Oregon State Hospital (OSH), modeled on the sex-offender program at Western State Hospital described in the preceding chapter, provides the widest range of sex-offender treatment modalities in any single residential setting in the United States. SOU, a voluntary program offered to imprisoned sex offenders during the last two and one-half to three years of their sentences, is one of three residential programs provided to sentenced sex offenders through the unique administrative structure of OSH's Correctional Treatment Programs (CTP). The two other specialized programs are residential groups for two traditionally neglected populations: (1) the Social Skills Unit (SSU), for sex offenders classified as "low-intellectual-functioning"; and (2) the MED unit, for sex offenders diagnosed as "mentally and emotionally disturbed." Each operates on a therapeutic format and is semiautonomous, with treatment programs tailored to its specific population. Though each unit evaluates its own residents, there is a broad and fruitful interprogram exchange of treatment and technological expertise.

CTP also offers, within Oregon State Penitentiary and Oregon State Correctional Institution, part-time treatment programs for sex offenders who do not qualify for or do not choose to be treated in the SOU.

In this chapter, we will focus on three unique and innovative areas of the CTP: (1) the rare cooperative effort between the corrections and mental health divisions of the state of Oregon, an effort that facilitates therapeutic programming; (2) the Sex Offender Unit's eclectic treatment repertoire; and (3) the Social Skills Unit, which treats sentenced sex offenders who have educational levels below fourth grade and/or serious deficiencies in adaptive behaviors.

THE CORRECTIONAL TREATMENT PROGRAMS (CTP)

In 1975, the Corrections Division and the Mental Health Division of the State of Oregon joined cooperatively to develop, operate, and maintain mental health services for clients of the Corrections Division.[1] Because the funding appropriation involved both mental health and corrections, two professions that traditionally do not work well together, the legislature requested a cooperative board be formed to assure the development of mutually acceptable rules and regulations. To further interagency cooperation, the legislature provided funds for this effort to the Department of Corrections' budget for transfer to the Department of Mental Health on a quarterly basis.

By early 1976, the Mental Health Programs in Corrections Policy Board was formed.[2] Its tasks were (1) to develop a cooperative agreement in which terms and conditions of treating mutual clients were outlined and (2) to develop the administrative rules of transfer for determining the clinical background of residents who would be eligible for the programs; the time frames for transfers; custody levels; and, finally, the terms under which an individual who volunteered for treatment could be terminated from the program and returned to the prison.

In 1978 the CTP was formally established at OSH with the hiring of Director Roger C. Smith, a criminologist and social worker by training. Smith, who reports directly to the OSH superintendent, contends the detailed policies governing the rules of operation contribute greatly to the smooth, cooperative nature of the programs.

Smith describes these residential programs as "transitional," since they serve people in the last few years of their incarceration.

> Though this wasn't the model we originally envisioned, it seemed to me we had a limited number of beds and the most effective approach would be to catch people a few years before they were to be released, provide intensive residential treatment, and phase them slowly into the community. Since I come from the field of corrections, I know what the recidivism curve looks like when men go right from prison to the community, particularly for people who have poor social skills, few community support systems, and often problems with alcohol and drug abuse. [Smith, 1983]

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1. In 1975, Oregon law provided for an alcohol and drug abuse program for prisoners at the OSH. That program, Cornerstone, was established in 1976 and incorporated into the CTP in 1978.
2. The board was composed of assistant administrators of both divisions, institutional superintendents, representatives from Field Services and Community Corrections, and a representative from the state's Community Mental Health Programs Director's Association.

A fourth CTP unit, the Correctional Institution Treatment Services (CITS),[3] provides sex-offender treatment to the men imprisoned at Oregon State Penitentiary and Oregon State Correctional Institution.[4] CITS contracts with up to 18 professional, part-time, outside consultants in an effort to furnish specialized and accountable services to the imprisoned. "From the prisoners' perspective," Smith says, "they are dealing with someone where there is a higher trust level than with a correctional staff member. From a therapeutic perspective, you can contract for the specific expertise which may not be available from regular staff. From an administrator's point of view, most importantly, you avoid staff "burnout" (Smith, 1983).

Smith (1983) cites the issue of aftercare as the most intense struggle that occurred between the mental health and correctional divisions:

> Did we, the parole officer, or the community health or corrections agencies provide aftercare? We argued that our clients had been involved in specialized kinds of treatment and that there needed to be continuity. It wasn't simply a matter of shifting them smoothly from one system to the next, but a matter of the content of their treatment being consistent. Because they had compulsive forms of behavior, the patterns that aftercare had to be aware of were the same in the community as they were in the program, and we wanted to insure that continuity. It was a major battle for us.

Presently, the arrangement allows CTP to work very closely with specially trained parole officers and the community corrections staff. "We set up the aftercare contracts, and our therapists do the supervision in the community. We work hand-in-glove. It is very satisfactory," says Smith (1983).

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3. CITS originally was funded by the 1975 legislature to provide alcohol and mental health services to the imprisoned. The 1977 legislature expanded these services to include mental and emotional disturbance services (including treatment for sex offenders) and Native American alcohol and drug abuse services. The 1979 legislature specifically authorized the CITS program to provide a "dangerous sex offender" program for offenders sentenced under ORS 426.670. Until 1980 CITS was operated out of the Mental Health Division's central office. OSH also provides sex-offender treatment in two other program areas: the Child and Adolescent Treatment Program and the Forensic Psychiatry Program. The latter determines "sexual dangerousness" of offenders for the courts and incarcerates those found "not guilty by reason of insanity." The program utilizes almost all of the SOU methodologies. The behavior of psychotic sex offenders is controlled with drugs.
4. In addition, CITS provides other mental health and diagnostic services to these men, as well as the women imprisoned at the Oregon Women's Correctional Center.

THE SEX OFFENDER UNIT: OVERVIEW

The SOU is unique for the range of treatment modalities offered to the 33 men who voluntarily enter the program during the last few years of their sentences at Oregon's two prisons (Oregon State Penitentiary, a maximum-security institution, and Oregon State Correctional Institution, a maximum-security institution for first offenders).[5] With the recent availability of Depo-Provera, the SOU's treatment agenda includes all methodologies being utilized in other residential and community-based sex-offender treatment programs.

After a 60-day evaluation and observation period, if the sex offender is accepted into the program,[6] he can expect to spend 24 to 30 months in treatment in the SOU's secure ward setting,[7] three to six months on community release, and 18 months in comprehensive and intensive outpatient treatment.

Because release dates are set by the parole board within a few months of the offender entering prison, treatment in the SOU does not shorten the men's period of incarceration. "As a matter of fact," says Robert Freeman-Longo, Director of the SOU, "currently about half the men have written to the board and asked for an extension of their release dates so they can complete treatment. This program is tough, hard work for the offender, and the only reward for being in it is self-improvement" (Freeman-Longo, 1983).

Like the WSH program, the SOU is a self-help, peer-run therapeutic community with 10 steps of progress[8] that the men must work through before graduating. As done in the parent program, SOU staff also will conduct psychiatric and psychological evaluations in the first 60 days, take an in-depth social and sexual history of the offender, and have him write a lengthy autobiography. The offender's sexual arousal patterns and fantasies will be physiologically monitored and behavioral techniques will be an integral part of his treatment plan for the remainder of his stay in the SOU. These

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5. Oregon has a determinate sentence structure. Once a person is sentenced, within a few months of his entering prison the Parole Board reviews a number of predetermined factors and comes up with a parole-release date. However, if a person acts out while imprisoned, he can lose his good time, he may have another parole hearing, and the parole release date can be changed or the parole supervision period extended.
6. Persons are placed on a waiting list and usually are selected on the basis of the least amount of time left to serve on their sentences.
7. The hospital is classified as medium security, but the SOU ward is locked, with TV surveillance of critical areas. The psychiatric security aides have dual responsibilities for security and custody. As at the WSH program, staff perceive the program's best security as rooted in the values of the therapeutic community.
8. For a list of the 10 steps of progress, see Appendix L.

techniques range from what the program perceives as "the least instrusive" to the "most intrusive" forms. Treatment becomes progressively more intrusive if the offender's deviant sexual arousal fails to decrease.

Like at WSH, the group process at the SOU is the central feature of the program. Each resident spends a minimum of 26 hours a week in guided self-help group therapy sessions that meet twice each day. He also is exposed to a variety of educational modules.[9] Unlike WSH, these include an ongoing learning process derived from Yochelson and Samenow's[10] philosophy of "thinking errors."

If all else fails to control the offender's deviant fantasies, the use of Depo-Provera, recently added to the SOU repertoire, is an option. As with other SOU behavioral procedures and use of the penile plethysmograph, the injection of this drug requires that the offender sign a specific consent form.[11] The form stipulates that the men can withdraw their consent at any time during treatment.

SOU TREATMENT MODALITIES

We now will describe briefly the range of behavioral techniques employed in the program, the SOU's perspectives on the appropriate use of Depo-Provera, and the teaching concepts involved in the reporting of "thinking errors."

Behavioral Techniques

Ron Wall, SOU's Chief Behavioral Therapist, conducts assessments for the residents upon entrance to the program. Most of the men have been found to be "untreatable" in a community setting because their deviant behaviors are considered to be quite compulsive and deeply ingrained. Approximately half were sentenced for offenses involving rape and half for some form of child sexual abuse.

A variety of techniques are used to determine the nature and depth of the offender's deviancy. The plethysmograph measures his penile responses

9. For a brief listing of the educational modules, see Appendix M.
10. The authors believe that the "criminal personality" is radically different from the "non-criminal personality." Among other approaches, they identify "thinking errors" in patterns of thought that lead to criminal behavior. "By 'thinking errors' we mean mental processes required by the criminal to live his kind of life. They are 'errors' solely from the standpoint of society, and not from that of the criminal" (Yochelson & Samenow, 1977, Vol. I, p. 359).
11. For sample procedure and consent forms, see Appendices N, O, and P.

to tapes and slides, and he is asked to self-report on a sorting task of 260 cards depicting various sexual scenes. The offender is assessed for his deviant arousal to all themes. "Although he may come in as a rapist or child molester, he is assessed for arousal to male and female children, teens, and adults; as well as rape, child molestation, incest, and certain aggressive themes," says Freeman-Longo. "Often a man may have a history of rape but may be sexually aroused to children as well. We wait for six months before we have a complete psychosocial and psychosexual history. We are constantly updating during that period because, as more trust builds with the therapist who does the report, we get more accurate information" (Freeman-Longo, 1983).

Covert Sensitization. After assessment, a therapeutic regime is determined for each resident. Covert sensitization is usually the first behavioral technique employed, serving as a steppingstone into other types of aversion therapy. As now utilized by the SOU, covert sensitization involves the covert pairing of the offender's preassault or antecedent behaviors with an aversive scene that is a natural or social consequence of his deviant behavior. The offender develops these pairings by himself and records them on audio tape for the therapist or group to critique for content and compliance with instructions. "This teaches the offender to intervene early in his deviant-cycle behavior," says Wall (1983).

These aversive scenes also can be utilized when the offender has a deviant fantasy on the ward. For instance, if he is watching a TV program and sees a child on the screen and begins to fantasize, he is to remove himself from the situation and use one of his aversive scenes to intervene with his deviant fantasy.

Masturbatory Satiation. Covert sensitization is a less powerful therapy that is suited better to intervening with the preassault or antecedent behavior phase than the sexual assault phase, according to Wall. Thus, after many sessions with covert sensitization, the offender automatically moves on to masturbatory satiation. "We generally proceed to this kind of therapy without waiting for the arousal to decrease to 20 percent or less," he reports (1983).

In masturbatory satiation, the offender first masturbates for five to 10 minutes to an appropriate, adult, mutually consenting fantasy. After achieving orgasm the offender switches to a very short segment or phrase from his deviant fantasy. He will continue to ruminate on this phrase aloud

and into a tape recorder for 50 to 55 minutes while continuing to masturbate. The therapist and group may critique the tape and the process used.

If the offender is unable or unwilling to masturbate, the procedure is varied by having the offender simply ruminate and verbalize without masturbating. This variation also precludes using the initial period for appropriate masturbation. Wall perceives the former method as more effective.

Olfactory Aversion. Both covert sensitization and masturbatory satiation are self-administered therapies, depending on the individual offender for control. Since a sex offender may be very compulsive in his deviancy, the SOU moves next into olfactory aversion, a more intrusive method used to control and reduce deviancy. "It is very difficult for an individual to create his own phobia," says Wall, "so we feel olfactory aversion provides him an opportunity to attain a phobic response" (Wall, 1983).

Pharmaceutical-strength ammonia fumes, administered through a nasal cannula, have been the primary agent used in olfactory aversion in the SOU. Placenta-culture fumes also are used on occasion.

A few physical problems have been noted as a result of offenders being exposed to ammonia fumes, particularly among residents inhaling them for more than the average 25 sessions of use. Says Wall,

> We have developed a self-report form and periodic examinations by our doctor to be sure there are no medical problems. A few people have experienced some labored breathing after 100 or more sessions with ammonia, but they have been examined and there haven't been many medical problems. Nevertheless, we want to be careful in the use of it because it is a caustic odor. We have a checklist for reporting any serious nosebleeds, headaches, watering eyes, or pain in the nasal tract so we can keep a handle on it. [Wall, 1983]

Wall reports that, after about 25 sessions of olfactory conditioning, generally the individual reduces his arousal to significantly under 20 percent. However, as a result of spending excessive amounts of time in fantasy reinforced by masturbation, about 20 percent of the men in the program do not respond adequately to olfactory conditioning.

Aversive Galvanic Stimulation. Those men whose results with olfactory conditioning are inadequate then are recommended for AGS, or aversive galvanic stimulation. AGS is a term coined at OSH for electric shock aversion. It is sometimes used in conjunction with ammonia fumes. The AGS device has a small, centralized electrode that fits either on the forearm, thigh, or calf. It can be placed on any of these areas and be changed around.

Wall explains:

> We hope that will add to the anxiety--not knowing where it will next be placed on their body. The shock is in the level of milliampers so it is a very small amount, but still we take precautions. It is a flashlight-battery-operated device. We are careful about crossing wires or having bare metal exposed where it could be accidentally touched. We have headphones that are rubber-insulated, so there is no chance of any transient current going anywhere else. It has worked very well and reduces arousal significantly. [Wall, 1983]

Masturbatory Reconditioning. SOU finds using masturbatory reconditioning alone as the least promising behavioral technique. This is true particularly for child molesters, who have high arousals to deviant themes and low arousals to appropriate themes. Wall reports that, after about 20 or 30 sessions of training the child molester to masturbate to appropriate themes, his arousal will increase to those themes but his deviant arousal does not decrease accordingly.

> There doesn't appear to be anything happening to decrease the excitement of deviant themes, particularly with those individuals who are still working on their social, assertiveness, and empathy skills. Until they are very successful in being assertive, communicative, and empathic, I don't think the deviant arousal will decrease much. Generally we employ masturbatory reconditioning, sensate focus, and systematic desensitization with offenders who do not have sufficient appropriate sexual arousal. It is necessary to increase any deficits in appropriate sexuality to provide a healthy outlet for the offender and to replace the high excitement he formerly got to deviancy. [Wall, 1983]

Freeman-Longo notes that rapists also can lack arousal to appropriate sexual themes. When measured on the plethysmograph, at least two rapists' appropriate arousal registered in the 20 percentile range, while their deviant arousal registered at 100 percent. "We are involving them in more exercises and are considering using video," he says (Freeman-Longo, 1983).

Depo-Provera

If all of the aforementioned behavioral techniques fail to reduce the offender's deviant arousal sufficiently, the SOU offers the hormonal drug, Depo-Provera, as a "last-resort" treatment.[12] "Before we use Depo-Provera,"

12. The Behavioral Modification and Ethics Committee that approves all procedures used in the program gave permission for the use of this hormonal drug. See Appendices P and Q for a copy of procedural and resident request forms for using Depo-Provera (MPA--Medroxy-Progesterone Acetate).

says Freeman-Longo (1983). "every man goes through a careful screening. It is a totally voluntary participation in this as well as all adjunctive or behavioral therapies."

As of January 1984, four of the 33 men in the program were receiving injections of Depo-Provera. Once each week, they are given full-dosage injections (400 mg/cc) to reduce their testosterone "to that of a prepubertal male," according to Smith (Manzano, 1984).

One of the offenders receiving the hormone is serving a second sentence for sex abuse and a first for attempted rape, though he admits to attempting to rape 20 to 25 women and abusing some 200 victims. Before receiving Depo-Provera he had 16 to 20 deviant fantasies each day and now reports only one or two per week.

A second offender receiving the drug had molested children and exposed himself to several thousand women victims. He reports he is now able to look at women and not fantasize about their bodies and has noticed a marked decrease in the amount of time he spends fantasizing.

A third sex offender, despite 28 years behind bars and almost three years of intensive therapy in SOU, still had strong sexual urges toward children. He had admitted to committing his first forcible rape of two girls at age 11. He also confessed to molesting boys until he was 20, at which point he was sentenced for kidnapping a seven-year-old boy. Now 48, after receiving injections of Depo-Provera, he states that his desire for such acts is ending and he no longer is hanging on to the notion that someday he would get out and have sexual contact with a child.

The history of the fourth offender who recently began receiving the drug involves a number of violent crimes. He murdered his mother, raped numerous victims, and reported almost continuous fantasizing during his waking hours. "One fantasy seemed to lead into another and I spent more time in fantasy than out," he said. Though on Depo-Provera only a short time, he already reports an almost total absence of deviant fantasies.

"These four offenders, however, even after receiving Depo-Provera," cautions Wall, "continue to have high deviant sexual arousal as measured during plethysmograph assessments.[13] Only after combined use of the drug

13. See Chapter 2, pp. 46 to 47 for comments on the effect of Depo-Provera on the physiological measurement of these clients' deviant arousal patterns.

with behavioral treatment methods have significant reductions in their deviant arousal been noted" (Wal , 1984).

Says the third offender, "I look at Depo-Provera as a tool, an aid to a lot of other things. The one thing I don't believe is that Depo-Provera is a magic panacea. And I guess I have a little bit of fear that it is going to end up like methadone or antabuse.... I don't want to see the drug used that way because I think there are too many kids out there that are going to get hurt" (Manzano, 1984).

Smith concurs: "We don't have a new miracle drug. We have a valuable new tool which, when used with other methods, has great promise in reducing sexual problems" (Manzano, 1984).

Cognitive Restructuring: "Thinking Errors"

One of the ongoing therapeutic modules in the 16 offered in SOU is designed to teach the residents to recognize and change cognitive distortions or "irresponsible" thinking. The goal is to alter thinking patterns drastically in pursuit of facilitating responsible decision making. Program content is derived from the premises and strategies set forth in Yochelson and Samenow's *The Criminal Personality* (1977) and from Samenow's training sessions with CTP staff. Perspectives include notions that, from childhood, the "criminal personality" is radically different from the "noncriminal personality." The search for power, control, and "high-voltage excitement," derived by doing the forbidden, are perceived as elements of a criminal (illegal) lifestyle. The "criminal" is thought to see himself as superior to other people, with his entire thinking structure based on illogical considerations that promote this view of himself and permit him to attempt to get whatever he wants. He is described as "superoptimistic" in believing he will never get caught. "Thinking errors" are identified as patterns of thought that lead to criminal behavior.[14]

Estelle Caldwell, Educational Coordinator/Trainer for the SOU, teaches the men to track their thinking in great detail and to report it. When someone does a phenomenological or "thinking report," it is as though "he turns on a movie camera inside his brain," says Caldwell, "and can see every thought go by on the reel of film. He reports it either verbally or in

14. See Yochelson and Samenow (1977), Vol. I, pp. 251-453.

writing. I prefer that he write it down, because that gives me a much better tracking system for following what is going on and I don't miss as much" (Caldwell, 1983).

Ideally, Caldwell would like to have the men write all their thinking down; however, she is one of only three staff members who review the 35 to 40 reports per week. The number of reports per person varies from three per day to one per week. These limitations do not inhibit staff from telling a resident who is experiencing difficulties that he needs to write a report so he can find out what is going on in his thinking. In addition, each resident carries with him a "thinking log" in which he daily records his thinking. These logs are reviewed in therapy groups, and feedback is given by peers.

Part of Caldwell's work is teaching the discipline of tracking thinking. She helps the offender do a step-by-step analysis on how a particular piece of thinking builds into behavior. "Emotions are not something separate and apart," she says. "We approach it in a very cognitive fashion." She tells the offender, "If you track your thinking and pay attention to what you are thinking, the harm and damage you do to other people and to yourself can be circumvented long before the deviant thought becomes a behavior, or even long before it becomes a fantasy" (Caldwell, 1983).

Caldwell reviews the written reports and analyzes the men's thinking. She pencil-underlines key sentences or phrases, points out the patterns they are revealing, and helps interpret the meaning. For instance, consider the following sample of an initial thinking report:

> I woke up this morning at 6 A.M. I was the wake-up man and had the clock set for 5 A.M. It rang at 5 A.M., I turned it off and went back to sleep. Jim wanted me to wake up at 5:30 A.M., but it didn't happen. I was embarrassed. I felt like an ass. I said to myself, "Shit, Jim is really going to be pissed at me." I wanted to hide from him. I didn't want to face what I did. Jim was counting on me and I let him down.

Caldwell's first comment might be, "The first step in the thinking is typical of your pattern of avoiding discomfort and being unwilling to be accountable in your behavior." Then, where the offender writes, "Jim was counting on me and I let him down," Caldwell might point out a second thinking error: "This is sentimentality, his fear of looking bad, more than it is true concern about letting Jim down." Three or four reports down the line, she might ask him to show her where he is repeating these same basic patterns. "The basic patterns are similar for everybody here," says Caldwell, "especially in regard

to looking bad and avoiding discomfort, the way anger is expressed, and the excitement experienced in terms of setting somebody up perhaps just to have an argument because they hope they are going to win" (Caldwell, 1983).

The most common "foundation" thinking errors (the elements of the belief system through which the person filters all information) among the sex-offender population, according to Caldwell, are fear, anger, concrete and rigid thinking (the inability/unwillingness to think conceptually), fragmentation (radical shift in mood and intention),[15] sentimentality, minimization, and the comfort orientation (wanting to feel good all the time). "I have them pay attention to their tiniest thinking errors, because it may be their red alert," says Caldwell. "Once somebody gets to the point where they will identify the pattern and acknowledge it and say, 'Yes, this is what is going on in my thinking,' it does wonders to break through their denial system, which has a tendency to flip-flop" (Caldwell, 1983).

Caldwell understands sex offenders' thinking patterns because they are similar to those of addicts and other offenders, with whom she has worked for many years.

> When addicts get uncomfortable they will do anything they can to avoid feeling that discomfort. They are what I call "comfort-oriented folks." They will fluctuate back and forth between two sets of feelings. One set of feelings is what Samenow calls the "zero state," which I call the "state of immobilization." They feel like they are nothing, the lowest thing on earth and nothing can ever be different. They have a tendency at that point to see themselves as a victim--what I call being a "victim of the cosmos." They feel there is nothing they can do about anything and it immobilizes them. However, I would like to emphasize that sex offenders are not very different from any criminal in their thinking. Even the incest offender, who may have no other recorded criminal activity, has basic thinking error patterns. His crimes reveal themselves in his thinking as more "nonarrestable" type crimes, but crimes against others, nonetheless. [Caldwell, 1983, 1984]

Because sex offenders are so power- and control-oriented, they have a tendency to fantasize or start doing something to create an excitement so

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15. An example of fragmented thinking is where a resident might say, "Today I know I am not going to have any deviant fantasies about female staff," and he <u>means</u> it. However, in a short time he may feel bored. He sees a female staff person and goes right into his fantasy structure. This is <u>not</u> the same as lying or manipulating, because when he makes the initial statement he means it. His sincerity is shortlived, however. It is a foreign experience for him and corrodes quickly (Caldwell, 1984).

they can swing back into the other set of feelings--the state of feeling powerful. Somenow calls this being "superoptimistic." Caldwell candidly labels it "the state of 'I have the world by the ass and I can do anything I want to do and nothing bad will ever happen to me and my life is going to be wonderful'" (Caldwell, 1983).

> When I do my teaching with the men, we make them very aware of what part of the pendulum swing they are in at the moment. We ask them what is going on and where they are headed in their thinking. Their denial system is very intact. Even after they acknowledge that they did a creepy, horrid thing to another human being, the tendency is to flip-flop back and forth in that denial, depending on the level of discomfort they feel. Once their pattern is identified, they cannot deny they are going off into their cycle, because you have the information they gave you. [Caldwell, 1983]

When the thinking pattern is identified, it is used in the change process. Caldwell notes how the sex offender's superoptimism manifests itself when he "decides" he will change. "He will say, 'I'm going to change; therefore, I have changed!' He does not pay attention to the steps necessary in between 'I want' and 'I have actually done it'" (Caldwell, 1984).

The men learn to differentiate between what it means to adapt to their environment and actually change their thinking and behavior. With Caldwell, each person designs some form of intervention in his thought process. Other SOU modules on Rational Emotive Therapy (RET) and anger management contribute new insights and techniques:

> A lot of our men have been victimized as kids or adolescents, or during imprisonment. They have a very difficult time differentiating between their actual victimization and feigned victimization. I do a great deal of work with them on how you tell the difference, for instance, between the anger you have toward your stepfather who molested you from the time you were six until you were 14, and the anger you have translated over to the staff person who is telling you that you can't do something you want to do. I am trying to teach him that this is not a very rational comparison to make and how to differentiate. I then talk to him about rational comparisons and use RET in a very practical fashion. [Caldwell, 1983]

RET teaches the men to recognize that their emotions are created from their thinking. Ron Reitman, a RET instructor, focuses on each person's series of beliefs and values and, in terms of reality testing, helps them to identify which are mistaken.

In identifying commonalities among sex offenders, such as anger,

power-thrusting, and control, the SOU staff find that many, in fact, feel emotionally and mentally very much *out* of control:

> Their tendency is to want to control everything and everyone around them to create the illusion they are in control and that they do have power. The issue is tied up with pride, saving face, and not wanting to look stupid. Their fears are enormous and very disproportionate in terms of reality. That is one of the reasons why these men are so frightened of emotions. They don't understand emotion. It goes back to the pendulum swing: They are either totally devastated and everything is just too overwhelming, or they are totally wonderful and everything is going to be just fine--hearts and flowers and sentimentality to the maximum. They don't understand about being responsibly concerned about someone or confronting a person openly about negative behavior. They don't do that because there is that fear of looking bad, a fear of making a mistake. That is why anger is such a big issue. To them, to be angry is to be rageful and vengeful. To be angry is to be very powerful. [Caldwell, 1983]

Caldwell teaches the sex offenders about the psychology of anger and the physiology of excitement and how similar they are. She believes these two issues have a great deal to do with why their crimes get so violent:

> With the excitement and the adrenalin starting to pump, they get revved up. Immediately they translate that into anger and don't recognize those feelings can happen from other things besides being angry. They have been culturally conditioned that anger is a man's emotion and that it is OK to be angry. But, once they get angry, they are out of control; they go into a rage, and there is an incredible amount of force in their anger, which they use as a threat around here. I find myself saying to them, "So you are angry, so what? Millions of people are walking around feeling angry but that doesn't mean they hurt somebody or act like a fool. Your emotion is no bigger than mine. I can get 10 times as angry with you as you are with me, but that doesn't mean I can put my hands on you." [Caldwell, 1983]

Wall trains the men in the techniques of anger management, control, and reduction[16] and teaches them that anger can be a positive stimulus for changing a behavior or a situation. Anger is usually the sex offender's most frequently expressed emotion, while other important feelings remain unexpressed. Thus he is taught both to express his anger appropriately and to deal with his other repressed emotions as well. For the occasions when his anger borders on the extreme, he is taught to use simple relaxation techniques before expressing himself to others. Covert rehearsal and

16. An example of a treatment team anger plan for a SOU resident can be found in Appendix S.

role plays are practiced by the offenders to increase their skills. The therapy supervisors monitor the design of the formal "anger plan." Thus the offenders get the same message from everyone on staff and are less able to ignore or minimize the information.

The men record their sexual and other fantasies in weekly "thoughts/urges" reports. The behavioral therapists and therapy supervisors review the information and, if it is too vague, ask the men to repeat the process for another week until the patterns are identified. Other staff are consulted about various ways to intervene with the deviant or violent fantasies. After three months of prescribed interventions, additional fantasy reports are requested and examined.

Staff also examine in great detail the thinking that precedes or occurs during the fantasies. Caldwell has discovered that the men use the same set of thinking errors in their fantasies that they use in their regular thinking. She contends that these fantasies eventually corrode reality-testing abilities to the point where they cut off the person's perceptions of the consequences and the fantasies easily can become realities.

The men identify and record their deviant behaviors, their deviant behavioral cycles, and their basic patterns and foundation errors on big flip-charts. They present them to the class before posting them on the walls of the therapy room. "This exercise increases their knowledge that other people have similar patterns and increases their stamina for getting feedback in front of other people," says Caldwell. "What we are trying to understand are the thinking patterns *before* these cycles occur, before there is any noticeable behavior" (Caldwell, 1983). (See box on next page for samples of sex offenders' charts, taken from those on the walls of the two group therapy rooms.)

Preassault thought and action processes are categorized and recorded in great detail in each sex offender's file and also appear on his discharge contract,[17] which each person signs before release. This insures that the sex offender is clearly aware that his sexual assault is not spontaneous and only rarely situational. It also provides him and his parole officer with a valuable tool for helping to identify the early thinking and behavioral signs that precede his sexual assaults.

17. For an example of a discharge contract using preassault information, see Appendix I.

CHARTS WRITTEN BY SOU RESIDENTS
OUTLINING DEVIANT AROUSALS, CYCLES, AND THOUGHT PROCESSES

My deviant arousal is pedophilia, girls and boys ages 5-14, rape and oral sodomy. I rub my penis on vagina, fellatio performed on me, fondling, attempted intercourse, mutual masturbation. I use coercion and manipulation on my victims.

My observable behaviors are:

I become silent, sullen, avoid others.
Face and ears become red.
Mouth becomes a slash.
Hands and feet agitate.
Arms and legs crossed.
Replies to questions will be short.
Voice tone will lower, become monotone.
Won't hold eye contact.
Stare at floor, stare off or fixed stare.
Rigid neck.
Hunched shoulders.

The thought process:

I don't think others really care about me. I want to give up. I think I'm in a rut. I get angry with myself. I generate revengeful thoughts. I think others are attacking me when confronting my behaviors. I think of things being catastrophic, making them into a major issue.

My deviant arousal is pedophilia, boys and girls 14-16. I perform fellatio and cunnilingus on victims and fellatio on me by victims, fondle and masturbate victims, fetish with women's underclothes, rape females 16.

My observable behaviors are:

My face will turn red.
My eyes turn red, watery and downcast.
I cross my arms.
I will talk almost to a whisper.
I isolate myself from others.
I will give short, sarcastic answers to questions.
I will glare at people.
I put others down with sarcasm.
I ignore others when they speak to me.
I begin clenching my jaw when angry.
I walk slow with my head down.
I hesitate answering questions by bowed head.
I blink my eyes.

The thought process:

I think I am superior to others. I think I have less ability than others, so why try? I think one cares for me. I think I must prove that I am right all the time. I don't think others can be trustworthy. I place high expectations upon others and myself.

My deviant arousal is pedophilia, girls 8-17, rape women 17 and on, intercourse, I will threaten my victims with a weapon.

My observable behaviors are:

My face and ears turn red and I pull on my chin.
I spend a lot of time by myself.
I give sharp, sarcastic answers.
Agitate my hands.
I cross my arms and legs tightly.
I take a right and wrong stance verbally.
I justify my behavior when confronted.
I become forgetful.
I avoid those I have conflicts with.
I isolate by reading personal books.

The thought process:

I think I am inadequate sexually and incompetent socially. I think others will reject me. I think people don't care about me. I get angry at myself. I think about giving up. I catastrophize situations. I think I will fail and be rejected. I think I can never do anything right.

My deviant arousal is intimidating girls ages 14-17 and women ages 18-21 to commit fellatio on me and into copulation.

My observable behaviors are:

I show anger inappropriately.
I swear at people.
I walk away from people, shake my head, no, I don't agree.
Face gets red.
Body gets tight.
Legs crossed.
I complain of being sick, fast heartbeat, more than from the norm.
I push issues in confrontations.

The thought process:

I feel set up by others, I feel inadequate, I feel people don't care. I fantasize hurting people. I assume at times no one cares to help me when they are busy. I feel people are always criticizing me. I feel at times people are fools. I catastrophize things using big words, making a small issue into a big issue.

Caldwell finds the thinking errors of child molesters and rapists very similar. One noted difference is the way child molesters perceive themselves as victims. "The child molesters have a tendency to go immediately into the zero state, to be more passive-aggressive. The whole world is against them and they are helpless. To generalize, the rapists seem to be more extroverted with their aggression, and their feelings about loss of face are much more in tune with Samenow's standard view of criminal pride, being a man, and being macho" (Caldwell, 1983).

Caldwell concludes,

> What we're trying to do is to teach people they are 100 percent accountable for their behavior. They may or may not be a product of their environment, but in the long and short of things it really doesn't make a bit of difference. Being a responsible human might not be the most exciting thing they have ever thought about, but in order to survive in the greater community, they are going to have to give up their mistaken ideas about what the world is about and realize that nobody owes them anything. They need to be responsible, but people are not going to stroke them for being responsible. It is an expectation. [Caldwell, 1983]

MONITORING SOU SUCCESS

Since its inception in 1979, the SOU has graduated 20 sex offenders into the aftercare phase of the program. Of the three who have completed their parole, all still are involved voluntarily in aftercare because they view it and SOU as good support systems. Thus far, two of the 20 have reoffended. Both committed thefts, the SOU requested their paroles be violated, and they were returned to prison. "We had some problems with three or four of the men who were the first to go through the program," says Freeman-Longo (1983). "These were the shining stars who went through very quickly, in 15 or 18 months. Some were not completely complying with parts of their discharge contracts and were getting back into their cycles. But we made some changes and our release procedures are now more stringent."

Release from SOU is carefully phased and support for the offender is unending. After completing step 10 (see Appendix L) and achieving minimum custody, the offender receives community passes until he acquires a job. During the first three to six months of work, he returns to the SOU each night. Social passes for up to 48 hours to go home to family or friends or to spend time in town with one of the other aftercare residents are also options during this period. The offender must live and work within 25 miles

of the hospital during the 18 months he is in aftercare and on parole. Staff approve his more permanent living arrangements. However, he still must return to SOU at least twice a week for evening groups (one solely for aftercare men and the other with his original therapy group) and monthly for plethysmograph assessments. Failure to participate could be considered a violation of his parole.

A specially trained parole officer works with all SOU graduates. She has copies of their preassault deviant cycles, does home visits and urinalysis, and conducts supervisory meetings, which are purposely longer than a perfunctory 10 minutes. If an offender appears to be reverting to his old patterns, any of the following may happen: (1) he can be pulled out of the community and returned to the SOU, (2) he can have his parole revoked and be returned to prison, or (3) he can be required to spend all free time, outside of sleep and work periods, at the SOU.

Freeman-Longo says the door is always open at the SOU: "At any point in time from now until the day the sex offender dies, as long as this program exists, a graduate can come back here. If he runs into a problem and feels he might reoffend, we will take him in and put him through the treatment again--anything to prevent a reoffense. They know that this is a support system that always will be around as long as the program is funded. They don't have that kind of option elsewhere" (Freeman-Longo, 1983).

THE SOCIAL SKILLS UNIT: OVERVIEW

The 33-bed Social Skills Unit (SSU) provides three separate treatment programs for its population of low-functioning convicted felons with educational levels below fourth grade and/or serious deficiencies in adaptive behaviors.[18] One of these programs is devoted exclusively to the treatment of sex offenders, who comprise roughly one third of the SSU population. It

18. People diagnosed as "mentally retarded" (below 70 IQ) have first priority for selection, followed by those within the range of the borderline-normal adult. The average IQ in the SSU is the adult borderline range of 78. Occasionally SSU takes persons who are higher functioning but who, due to cultural deprivation and other serious adaptive skills problems, appear to be lower functioning. About 10 percent of the people are mentally ill but are so low functioning they are sent to SSU rather than MED. Others normally would be in the SOU, except that their IQ is below the program's criterion of 80 IQ or above.

is one of a few specialized residential[19] treatment programs in the country serving the long-neglected sex offender who, because of low intellectual capacity, cultural and social deprivation, or deviant lifestyle, lacks the basic skills necessary to function adequately as an independent, productive member of society. As such, its treatment agenda is pioneering, innovative, and somewhat experimental.

James Haaven,[20] Director of the SSU, supervises all clinical treatment activities and facilitates the sex-offender group with a female behavioral co-therapist. Haaven finds the low-functioning sex offender[21] a challenging and complex population to work with but is encouraged about the prognosis:

> 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. That is why the assessment of a low-functioning sex offender is so important in identifying the cause. A great deal of what they are acting out sexually has to do with their inability to manipulate the system to meet their own needs in a socially responsible way and with the frustration and rejection they feel from living in the community. Because they are acting out a generalized frustration, they have a wide range of victims in terms of sex and age. They are less discriminating than the higher-functioning sex offender, who picks and chooses his victims because he has a very ingrained fantasy system that creates his arousal. Because people perceive the low-functioning sex offender as being involved in impulse situational offenses, they feel he is not as dangerous. I don't agree with that at all. He is just as dangerous. The pathology is similar, but the elements that go into it are different. The low-functioning sex offender

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19. See the listing of sex-offender treatment programs in Appendix A, which includes the Moderate Security Unit, Princeton, New Jersey, a residential treatment unit with specialized sex-offender groups for males with IQs ranging from the fifties to the sixties. Also see the Special Problems Unit of the Department of Psychiatry, University of Tennessee, a nonresidential sex-offender treatment program that includes retarded adults. Also see Murphy, Coleman, and Haynes (1983), for description of procedures used in the program.

20. Haaven was formerly a sex-offender therapist at WSH and also directed a mentally-ill offender program in a hospital for the criminally insane.

21. The term "low-functioning" is used here to refer to people with mild mental retardation. It is important to note that, while the same term sometimes is used to describe people with severe or moderate retardation, we do not have that intention here. In this section, "low-functioning sex offender" means "mildly retarded or borderline-retarded sex offender."

needs to talk about his thoughts and feelings, and we need to encourage that in an eclectic way. I believe there is a good prognosis with many of them. [Haaven, 1983]

The goals of the SSU's sex-offender treatment program do not differ substantially from the goals of programs serving higher-functioning sex offenders. Broader goals include increasing the offender's level of social coping skills and reducing his criminality. More specific goals are described as (1) providing an environment where residents have an opportunity to witness their own dysfunctional behavior within the limits of the law; (2) increasing the degree to which residents will accept responsibility for their own behavior; (3) helping residents understand how to produce self-change; (4) providing an opportunity for residents to develop basic educational and living skills; and (5) insuring that residents who complete the program receive continued and consistent treatment in the community.

Within the SSU framework is the basic assumption that deviant behavior is learned. Treatment methodologies are similar to the SOU, with the primary difference being in application of these methods.

As with the other CTP units, upon admission the resident enters a 60-day observation and assessment period in which medical, psychological, psychiatric, academic, and social and leisure skills needs are assessed. Additionally, he is assessed for deviant arousal to all themes, using the plethysmograph to measure penile response to tapes and slides. His motivation for self-change and his willingness to invest in the goals and purposes of the treatment program also are evaluated. The program is voluntary, and the resident can be returned to the parent institution if his behavior is too disruptive for the SSU.

In the SSU, there is a residential treatment period of nine to 18 months, followed by a transitional phase of six months during which community-living skills training is heavily emphasized and treatment intensity maintained. The final phase of treatment is a 12-month aftercare period during which residents live in the community and receive ongoing treatment by attending group and individual counseling and following the conditions of their discharge contracts. Their treatment is directed by an aftercare therapist who is a staff member at the SSU.

Assessment of residents admitted to the SSU suggests that the majority, while lacking in social survival and academic skills and possessing considerable learning deficiencies, are not mentally retarded. They have antisocial

traits but don't clearly conform to the antisocial personality type. They tend to be passive and dependent on others for direction, and they lack impulse control. Generally, they are labeled "losers."

SSU TREATMENT MODALITIES

As in all CTP programs, treatment occurs within the context of the therapeutic community and rests on the assumption that the resident is capable of self-help--taking a responsible role in the functioning of the unit and in understanding his own behavior. Says Haaven (1983),

> We have developed a milieu therapy approach that maximizes responsibility but also goes one step beyond. We try to facilitate an environment that will increase reasoning skills. This means staff must never do anything for a resident that he can do for himself. It also means that intervention occurs in a way in which the resident is presented with options. He then has to reason his preferred option. We find this has a lot of impact.

The sex offenders work and live in a separate section of the SSU.[22] Treatment, both group and individual, is immediate and relevant to each resident's behavior and thinking patterns.

Cognitive Restructuring

Some of the approaches that were described previously as they are used in the SOU, such as Yochelson and Samenow's concept of "thinking errors," needed to be modified to be useful for the low-functioning sex offender. Thus, the SSU has its own innovative cognitive restructuring model called Mistaken Beliefs.[23] This model still is being tested and expanded but appears to be effective, according to Haaven:

> The Samenow/Yochelson approach [of "thinking errors"] was the prescribed concept when we first started the program. I questioned its use with our people. I was interested in trying something cognitive, because it is an area that seems to be overlooked with this population, especially since many of them appear not to have the ability to reason. My thought was that, if you can teach them to brush their teeth, you can teach them to reason a little better.

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22. While separating sex offenders invites some labeling by other residents, the SSU's community process overcomes such barriers. For instance, the other two SSU programs are invited to the sex-offender group for discussion of such mutual sexual issues as homosexuality and masturbation, or to parties in the sex-offender quarters. At the time of the interview there were eight child molesters and two rapists of adults in the sex-offender group (rapists of children are considered child molesters).

23. See Appendix U for a listing of the Seven Mistaken Beliefs, based on Yochelson and Samenow's (1977) "thinking errors."

There is no reason why cognitive restructing doesn't have as much of a chance of success as behavioral methods if you put it into behavioral terms.

We thus have developed our own concept, merging the Samenow/Yochelson elements with Rational Emotive Therapy (RET). Our concern was that people who are borderline types of personalities do not fit well into the Samenow/Yochelson framework, which focuses on innate criminality and doesn't reflect the kind of person who reacts to fear of loss of respect and approval. We merged the two together and developed our own concept of "mistaken beliefs." It utilizes cognitive restructuring--identifying some of the scripts you tell yourself and then trying to replace those with disputing thoughts. In teaching this method we use a lot of repetition and labeling, rather than insight training. We've found that, while higher-functioning individuals learn things through different ways of reasoning (like induction, deduction, or logic), mentally retarded or lower-functioning individuals learn by labeling. They label things, the label fits, and they know what it is.

We have used that as our teaching tool. We will take their journals, which they write in daily, underline their thinking, and label it with the mistaken belief it expresses. They may not understand what that really means, but they learn to identify and label their thinking, and we use these labels as our treatment process. Eventually we replace it with a new statement, a disputing thought, a new label. Even though insightfully they don't understand the process, it provides them with a mechanism for identifying "danger signals" in their thinking.

We foster this process of cognitive restructuring in all of our treatment phases and in all of our treatment activities, including activity therapies. This labeling approach was focused on as a key concept of cognitive restructuring, [based on] the information we had gained on the results of our cognitive mapping tests on our residents and from our experiences as typified in the following example: We had a low-functioning sex offender with an IQ of approximately 65. He had lived in the community for over a year, despite a prior history of more than 19 years of incarceration and an inability to control his sexual offenses against children for longer than 30 days at a time. Before he left, I interviewed him constantly as to what his self-talk was when he would happen to see children in the community. He came up with a statement. He would tell himself, "those brats," and it became his cue to get away from the children and leave the area immediately. And evidently that is what he did when he saw little children.

We feel this is what we can do. Instead of insight training, we can introduce a label that turns on a light. This can be an impactful technique with this group. We are putting a great deal of emphasis in this area and believe much more can be done with cognitive restructuring as well as increasing reasoning ability. [Haaven, 1983]

Behavioral Techniques and Depo-Provera

The SSU, like the SOU, uses a wide variety of behavioral techniques in its treatment of sex offenders. These include covert sensitization, masturbatory

satiation and reconditioning, olfactory aversion, and aversive galvanic stimulation. Also, the SSU recently established procedures for the use of Depo-Provera. To date there are no hard data to indicate the effectiveness of these various approaches, except for covert sensitization, which has proved ineffective, possibly because it relies too heavily on self-expression and imagery. Haaven notes that, in his experience, behavioral techniques by themselves are not satisfactory interventions with low-functioning sex offenders. That is why he places a great deal of emphasis on cognitive restructuring. The use of the penile plethysmograph also has been incorporated into the cognitive restructuring model and appears to be promising. Haaven is encouraging the sex offenders to develop self-talk, using the plethysmograph for biofeedback. "In this way, we can give the men feedback as to how they can verbally affect their arousal level and then verbally decrease it. Right now it looks as if they are learning from this. They are picking up the terms and [substituting] new labels for old labels as to how this is impacting them. Time will tell, but it looks very exciting" (Haaven, 1983).

SSU CURRICULUM

All three treatment groups in the SSU follow the same intensive, structured schedules and rely on the Social Skills Developmental Change Model as the treatment guideline.[24] There is heavy emphasis placed on social skills development, presented in 36 classes grouped into six-week modules. Every six weeks there is a new term and then a break week. Residents must pass these classes, even though it may mean they will have to take them several times. Skills such as conversation, communication, assertiveness training, relaxation, and leisure skills are taught. A great deal of emphasis is placed on the Mistaken Ideas, Disputing Thoughts, Anger Management, and Sexual Education modules. As much as possible, staff design the activity classes to suit the individual resident's specific pathology. Staff try to avoid the traditional classroom setting and instead use more participatory or active instruction, including role playing, video feedback, and so forth. Residents seem to remember learning experiences best when that experience is either fun, bizarre, or dramatic.

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24. For a brief outline of the Social Skills Developmental Change Model, see Appendix V.

There appears to be a high correlation between good time-management skills and adapting in the community. Training the low-functioning offender to maintain support systems, leisure skills, communication systems, and time management is valued more than teaching vocational skills in the SSU. "If they can't maintain their temperament in order to keep friends and their jobs," says Haaven (1983), "the vocational skills will do little good."

Haaven feels there is a great deal that can be done to increase academic skills among the lower-functioning sex offenders, through the way the milieu is organized and especially through the technique of journal writing. "Many of our people can't read or write, so we team everybody up. A person who can't read and write is always with someone who can. Everything he has to write, he tells to his literate partner, who writes it down. The nonliterate person has to transcribe it from one paper to another, and by this kind of mimicking he learns. Their skills increase dramatically.[25] It has been very impressive" (Haaven, 1983).

SSU THERAPY GROUPS

The three separate SSU therapy groups meet simultaneously. Each group meeting has a special topic of emphasis. Initially, the sex-offender group focuses on openness and breaking down the barriers of denial. "We don't put a lot of emphasis on the crime itself," says Haaven (1983). "What we do emphasize is honest disclosure of the thoughts and behaviors of the crime. We know the first treatment plans have been successfully completed when the sex offender has given an accurate detailing that matches all the other reports of the crime we have received."

The sex offenders spend a great deal of time in understanding their own arousal cycle and discussing their past crimes and victimizations. They examine their own experiences as victims of abuse. Generally, low-functioning sex offenders have been institutionalized in a variety of settings for longer periods of time than other sex-offender populations. As a result, a high percentage (approximately 60 percent) were victims of sexual abuse themselves.

MONITORING SSU SUCCESS

Of 30 persons who have completed the SSU program, six were sex offenders.

25. SSU is developing a workbook on cognitive restructuring. It is being written at a fourth-grade level and includes cartoons. It should be available to outside groups by the end of 1984.

None of these have reoffended, and two have been in the community for more than two years.

Haaven points out that the SSU sex-offender population is comprised of people who have had a long history of repetitive crime and an inability to maintain relationships. "Most have not married or even had a close friend. Due to their lack of survival skills, poorly integrated sexual identities, and limited reasoning abilities, the incidence of acting out in an irresponsible way may be higher" (Haaven, 1983).

Nevertheless, Haaven believes low-functioning sex offenders may have a better prognosis of controlling their behaviors in the community than high-functioning sex offenders.

> The reason I believe their control capability may be better, is that the variables causing their frustration can be addressed. Our people don't have the higher-functioning sex offenders' sophisticated and ingrained fantasy system or their manipulative system of grooming and arousal--the excitement of the planning of the act--which may be more difficult to address. We are encouraged. We are getting to the point though, that our unit feels as much a research unit as a residential treatment program, because everything we are doing is on a cutting edge. [Haaven, 1983]

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