ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
5269 SHES SB 467

Social welfare agencies in Alaska take a serious approach to child sexual abuse, and in most places work closely with law enforcement officers in dealing with reported cases of interfamilial sexual abuse. Prevention and prompt reporting of child sexual abuse is the goal of a number of educational and social service programs within the state, in both the public and private sectors.

The Department of Law and the District Attorneys responsible for the prosecution of child sex offenders have, for the most part, vigorously carried out their duties, presenting strong cases and seeking appropriate sentences.

From a law enforcement perspective, much has been done to combat child sexual victimization in many parts of Alaska. Governmental and public awareness of the pervasiveness of this problem has increased. There has been an increase in reporting of these types of crimes. Avenues for cooperation between public and private agencies have begun to be established. New techniques have been borrowed or developed to help address investigative and prosecutorial problems peculiar to these types of cases. Many law enforcement officers have been trained in the dynamics of this type of criminal activity.

Exploited child investigations can be complicated, lengthy, and time-consuming. Some of these cases are every bit as complicated and lengthy as a homicide investigation. Investigators in the Child Exploitation Investigative Unit estimate that the average amount of time needed to investigate an exploited child case is 160 person-hours (or roughly one month of an investigator's available work time). Some investigations consume even more time than this average, and

can take months to complete. Investigators assigned to the unit dealing with these types of crimes must be well trained and highly motivated. The investigator must have the ability to deal in a compassionate and professional manner with victims and their families. The investigator must also develop a broad educational background in this area in order to testify effectively in the court room.

Victims who report the crime to the police often do not do so until well after the crime has been committed. At that point, it is, in effect, the victim's word against the suspect's. Although there is no legal requirement that a victim's statement be "corroborated," as a practical matter it is difficult to prove a criminal case beyond a reasonable doubt unless some substantiating evidence can be developed. This is done in a number of ways, including seeking out other children who were also victimized and developing probable cause for search warrants that will produce corroborative evidence (including the use of covert recording techniques). Coordination with other agencies that have had dealings with suspected perpetrators and the use of behavioral profiles can assist investigators in identifying the perpetrator. Use of covert techniques such as surveillance, confidential informants, and undercover investigations is common.

Child victims of sexual exploitation often do not take the initiative to report the crime themselves. There are many reasons for this, including the fact that the victims often feel terribly ashamed about what has occurred and project the blame upon themselves. The offender's most potent weapon in these crimes is the child's trust; perpetrators are skilled at projecting blame and shame upon the victim.

Consequently, part of the investigative technique in these cases is to take a proactive approach: to identify victims and crimes that have occurred, and then to investigate.

The Child Exploitation Investigative Unit has developed and implemented a number of proactive approaches, including:

1. training youth counselors, social workers, and family service professionals in the dynamics of child sexual abuse so that they are able to actively work with child victims to obtain disclosure;

2. surveillance of areas where potential child victims congregate and where perpetrators often come to target potential victims;

3. use of covert techniques, often in cooperation with U.S. Customs and U.S. Postal Inspectors, to identify and target adults with known involvement in child pornography;

4. use of confidential informants;

5. training of patrol officers concerning the dynamics of victimization so that they can provide data about previously unknown victims or offenders with whom they may come into contact in the course of their normal duties;

6. liaison with probation and parole authorities to monitor convicted serial offenders under their supervision; and

7. establishing contact with other local, county, state, and federal agencies that provide information concerning local offenders and/or victims whom they identify through their investigations in other areas.

Significantly, only a few of the cases handled so far by the Child Exploitation Unit originated within normal law enforcement channels. Most were developed through other sources that had been proactively developed by unit investigators. The unit monitors the activities of known child molesters who are traveling between jurisdictions and of cults where children are ritualistically exploited by adults.

ENFORCEMENT EFFORTS DURING 1987

Case Statistics

Total Cases Investigated	95
Cases Closed by Arrest	31
Cases Closed - Other	42
Cases Currently Under Investigation	13
Investigative Assists	9
Search Warrants Served	14
Arrests	21
Felony Charges	44
Misdemeanor Charges	18
Convictions to Date	15
Acquittals	1
Cases Pending in Court	5

During the course of its investigations in 1987 the unit contacted 73 alleged child exploitation victims. As a result of those contacts, criminal charges were filed on behalf of 29 victims. In the remaining cases either the complaints turned out to be unfounded or evidence sufficient to support a successful prosecution could not be developed.

Description of Charges Filed

Sexual Assault in the First Degree	1
Attempted Sexual Assault in the first Degree	1
Sexual Abuse of Minor - First Degree	11
Attempted Sexual Assault of a Minor - First Degree	1
Sexual Abuse of a Minor - Second Degree	7
Attempted Sexual Abuse of a Minor - Second Degree	1
Kidnapping	2
Contributing to the Delinquency of a Minor	3
Disseminating Indecent Material to a Minor	2
Unlawful Exploitation of a Minor	1
Attempted Unlawful Exploitation of a Minor	2
Delivering Controlled Substances to a Minor	4
Furnishing Liquor to a Minor	3
Enticement	7
Assignation	3
Hindering Prosecution	1
Escape	2
Misconduct Involving Controlled Substance - Third Degree	4
Malicious Destruction of Property	1
Probation Violation	3
Runaways	2
Total Charges	62

Investigative Assistance

Besides the normal investigative duties, the unit assisted in a triple homicide investigation that was conducted by the Anchorage Police Department. Assistance provided by the unit to other agencies last year resulted in the arrest of an adult and some juveniles involved in a car theft ring and the recovery of several stolen automobiles.

The unit also assisted in investigations of gambling and drug law violations and adult sexual assault crimes, all of which led to arrests in those particular cases.

TRAINING PROVIDED BY THE UNIT

During 1987, training sessions focusing on the dynamics, characteristics, and behavioral aspects of child sexual victimization and child sexual abuse were provided to the following organizations:

1. McLaughlin Youth Center staff (two sessions)
2. Alaska Youth and Parent Foundation staff
3. ARCH (Adolescent Residence Center for Health) home staff - Eagle River
4. Village Prevention Committees, Kawarak Inc. - in Unalakleet
5. Nome Teen Center - two-day training for teen center staff, local and state police officers, and other health care professionals in Nome
6. Juvenile Intake Officer - conducted at McLaughlin Youth Center
7. University of Alaska - class on Families and Violence

8. Second National Conference on Missing and Exploited Children, Chicago, Illinois, funded by I-Search (Illinois State Police) and the National Center for Missing and Exploited Children
9. Advanced Conference on Investigation of Exploited Child cases - Washington, D.C. - funded by the F.B.I.

In conjunction with the Anchorage Police Department's Training Section, the Child Exploitation Unit sponsored a one-day training session on the Investigation of Exploited and Missing Child cases conducted by Mr. John Rabun, Deputy Director of the National Center for Missing and Exploited Children. This was held in Anchorage and attended by 25 local, state, and federal law enforcement officers.

The Child Exploitation Unit maintains a stock of publications that are used as training aids in courses on investigation of these types of cases. These are used in conjunction with unit-sponsored training and are available to other trainers as well. Lesson Plans have been developed by the unit for use in training law enforcement professionals and other groups. Training aids, including audio, visual, and printed matter, have also been developed to aid in training.

Child Exploitation Unit investigators are available to other police agencies in the state for technical consultation concerning cases within their jurisdiction. Several times in the past year, other police agencies have contacted unit investigators for consultation on cases they were working. Advice, education, and reference material have been provided to these requesting agencies.

The expertise of one of the unit members has been recognized on the national level; that officer has been selected to travel to Washington, D.C. in March of 1988, to be a member of a group of experienced educators and investigators who will develop a curriculum to be used nationwide to train law enforcement officers in child exploitation investigations.

FUTURE GOALS FOR THE UNIT

While much has been accomplished to increase protection for children in Alaska, there is much more that needs to be done. Among the tasks that the Child Exploitation Unit intends to address in 1988 and subsequent years:

1. Continue present investigations and initiate investigations of new cases involving the sexual victimization and exploitation of children.

2. Conduct proactive investigations to identify previously unreported victims and to identify perpetrators involved in the sexual victimization and exploitation of children.

3. Increase training of law enforcement personnel in order to increase awareness of these types of crimes and to facilitate a greater flow of information between other agencies, patrol units, and the exploitation unit.

4. Establish a system of communication and information sharing among local and state law enforcement units dealing with sexual victimization crimes.

5. Increase participation in federal covert investigations relating to child pornography.

6. Continue to expand existing data base systems and provide assistance where needed to other units within the Anchorage Police Department, the Alaska State Troopers, and local law enforcement agencies employing these data base systems.

7. Establish a computer-based program that will allow investigation into local computer "bulletin boards" where sexual involvement with minors is sought through bulletin board advertising.

8. Identify needs and develop proposed legislation to enhance the laws protecting Alaska's youth.

9. Continue close positive liaison with governmental and private organizations dealing with children who have been sexually victimized and who deal with legislation in this area.

10. Explore the possibility of including forensic social workers in the unit to deal directly in an advocacy and investigative manner with identified and potential victims of child sexual exploitation.

11. Seek increased cooperation with Alaska State Trooper Investigation Units handling cases of sexually victimized and exploited children and consider plans for a joint task force with these units to handle major cases of this type.

12. Expand on cooperative efforts with Adult Probation and Parole Officers to more effectively monitor convicted child sex offenders who are on probation and intervene more quickly when it is suspected an offender is violating the conditions of his release.

13. Work with national experts in this field to establish a protocol outlining expert witness testimony in sexual victimization/exploitation cases.

14. Develop standardized training programs for law enforcement and other professionals in this field.

15. Monitor more closely the status of runaway minors for intervention in cases where the minors are being exploited or endangered while "on the run."

16. Continue to have unit investigators available for consultation with other law enforcement agencies and other professional organizations in matters involving the sexual victimization and exploitation of children.

17. Concentrate enforcement efforts on minors actively engaged in prostitution by conducting investigations of promoters of prostitution and "houses of prostitution."

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Prepared by Patty Barnes
Children's Counselor
Women In Safe Homes
January 29, 1988

Exerts From The Experts

1. Faye Knopp, The Rational and Goals of Early Intervention

Offenders begin deviant sexual interests at an early age, through fantasy and reinforcement by orgasm. The deviant themes continue over and over again. This is the key to persistent deviant arousal. When the problem becomes chronic it takes on life of its own. Specialists who are veterans of treating sex offenders never mention "cure" only control and reduction. These compulsive behaviors are compared to addictive, habitual behaviors such as alcohol, gambling and eating.

Offenders learn through observation and direct experience (molestation), cultural influences, socialization process, chaotic, enmeshed or rigid families and sexual trauma as a child. These all contribute to the dynamics that are used to rationalize abusive behaviors.

2. Gene Abel, Judith Becker, Characteristics of Men Who Molest Young Children, 1983 presentation to World Congress of Behavior and Self-Reported Sex Crimes of Nonincarcerated Paraphiliacs, Journal of Interpersonal Violence, March 1987.

Most unique study and data gathered because 561 paraphiliacs were interviewed who were voluntary subjects not under court order to receive evaluations or treatment (nonincarcerated).

Results show that nonincarcerated sex offenders are:

- Well-educated and socioeconomically diverse.
- Report an average number of crimes and victims that is substantially higher than represented in current literature.
- Sexually molest young boys with an incidence that is 5 times greater than the molestation of girls.
- *- 44% of incest fathers admitted to offending outside the home.
- 50% of men had multiple deviations.
- 232 molesters were responsible for a total of 17,585 victims. (Knopp)
- According to a study of adolescent males they may be expected to have contact with 380 victims during lifetime. (Knopp)
- Offender does not outgrow sexually exploitive preferences. Begin deviant fantasies as early as 12 years old. (Knopp)

- A total of 53 offenders treated at Oregon State Hospital reportedly committed 25,757 sexual crimes.

5. Dr. Irwin Dreiblatt, Ph.D, Pacific Psychological Services, WA, Issues in the Evaluation of Sex Offenders, 1982.

- Sexual Assault is often a chronic behavior problem. Even with only 1 victim. We are unable to predict what his future sexual behavior will be or how it will be managed.

- Strongest predictor of future sexual offense is past offenses.

- Sexual deviant behavior must be viewed as a highly, habitual sexual preference, a habit not very dissimilar than alcohol abuse. One must view the offender as vulnerable to his deviant sexual preference indefinitely. He will fall prey to reoffense if he does not respect his vulnerability and cease to manage his life in ways necessary to prevent reoffense. Such a vulnerability model emphasis that there is no cure, but rather mastery of a serious behavioral problem.

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Sexual offenders act out their deviances at high rates. Behavior does not show the pattern of decline in frequency with age as found in property offenders. It appears they do not outgrow their sexually exploitive preferences. Recidivism rates are high and increase in relation to the number of previous sex offenses and with attraction to male (non-incest child victim). Sexual offenders are motivated to act out their deviances as a sexual preference. In simple terms, they like what they do. They are not in any large numbers psychotic or schizophrenic. Once their sexual preference is established they tend to continue to pursue it. They will most often at the time of discovery have more than one victim and probably more than one deviant sexual focus. In incest cases they molest children outside the home almost half the time.

Offenders tend to return to deviance shortly after they feel safe from criminal justice sanctions. In their histories.

7. Diana Russell, researcher and author, The Secret Trauma, in widely utilized study of 930 women in San Francisco survey found that only 2% of intrafamilial abuse and only 6% of extrafamilial abuse was reported. 38% of women admitted to having been sexually abused, 152 abused by family member.

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February 22, 1988

Mitch Abood, Senator
Alaska State Legislature
P.O. Box V (MS3100)
Juneau, Alaska 99811

Dear Senator Abood:

Re: "Abood wants sex offenders to register"
Anchorage Daily News (02/20/88)

I was glad to read in the newspaper that you have introduced a bill (SB467) that would require a person convicted of a sexual offense against a minor to register with the police. I have long held a introduce in fighting child exploitation and abuse. I feel that your proposal to mandate the registration of child sexual offender with law enforcement officials is a positive step. You might think of expanding the coverage of your bill by including other forms of crimes against children including exploitation, abuse and abduction. In any event, I support your legislation even if it is not amended to cover a wider range of crimes against children. I trust that it will receive favorable consideration in the state legislature. Good luck!

Sincerely,

John W. Sivertsen, Jr.

JWS/CC

Enc: newspaper article

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

Prepared by Patty Barnes
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3. Nicholas Groth, responsible for fixated-regressed typology, author of Men Who Rape and numerous publications on offenders.

- In study of incarcerated rapists and child molesters, (1982), offenders admitted committing up to 5 times as many sexual offenses for which they were apprehended. Child molesters committed first offense as early as eight years, rapists at nine.

- A similar population, 1982 study reflects potential for escalation. Of incarcerated sex offenders interviewed, 35% reported progression from compulsive masturbatory activity, repetitive exhibition to the more serious crimes for which they were convicted as an adult.

- Groth reports in Psychology Today, The Unspeakable Family Secret, 1984 that "sexual abuse is a chronic problem like alcoholism. Offenders shouldn't think of themselves as cured. It's something they have to work on every day of their lives." In evaluating current data on offenders, it appears dangerous to identify intrafamilial offenders as egressed offenders and therefore unlikely to offend outside the home. According to Abel and others almost half of incest fathers admit to pedophilia. Also of interesting note is David Finkelhors data that reveals girls with a step-father are 6 times more likely to be abused than those without. Pedophiles can enter families with ease.

4. Robert Freeman-Longo, director of Sex Offender Unit, Oregon State Hospital, lecturer, researcher, administrator, therapist, Changing a Lifetime of Sexual Crime, Psychology Today, 1986 and Life Magazine, Special Report, The Offenders, 1984.

- Sexually deviant behavior is usually deeply engrained and most sex offenders need extensive psychological help to change deviant thought and behavior patterns.

- No responsible professional in our field would claim that sexual deviancy can now be cured. We can give sex offenders skills and methods for controlling their deviant behavior, but it seldom can be eliminated.

- Sex offenders may adapt their behavior superficially, but unless they develop noncriminal, even empathetic thinking patterns they are likely to revert to their deviant patterns.

- There are no cures in this business. We tell these men they will need to work on their problem everyday for the rest of their lives.

- Estimates of the recidivism rate among untreated sex offenders range between 35 and 80%. These offenders not only commit more sex crimes, but their behavior may help to create a future generation of sex offenders.

- A total of 53 offenders treated at Oregon State Hospital reportedly committed 25,757 sexual crimes.

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Women In Safe Homes
Ketchikan, Alaska

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February 22, 1988

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Sincerely,

John W. Sivertsen, Jr.

JWS/CC

Enc: newspaper article

GEORGE W. BROWN PEDIATRICS

January 18, 1988

Honorable Senator Abood:

As a sense of mutual respect and realistic need for closer cooperation surrounds the start of our U.S. Legislature's second session, I feel even more optomistic that you will help create our Alaska Children's Trust Fund for prevention of child abuse and neglect.

Passage of enabling legislation came very close in the closing hours of the last session. Concerned and capable leadership from among the Children's Caucus in both houses and crossing party lines demonstrated rising priority for Alaskan children. The Governor's hard working Commission on Children and Youth also reflects increasing political leadership for children and families. Economic hard times seem to more clearly focus our awareness of really important values. Children's lives and self esteem are more than simply the "motherhood and apple pie" resources we sometimes caricature and take for granted.

Alaskans always respond as needed to help one another, and especially children. They will support the Children's Trust Fund by their permanent fund dividend check off in 1988 and annually. Experience from other states confirms the soundness of this grass roots approach to prevention of child abuse and neglect.

Thank you for your vote for Alaska children and confidence in Alaska's citizens.

George W. Brown MD

P.O. BOX 2101 PALMER, ALASKA 99645

SECTION I

SEX OFFENDERS AND THEIR TREATMENT

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

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

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

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

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

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

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

HETEROGENEITY: THE REALITY

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

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

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

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

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

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

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

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

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

1400 variables per offender.[8]

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

ARE SEX OFFENDERS "MENTALLY ILL"?

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

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

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

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

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

Medical/Psychiatric Disorders or Diseases

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

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

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

Men with Antisocial Personalities

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

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

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

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

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

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

Paraphiliacs

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

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

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

Abel (1982) concurs:

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

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

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

physical and emotional abuse.

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

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

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

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

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

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

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

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

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

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

and men who have that fantasy and do not rape:

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

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

Multiple Paraphilias

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

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

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

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

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

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

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

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

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

Rapes
(N = 89 rapists)

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

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

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

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

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

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

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

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

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

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

TREATMENT OR PUNISHMENT?

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

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

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

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

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

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

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

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

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

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

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

CAN SEX OFFENDERS CHANGE THEIR PATTERNS?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TREATMENT: CONTROL, NOT "CURE"

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

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

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

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

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

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

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

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

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

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

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

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

observed:

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

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

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

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

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

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

THE RESPONSIBILITY TO TREAT

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

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

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

22. Because this is an incest treatment program for the entire family, it is not described in this book but will be included in a future PREAP publication on treatment of incest offenders and their families.

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

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

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

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

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

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

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CHAPTER 2
MEETING THE GOALS OF TREATMENT: METHODS AND OUTCOMES

The progress of sex-offender treatment has been impeded intermittently by both punitively oriented legislators and inconsistent funding. Sex-offender treatment nevertheless remains a rapidly evolving, multimodal, self-defining, and promising discipline. The 10 sex-offender treatment programs described in this book demonstrate the profound changes in treatment approaches that have occurred since the first American programs were established in 1948 (Brecher, 1978, pp. 5-9). The treatment repertoire has broadened considerably and is rich with innovative, eclectic approaches.

CHANGES IN TREATMENT

At least two factors have affected significantly the direction of sex-offender treatment over the years: (1) the gradual movement away from the "medical" or psychiatric model and (2) the new perceptions that are growing out of the women's movement that address the mythical theories on which therapists have based their treatment of rapists.

The pioneer sex-offender treatment programs were based primarily on the traditional medical or psychiatric model. At that time, the preferred forms of treatment involved one-to-one individual psychotherapy sessions, plus group psychotherapy led by one therapist, usually male. These traditional approaches proved unsatisfactory, so in today's specialized sex-offender assessment and treatment programs it is rare to find offenders "diagnosed" in conventional psychiatric terms or treated by such traditional modes. Rather, sex offenders are perceived as requiring a highly eclectic and multidisciplinary approach, determined by the sex offender's patterns and perceived needs and reflective of the multiplicity of issues surrounding the offense. Says Groth (1983),

> We are obviously talking about an issue that is much broader than simply a clinical or a psychological issue. It is a cultural, a legal, a political, an economic, an educational, a medical, and a spiritual issue. And if we are going to be effective in combatting this problem, it really means approaching it from all of these perspectives.

The pioneer treatment programs, instituted before the development of a cohesive women's movement, were to a large degree captives of the prevailing myths and attitudes about rapists being sexually unfulfilled men carried away by sudden, uncontrollable surges of sexual desire. It was believed that these desires might have been unleashed by provocative victims and that rapists were psychologically sick men or part of a criminal subculture (Knopp et al., 1976, pp. 138-139). Though many of these myths still prevail, feminist theory and advocacy have affected sex-offender treatment approaches significantly, particularly with rapists.[1]

Today, the overwhelming majority of programs are rooted in the perception that (1) rape is basically an assaultive and violent crime acted out sexually;[2] (2) that such behavior is generally culturally or experientially learned; and (3) that rape victims include a powerless range of subjects such as little babies, young children, elderly women, and the infirm, as well as other more able but equally unprovocative victims--young women and young men.

Sex-offender treatment programs have become vehicles for various elements representing a variety of disciplines and perspectives, integrating them into a new and inclusive "sex-offender assessment and treatment discipline." Glaringly absent from the traditional training grounds and curricula of schools of medicine, mental health, and social work, the new discipline is being hammered out painstakingly on a day-by-day basis within the confines of the programs and research laboratories.

THE NEW DISCIPLINE AND ITS GOALS

The new sex-offender discipline includes a variety of psychodynamic, behavioral, cognitive, and biomedical elements and incorporates a wide range of educational and training components. The concept of treatment is an integrated one. Assess-

1. For example, Ralph Garofalo (1982) of the Massachusetts Treatment Center states, "I think partially the change in society's attitude about rapists and rape has come about by reason of the work that the women's movement has done. We wrote a paper on the psychology of the rapist before people viewed rape as an assaultive crime. It was well received, and when the women's movement started to talk about rape as an assaultive crime we began to get more accurate information about the incidence of rape." Also see Greer (1983, p. viii).
2. Says Groth (1984), "The themes of aggression are more helpful in understanding the problem of rape, though it must not be misconstrued that there is no sexual aspect to this behavior. I differentiate the rapists in terms of the dynamics of aggression: the anger rapist, where it is retaliatory aggression; the power rapist, where it is compensatory aggression; and the sadistic rapist, where it is eroticized aggression."

ment of the sex offender, for example, is perceived not only as an initial part of treatment but as a continuing strategy. Similarly, on the other end of the spectrum, postrelease treatment for residential clients is viewed as an extension of the offender's total treatment plan.

Practitioners shape their programs by selecting various combinations of assessment and treatment approaches from this broad repertoire of behavioral, psychodynamic, and biomedical components. In the majority of programs, guided peer-group therapy, usually co-led by a woman and a man, forms the core of the program design, supplemented by individual, and, where possible, family therapy.

In the 10 programs described in this book, the methods for assessing and treating sex offenders are variously interpreted and applied. Collectively they (1) provide us with a comprehensive agenda for fulfilling the offender's assessment and treatment needs and (2) allow us to outline six comprehensive treatment goals for the new sex-offender discipline, which are as follows:

1. Each sex offender needs a complete, individualized assessment and treatment plan; effective initial and ongoing assessment are prerequisites for successful treatment.

2. Each sex offender needs to (a) accept responsibility for the offense(s) in which he has been involved and (b) have an understanding of the sequence of thoughts, feelings, events, circumstances, and arousal stimuli that make up the "offense syndrome" that precedes his involvement in sexually aggressive behaviors.

3. Each sex offender needs to learn how to (a) intervene in or break into his offense pattern at its very first sign and (b) call upon the appropriate methods, tools, or procedures he has learned, in order to suppress, control, manage, and stop the behavior.

4. Each sex offender needs to engage in a re-education and resocialization process in order to (a) replace antisocial thoughts and behaviors with prosocial ones, (b) acquire a positive self-concept and new attitudes and expectations for himself, and (c) learn new social and sexual skills to help cultivate positive, satisfying, pleasurable, and nonthreatening relationships with others.

5. Each residential sex offender needs a prolonged period during his treatment when he can begin to test safely his newly acquired insights and control mechanisms, in the community, without the risk of affronting or harming members of the wider community.

6. Each sex offender needs (a) a post-treatment support, peer, or "rap"

group and (b) continual postrelease access to therapeutic treatment so he can maintain permanently a safe lifestyle.

In the remainder of this chapter, we will examine each of these six goals in turn, as they are addressed by the 10 programs reported on in Sections II and III of this book. We will provide a *very brief* overview of the various assessment and treatment modalities used in these programs, in order to give the reader a general perspective on how the field of sex-offender treatment functions in regard to the six goals. On two exceptional points, however, we will provide a more detailed discussion:

1. The techniques for assessing sex offenders through physiological monitoring on the penile plethysmograph, combined with subsequent behavioral treatment, as practiced by Richard Laws, Director of the Sexual Behavior Laboratory at California's Atascadero State Hospital

2. The applications of the hormonal drug, Depo-Provera, in controlling paraphiliacs, as it is used by Fred S. Berlin, Co-director of the Biosexual Psychohormonal Clinic at Johns Hopkins Hospital

These two more in-depth examinations are included here because both techniques are less well understood than other modalities and require more adequate exploration than is contained in the individual program descriptions.

GOAL ONE

Each sex offender needs a complete, individualized assessment and treatment plan; effective initial and ongoing assessment are prerequisites for successful treatment.

Evaluation and assessment of the sex offender are crucial not only for determining individual treatment needs but also for assessing risk to the community in terms of selecting appropriate settings for treatment.[3]

Groth (1983) views assessment as the first step in the treatment of the sex offender, in that it is in part a kind of therapeutic intervention. "When you are doing treatment," he says, "you are continually refining your assessment. The two go hand in hand."

The methods used to determine the treatment needs of individual sex offenders generally include a lengthy personal interview with the client and his

3. See "Evaluating Risk to the Community," in Chapter 3 of this book, for a list of risk criteria and other factors involved in community placement.

family; a review of criminal justice, social work, and mental health agency reports; the use of a substance-abuse checklist; and some of the following tests and procedures.

Psychological and Psychosocial Testing of Personality, Intelligence, and Ability

These tests include the Minnesota Multiphasic Personality Inventory (MMPI), the Millon Clinical Multiaxial Inventory (MCMI), the California Psychological Inventory (CPI), the Adjective Check List (ACL), the CAQ Par II, the 16 PF Form c, the Motivation Analysis Test, the Pacht Hostility/Guilt Inventory, the Spence-Helmreich Attitudes toward Women Scale, the Bender-Gestalt Test (which detects damage to the cortical area of the brain), the Shipley Institute of Living Scale, and the Wechsler Adult Intelligence Scale (WAIS).

Psychosexual Testing

Tests include the Clarke Sexual History Questionnaire, the Thorne Sexual Inventory, and various sexual inventories formulated by the programs.

Ongoing Guided Sex-offender Treatment Groups

Requiring an offender to spend a period of time in such a group is particularly prevalent among residential treatment programs, where the offender is subjected to a 30- to 60-day evaluation and assessment period. Peer-group members often are considered more keen evaluators of fellow sexual aggressives than professional staff.

Autobiographies

Since assessment is an ongoing process, a full autobiographical account of the sex offender's life may provide the therapist with insight into some of the familial, characterological, and other factors that may have contributed to the offense and may require special focus in the treatment plan.

Social and Empathy Skills Testing

Through various tests, role plays, self-report inventories, and the use of videotapes, the offender's social and empathic skills can be tested. Self-report inventories on shyness, fear of rejection, social anxiety, and distress are used in several programs.

Physiological Penile Assessment

The penile plethysmograph measures the erection response to various stimuli. The

assessment procedures described here include (1) videotape assessment procedures for rapists, (2) audiotape assessments for rapists and pedophiles, (3) slide assessment for pedophiles, and (4) the Abel or Laws 260-item card-sort of sexual preferences.

Richard Laws, a pioneer in the development of these behavioral procedures, operates on two premises: First, that all sex offenders, irrespective of whatever else may be wrong with them, have problems with deviant sexual arousal; and second, that all sex offenders have problems with self-control of that arousal.

> They are impulsive, they do not think about consequences, and generally do not even care about such things. They care only about the gratification involved in the commission of these offenses. As behaviorists, we are attacking in a very straightforward manner the central problem that we find in sex offenders, that is, lack of self-control over the deviant sexual arousal. The way we do this is extraordinarily simple. We measure sexual response in the male.[4] That is the central measure we use, though we obtain a great deal of other information that is useful through self-reporting or other methods. [Laws, 1981]

The central index of change is the penile erection response, measured by a simple circuit that directly assesses male sexual arousal by monitoring penile tumescence. The sensing device, a transducer attached to the penis, detects the arousal response and sends an electronic signal to a recording device that can read out the minimum, maximum, and all intermediate values of the response. The behavior is recorded on a polygrapn, a piece of moving paper with a pen that writes on it. When viewed on the polygraph, the sexual response in the male very much resembles a normal distribution curve. Also used are smaller, portable units, where the response is recorded digitally as a percentage from zero to 100. These procedures are used both for initial assessment and for monitoring treatment.

In the assessment procedures, Laws uses the erection response to get a profile of the kinds of things that arouse a particular individual, the kind of deviant stimuli or nondeviant stimuli that will "turn a person on." Laws has found that many rapists have adequate arousal to appropriate descriptions, pictures, videotape sequences of what appear to be people engaging in mutually consenting intercourse. He also finds that they have high arousal to scenes and descriptions of rape and of pure physical assault with no sexual activity

4. Sexual responses in women also can be measured by using the vaginal photoplethysmograph, which measures vaginal blood flow.

involved. "With a man like that," says Laws (1981), "treatment efforts are going to be directed toward suppressing the arousal in those deviant categories and, if necessary, using some kind of mechanism to keep appropriate arousal strong."

Sometimes Laws finds just the opposite situation with pedophiles. Using this particular index, pedophiles may show no sexual interest in adults, whether male or female, but show extremely high arousal to children. In such instances, Laws endeavors to reverse the relationship by cultivating nondeviant arousal and suppressing the deviant arousal. Thus, treatment for a pedophile would differ from that of a rapist, as we shall see.

Two other assessment procedures are used with rapists: videotape and audiotape assessments. Laws claims the videotape assessment is very effective with rapists, "effective" meaning that 90 percent of the rapists referred to the program can get sexually deviant arousal from a videotape in a laboratory setting.

The video assessment has 12 sequences, four sets of three scenes. The three scenes depict mutually consenting intercourse, a rape attack, and a physical assault with no sexual activity. The scenes are two-minute silent simulations in black and white, with a little bit of nongenital nudity. In the mutually consenting scene, a man knocks on the door of an apartment and is admitted by an attractive female. They embrace, undress one another, and appear to be having consenting intercourse. In the rape attack, the man barges into the room, drags the woman around--generally into a bedroom--pulls off her jeans, and appears to force himself on her sexually. In the physical assault scene, the man barges into the apartment, hits the woman and knocks her around physically, bangs her down to the floor, and throws her around the room.

Half of the 12 scenes are presented along with instructions to the offender that he not try to interfere with his arousal. The remaining six scenes are presented with instructions for him to try to suppress arousal and exert self-control. In all these instances the viewer is asked to give an estimate of how aroused he was and the maximum arousal he reached, stated as a percentage.

At the conclusion of these visual procedures, the therapist has essentially three indices from the sex offender: (1) a picture of his behavior in terms of how he responds to various stimuli when he is not trying to control himself; (2) an index of his self-control under instructions to suppress his erection response; and (3) an index of his personal awareness of how aroused he was.

Laws (1981) comments on one of the specific responses some rapists have:

> Let us say we measure 85-percent arousal in the scene of consenting intercourse, and we ask him to estimate that for us, and he says it is about 80 percent. Then we show him a rape or a physical assault scene and we measure 100 percent--a full erection to the scene of rape and assault. We ask him how aroused he was to those scenes, and he says about 35 percent. There is a tremendous amount of feedback to the erection response. There is no way you can get a 100-percent erection and label it 35 percent. So what are we faced with in this instance? Either the rapists are absolutely refusing to acknowledge that they are getting aroused or they simply are lying.
>
> This procedure turns out to be an extremely useful technique. Once again, it is not a diagnostic technique. We already know the man is a rapist. But by looking at the amplitudes in that erection-response curve, it is possible to correlate them with various sequences in the videotape and know which part of the videotape turns him on the most. This procedure will give us a far better picture of his arousal than you could ever get from a self-report or any existing public records.

The audiotape assessment used with rapists is essentially an alternative form of the video procedure. Instead of videotapes of the scenes, there are audiotape descriptions. For most people, audiotapes produce less arousal than videotapes but considerably more than slides, which are the weakest medium except for use with some pedophiles.

For pedophiles, both a slide assessment and audiotape assessment are used. Laws (1981) reports that pedophiles appear to be less arousable in a laboratory setting than rapists, and the older the pedophile the less likely he is to be aroused in such a setting. The slide assessment is about 65- to 75-percent effective under such circumstances.

The slide assessment consists of about 40 slides divided into eight categories of five slides each. There are four categories picturing males and four with females, with the sexes broken down by age groups (five slides in age group one to seven, five for age group eight to 12, five for the group 13 to 17, and an adult category). The slides, which are shown for two minutes each, are all of unclothed male and female subjects who are not engaging in sexual behaviors. The maximum amplitude of the erection is recorded, means for each of the categories are computed, and a profile of sexual arousal is plotted. Thus, a pedophile who molests boys in the eight-to-12-year-old range would peak in the profile at that age category, go down toward zero as the boy's age increased, record no interest in adult males, and register nothing in arousal to females. On the other hand, a number of pedophiles who are attracted to females show adequate adult arousal, which is considered a real strength. "Obvi-

ously, a male who is married or in a relationship and can function adequately in an adult sexual role has a better chance of success than a person who doesn't have those skills or opportunities," says Laws (1981).

The audiotape assessment used with pedophiles offers a method for differentiating pedophiles who appear to have a potential for violence from those who do not. For this purpose, Laws and his colleagues have developed a graduated series of audiotapes describing situations of increasing use of violence by the offender to effect a relationship with a child. There are separate series for the heterosexual pedophile and for the pedophile attracted to the same sex.

The six categories described are (1) fondling of the child with no sexual activity; (2) mutually consenting intercourse with a child; (3) psychologically coercive and nonconsenting intercourse with a child (the person, through adult authority, simply forces himself on the child); (4) rape of a child; (5) sadistic assault of a child without sexual activity; and (6) a control tape that describes consenting relationships with a male or female adult. Says Laws (1981),

> The series was dynamite! You did not need any statistical analysis to tell you that this procedure had very handily separated these people. There were no differences in the fondling, consenting intercourse with the child, or psychologically coercive categories--they were identical at that point. But when you described rape and sadistic assault, the people who had been designated as violent men continued to respond at a very high level. The people who had been designated as nonviolent dropped way down; there was this enormous separation. We have used this method very successfully over the past years, and it is easily one of the best assessments that we have.

This series has proved effective with more than 80 percent of the pedophiles who are responsive in the laboratory setting. It further contributes to the means for more adequately assessing risk for community-based versus residential treatment settings for pedophiles.

Laws designed 12 audiotape sequences for assessing exhibitionists. These represent classic exhibitionist situations: Four describe the victim showing interest; four describe the victim appearing to be repulsed and fleeing the scene; and four describe the places where the exhibitionist traps the victim and forces her to observe his actions. He traps her in an alley, an elevator, and in her car (by taking the interior handle off the door on her side of the vehicle). In each of these instances, he forces her to observe his exhibitionist type of behavior, which always includes masturbation and ejaculation (which not all exhibitionists do).

Laws also uses a 260-item card-sort on regular three-by-five index cards, which is a revision of the original set developed by Gene Abel and his co-workers. There are 13 sets of 20 cards each, and 13 kinds of different sexual behaviors (for example, adult heterosexuality, adult homosexuality, male and female pedophilia, male and female incest, and so forth). A two-to-four-line statement on each card describes a specific kind of sexual activity. Whether he ever has performed the behaviors or not, the person is asked to read the statements on the cards and rate each one on a scale from one to seven ("one" being highly repulsive and "seven" being highly attractive). He uses this procedure to sort all 260 cards into a series of seven corresponding bins. The means then are computed, based on the number of cards in each bin. This provides a self-report profile of sexual interest. Four is considered the line of neutrality; everything below three is a strong rejection of the statements, and everything above five a strong endorsement. The pattern of a person who is not lying will very often corroborate the erection-response measures and also will provide additional information on categories not available in other assessment materials. Laws (1981) comments,

> It is interesting to note that, if you measure their erections first and then give them the card-sort, you are much more likely to get an honest profile. If you give them the card-sort first, they will pile up all the cards at the adult end--adult homosexuality and so forth--and reject almost everything else. Sex offenders, if you give them the opportunity, are often chronic liars. They are trying to suppress information, and it doesn't really matter how much you have the goods on them--they will still try to weasel out of it.

Laws (1981) believes the physiological measurements are crucial to treatment, because he cannot rely entirely on self-report from offenders[5]: "They tend to deny, rationalize, and minimize everything they have done to make themselves appear as nondeviant as they possibly can. Were I in their position, no doubt I would do the same thing; however, once we have this reliable information and the client is cooperative, we can institute and carry out the proper treatment procedure."

5. The Sexual Behavior Clinic at the New York State Psychiatric Institute confronts the offender with the results of the psychophysiological assessment, specifically asking him to explain the discrepancies between his self-report and the erection data. About 40 percent have admitted to other sex crimes as a result of utilizing this technique (Becker, 1984).

GOAL TWO

Each sex offender needs to (a) accept responsibility for the offense(s) i which he has been involved and (b) have an understanding of the sequence of thoughts, feelings, events, circumstances, and arousal stimuli that ma up the "offense syndrome" that precedes his involvement in sexually aggre sive behaviors.

Offense Responsibility

Given the tendency of sex offenders to deny, minimize, rationalize, or lie abo their sexually assaultive behaviors, getting them to own and accept responsibi ity for their acts is one of the first elements on the treatment agenda. Some programs will not accept offenders if, during their orientation period, they refuse to be honest and continue to shift blame elsewhere or insist that becaus of drugs or alcohol they cannot remember the incident.

Often police reports and victim statements describing the crime are read aloud to refresh memories, and in a few instances a polygraphist is employed to assess the truthfulness of statements.

The confrontive, guided-therapy groups, with their strong peer cultures, are usually instrumental in getting the offender to take responsibility for his behavior. In many groups, a first procedure is for each member to introduce himself and give a description of his behavior; for example, "My name is John and I am here because I raped my 12-year-old daughter, made her pregnant, and molested three of her young girlfriends, ages 11, 12, and 14." This encourages the reluctant new participant to speak up. Some programs require this type of self-introduction every day that the offender remains in the program. If anyone neglects to include all of the crimes in which they were involved, the peer-group members prod him until all the assaults are included.[6]

Understanding Offense Antecedents

A combination of (1) psycho-socioeducational modules, (2) insight, cognitive and Rational-Emotive therapies, and (3) behavioral approaches is employed in getting the offender to become familiar with the sequence of thoughts, feelings, events, circumstances, and arousal stimuli that comprise his offense

6. This writer has been surprised to visit programs (not reported on in this book) where, even after one year in treatment, the sex offenders were still shifting blame and refusing to take responsibility for their acts.

syndrome--the chain of factors that he activates prior to his offending.

Here, some of the underlying theoretical differences between behavioral and psychodynamic/insight therapies may be accentuated. Nevertheless, when the theories are extended from the theoretical into active techniques and integrated into programs with eclectic treatment agendas, each approach appears to be enhanced or complemented by the other. These theoretical differences, long standing in the mental health field, deserve a more detailed discussion than the scope of this book allows. However, the following perspectives of two respected and experienced sex-offender research and treatment specialists reflect briefly some of these differences as they relate to the issues of antecedents and methods of intervention.

A. Nicholas Groth, whose clients are largely but not exclusively incarcerated sexually assaultive men, focuses on the offender's experiential and developmental history and resulting characterological disorders. He perceives many of the offenders' sexual crimes as being one way they choose to act out unbearably stressful situations that they never learned to handle in appropriate and nonassaultive ways. His psycho-socioeducational treatment agenda includes helping the offender to learn about the causal factors and stress areas involved in his offenses and to learn more appropriate ways of handling them.

> When we talk about rapists and child molesters,...we are dealing more with problems surrounding emotional immaturity than emotional disturbance. When we are talking about sexual assault, we are talking about a behavior that anyone could exhibit.... Maybe some of us--only under extraordinary circumstances and for a temporary period of time--are likely to do ourselves harm, but there are some people for whom ordinary life demands are so overwhelming, so stressful, that their resources for coping and managing their lives effectively--making their lives happy--are so deficient that we think of them as high risk for committing suicide or harming themselves in some fashion. Much in the same way do I think about a sexual assault. Maybe some people think about it or fantasize about it and never act on those thoughts or fantasies. There may be some people who do it once or twice and then appreciate its incorrectness or inappropriateness and self-correct their behavior.... But the people I am talking about, who I have had a chance to work with, who I identify as rapists and child molesters, are people for whom ordinary life demands seem so overwhelmingly stressful that their characteristic response is through sexual assault. We see these people as high risk for such behavior.
>
> We do not think rapists and child molesters are born that way. We do not think that they have somehow led happy lives and then suddenly overnight at age 21 have turned into a rapist or child molester. We think of it as a developmental defect, that something has transpired in their lives that has shaped them or propelled them toward such behavior. We are suggesting that this behavior is in some respects stress related. We see

sexual assault less as the expression of sexual desire and much more the expression of aggression; this response is in reaction to what the offender feels or experiences to be overwhelming stresses.

The question, of course, comes up: Why, when stressed, does this offender exhibit his behavior in terms of sexual assaultiveness, when other people who have equal misfortune, or equal stresses in their lives do not? We do not yet know what all the factors are--in what relationship to each other, at what critical point in development, with what intensities--that need to occur for a person to develop into a sex offender. We do recognize there are individual differences. Some people when stressed develop ulcers. Some people when depressed lose their appetites, other people overeat. So sexual assault, like all other types of behaviors, will be determined in part by biological, psychological, social, and environmental factors.

What we are finding as a prominent influence in the life histories of sexual offenders is their own experience of sexual victimization as children, and this discovery has influenced our thinking in how to help offenders. In one sense, we'd ask the question: How do we help people who have been sexually abused? [Groth, 1983]

Gene G. Abel, a pioneer in behavioral treatment for sex offenders, whose clients are largely nonincarcerated and voluntary participants in treatment, validates the need for identifying the antecedents to sexually aggressive behaviors, if only for the purpose of learning the key points at which behavioral intervention can disrupt the chain reaction. Because he perceives sexually aggressive behaviors as taking on a life of their own through chronicity, however, his treatment strategies deal primarily with the deviant arousal itself, rather than the characterological deficits that developed as a result of early life experiences or other events.

As a behaviorist, my need to understand the history of the patient is related only indirectly to its use in treatment. That is, if we know the factors that contributed to the commission of this crime, if we know what factors are antecedent to the urges, if we know what behaviors are antecedent to actual involvement with the kids, then we can disrupt the secuence of behaviors leading to child molestation. For that reason, it is helpful to know the antecedents to the individual's approaching children.

I do not believe that understanding the original etiology of these crimes is of value, because all deviations do emanate from some cause. But once the individual begins to perpetrate the sexual crime, the crime in itself, because it is a reinforcing experience for the offender, becomes rewarding. The original cause of the behavior could be resolved completely and yet, because the behavior of offending upon a child, or raping a woman, or exposing yourself is so reinforcing to the individual, it carries on a life in and of itself. Therefore, the "historical how" of this problem is not critical to understanding what the treatment needs are, specifically, because the behavior propagates itself.

I do not know the cause of child molestation, but I do believe the reasons for this and most other sexual deviations rest with an arousal pattern. That is, individuals don't molest children just because they

> weren't doing anything that day. They have interest in children. They like children. They find children sexually attractive. And it should be no big surprise that they commit child molestation, because that is what they are interested in. I think that is the key to it: understanding where the arousal pattern is and dealing with that. [Abel, 1982]

The approaches used by the programs described in this book to help offenders identify the chain of factors that lead to their sexual offenses are wide ranging. Group and individual sessions, the writing of autobiographies and wall charts, journal and log keeping, and penile plethysmograph assessments of sexual arousal patterns all assure that the men will learn their preoffense emotional, cognitive, physical, and environmental patterns.

In many programs, these offense cycles are noted in the offenders' files and contribute to the reshaping of individual treatment plans and the structuring of release contracts that list environmental and other restrictions based on these reports. Parole and probation officers who are specially trained to work with sex offenders in the community become familiar with the offenders' offense cycles so they can recognize the patterns when they begin to develop. Programs strive to have the offenders recognize the warning signals as early as possible so they can intervene in their drift toward reoffending.

GOAL THREE

> *Each sex offender needs to learn how to (a) intervene in or break into his offense pattern at its very first sign and (b) call upon the appropriate methods, tools, or procedures he has learned, in order to suppress, control, manage, and stop the behavior.*

The first step in breaking into the offense pattern is to recognize the earliest link in the chain of thoughts, feelings, and events that lead to offending. Testing new interventionary tools is more difficult in the artificial confines of residential programs that do not offer gradual and controlled release procedures that permit a testing period for offenders who have been locked up for a long period of time.

Control techniques range from the least-intrusive to the most-intrusive methods. They sometimes can be called into play autonomously; in other instances they may require assistance.

If, for instance, heightened stress, anxiety, or tension are the warning signals that have been identified as the feelings preceding the sexual aggressive's thoughts and fantasies, as a first step the offender might call upon the

relaxation methods and stress-management techniques he has learned through the use of relaxation instructional tapes, biofeedback, and relaxation groups.

If his thoughts persist he can engage in a range of interventions beginning with simple techniques of thought-stopping, thought-shifting, impulse-charting, and cognitive deterrents. Next he can employ stronger interventions, such as scheduled overmasturbation, asking his spouse or significant other to monitor his behavior; or manipulation of the environment so that he removes himself from the settings where the tempting stimuli are located, or has others help him do s

If his deviant thoughts and fantasies still persist, he can call upon the aversion/behavioral-suppression methods he has learned. These might include covert sensitization, cognitive aversive conditioning, modified aversive behavioral techniques, masturbatory satiation, and olfactory aversion.

Laws recommends the use of at least two behavioral interventions to decrease deviant arousal[7]: olfactory aversive conditioning and verbal satiation. Berlin is a proponent of the hormone, Depo-Provera.

Olfactory Aversion

This intervention usually is used with a person who already has high nondeviant arousal as well as high deviant arousal. The intent is to wipe out the second category. A nasty smell (ammonia fumes) is paired continuously with brief two-minute slide presentations of, for instance, a naked eight-year-old girl, if that has been the pedophile's deviant-arousal subject. The viewer smashes a small net-enmeshed capsule of spirits of ammonia and waves the smashed capsule under his nose. The noxious fumes make it nearly impossible to produce an erection response. Says Laws (1981),

> We do that over and over again, and it absolutely suppresses deviant sexual arousal. It is extremely efficient and effective to use in a community-based treatment program. We are trying to design treatments that don't require a laboratory to carry them out. These little capsules are so small you could carry two or three dozen of them in your pocket and use them anywhere you get turned on to deviant behaviors. You never have to be afraid, because you always know it will have the effect of wiping out the arousal. We think that is a good kind of procedure.

Laws (1981) notes that other aversion conditioning procedures include requesting the offender either to report peak arousal to various deviant stimuli

7. Other behavioral interventions are described within the context of the programs in Sections II and III.

or to have such arousal measured on the polygraph. If the arousal hits a certain point, the person receives a mild electric shock (aversive galvanic stimulation). Laws is firmly and resolutely against the use of electric shock in aversive conditioning procedures:

> I do not use electric shock, because I think it is a phony way of teaching somebody. Electric shock has never shaped anybody's behavior for doing anything useful. I think it is an inhumane treatment, not to mention that the literature is replete with examples of it not working very well with human beings. The animal literature shows that you practically have to lay the organism out flat with electric shock if it is going to have any effect on suppressing behavior. No one ever uses the intensity of shock anywhere near what is required with humans. You couldn't. In fact, they usually let sex offenders set their own shock level, and that is ridiculous.

Verbal Satiation

This intervention involves a very simple procedure used thrice weekly in the laboratory. The person is hooked into the erection-response measurement equipment while wearing a headset. He is asked to sit there and recite deviant sexual fantasies aloud for 30 minutes without stopping. His headset is hooked up to a voice-operated relay; if he pauses for more than five seconds, a loud tone goes off in his ears and the only way he can shut the tone off is to start speaking again. The deviant fantasy is monitored by laboratory staff via the intercom. "What happens," explains Laws (1981), "is that it blows away fantasies immediately. Within two or three weeks, or within a very few sessions, the person has totally exhausted his repertoire of effective fantasies. If he can't think of anything to say, the tone goes off in his ears, so he has to talk, and only deviant fantasies will do. It becomes very boring."

After about three or four weeks, the procedure seems to have the effect of staying ahead of the ability to create new fantasies, because as soon as he tries to create a new one and makes it effective, the procedure destroys it.

Depo-Provera

A treatment intervention suggested for selected compulsive sex offenders is the hormonal drug Depo-Provera (Medroxyprogesterone Acetate, or MPA). Fred S. Berlin, psychiatrist and Co-director[8] of the Biosexual Psychohormonal Clinic at Johns Hopkins Hospital in Baltimore, administers approximately 500 mg of the drug to about 80 sex offenders weekly. Most of the men are on probation or

8. Berlin is co-director with John Money, the medical researcher and clinical psychologist who started treating sex offenders with Depo-Provera on a limited basis in 1966 at Johns Hopkins Hospital.

parole and about one dozen are incarcerated in the Maryland State Penitentiary. All are voluntary candidates for Depo-Provera.

Berlin contends that the weekly injections of the drug provide the potential for compulsive offenders to curb their sex drive and sexual fantasies through the suppression of production of the male hormone testosterone. This reduction in testosterone is perceived as increasing their capacity for self-control and diminishing "obsessive ruminations and preoccupations that they are unable to extrude from their minds" (Berlin, 1982). The drug has been used primarily with the most compulsive paraphiliacs, namely, exhibitionists and male pedophiles attracted to the same sex; with voyeurs, masochists, and other paraphiliacs; and least often with compulsive rapists. Says Berlin (1982),

> The rationale for the treatment that we are using with sex offenders whose sex offenses are the manifestation of a deviant sexual desire or a deviant sexual appetite, is to try to suppress that appetite in order to facilitate self-control. The idea is, if what you hunger for sexually is little children, probably you are going to be better off being less hungry so that you will be less tempted and better able to control yourself. The way we reduce that hunger is by providing a medicine that reduces testosterone, which more or less fuels the male sex drive.
>
> If the sexual desire is for age-appropriate partners--fine. But if they discover within themselves that the desire is to expose themselves on the street corner, as the exhibitionist discovers; to have sex with children, as the pedophile discovers; to spend most of their life running around peeking in windows as the voyeur discovers; if they discover they have deviant sexual appetites, then in our society they are going to be in a great deal of trouble. They may want to *not* hunger so much in those ways in order to try and stay out of trouble, both for the sake of others and for their own sake.

The production of testosterone begins with a tiny organ in the brain called the hypothalamus, which releases a hormone that activates the pituitary gland to begin secreting LH and FSH hormones.[9] When injected, Depo-Provera acts on the hypothalamus and thus on the pituitary to slow or stop the release of LH and FSH and so temporarily stops or decreases the functioning of the testes and thus reduces sperm production. These injections do not create impotence but have the effect of "cooling down" the sex offender while other psychotherapeutic and behavioral interventions can be administered. In other cases, the injections may be lowered in dosage and maintained for an extended period of time.

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9 In women, these two hormones stimulate ovulation; in men, they stimulate the testes to produce testosterone and sperm. Testosterone is the hormone that fuels the male sex drive and also causes the growth of facial hair, the deepening of the voice, and the enlarging of the muscles.

Before Depo-Provera is administered, Berlin and his staff screen the sex offender to determine whether the behavior is a reflection of a problem discerned as treatable through means other than Depo-Provera, or whether the behavior is so ingrained and compulsive that it eludes other modalities alone. Procedures usually consist of three steps: (1) preadmission screening (outpatient); (2) inpatient admission for a period of 20 or 30 days while further assessment and treatment are planned and the effects of the drug are monitored; and (3) outpatient treatment and follow-up.

Assessment includes a complete physical; a personal, psychiatric, and family history; a biological examination of the various hormone levels in the body; and in some cases a chromosomal analysis and x-rays or EEG's of the brain.[10] If a person requires immediate treatment, seems well motivated but presents a potential threat to the community, and none of the hospital beds are available, he may be started on the antiandrogenic medication and placed on the waiting list until he can be evaluated more fully. Less than 40 percent of the men the clinic treats receive Depo-Provera, but all patients are involved in counseling, usually in groups.

If the person is found suitable for Depo-Provera, he receives weekly injections for an indefinite period of time, accompanied by one and one-half hours of group counseling during the first two years in the program. After completing counseling, he is monitored during his weekly appointments and is contacted by the counselors at least twice a year.[11] If while on probation or parole he does not comply with the conditions of treatment, he is reported to the courts or his probation officer.

Controversies over the use of Depo-Provera are wide ranging. Questions have been raised about

1. Its short-range negative effects
2. Its potential for more harmful long-range effects
3. Its potential for use under conditions that are nonvoluntary, unmonitored, and indiscriminately punitive rather than remedial
4. Its efficacy in controlling sexually aggressive behaviors

Short-range Negative Effects. The short-range side-effects of the drug

10. For a discussion of biological pathologies, see Berlin (1983, pp. 83-123).

11. Seventeen patients have been on Depo-Provera for at least five or six years and are followed individually rather than in group sessions.

may include weight gain, sometimes up to 30 pounds. In some cases, hypertension has been reported. Other drug recipients complain of nuisance symptoms similar to postmenopausal symptoms, such as hot flashes, cold sweats, and nightmares. Mild elevation of blood sugar in some clients, weakness and fatigue, loss of some body hair, and tenderness in the testes are other reported effects. Though the drug does not "feminize" the men, it does decrease the size of their testes becausc it slows or shuts off their functioning (a symptom that is reversed when Depo-Provera is discontinued).

Though such side-effects are not always present, the potential for them to occur with certain clients is; therefore, careful medical monitoring, such as that provided by Berlin and his staff, should be a requirement for administering the drug. "All drugs have short-term side-effects," says Berlin (1984b). "These must always be considered in deciding to use any drug."

Long-range Harmful Effects. The long-term effects of Depo-Provera are difficult to pinpoint scientifically, particularly since the longest period of time any humans have been receiving injections is for 10 to 15 years. Opponents of the drug, however, fear it may be carcinogenic. Animal studies conducted by the Upjohn Company (the manufacturers of the drug) showed that doses 25 times those proposed for human subjects caused breast cancer in female beagle dogs (which are reported to be particularly susceptible to this type of cancer). Also uterine cancer developed in rhesus monkeys who were given 50 times the human dosage.[12] Depo-Provera has been approved by the Food and Drug Administration (FDA) for treating inoperable cancer of the endometrium and kidney, but not specifically for the treatment of sex offenders.[13]

Use As Punishment. Berlin and other responsible treatment practitioners administer the drug only under conditions considered voluntary (each recipient signs a voluntary consent form). Some uninformed judges, however, erroneously view Depo-Provera as a panacea and have meted out sentences that require the offender to receive such injections. Critics recognize the fact that, in such cases, the drug is being called upon as a punitive alternative to a failing

12. Depo-Provera is used in 82 countries of the world as a female contraceptive. It provides long-term suppression of ovulation. Thus far there is no evidence to indicate that this drug is carcenogenic with humans, but record keeping and the tracking of subjects are difficult among Third World populations. Nevertheless, the drug has the approval of the International Planned Parenthood Federation, the World Health Organization, and others.

13. Although the FDA technically has not sanctioned use of Depo-Provera specifically for the treatment of sex offenders, it can be administered through FDA regulations that stipulate that, once a drug has been approved, physicians make the decisions about how it is used.

prison system, a factor also recognized by Berlin, who is vehemently opposed to using the drug as punishment. "There is no doubt," he says (1984a), "that use of Depo-Provera has escalated in recent years and that with the escalation has come some improper use--and this must stop. This is not a country, for example, where we cut off hands and feet to teach a lesson and I don't think we want to start prescribing medical treatment as punishment."

Efficacy. Berlin's program claims success with 85 percent of the men. Since the beginning of the formalized program in 1979, none of the men receiving the drug have been discovered to have committed a physically aggressive sex offense, but there have been some instances of exhibitionism or voyeurism. "There is probably more known about the mechanism of action of this drug than any other psychotropic medication," says Berlin (1984b). "The literature documenting the relationship between low testosterone levels and low sexual libido is voluminous. This is true of every species studied, including humans."

Though some treatment programs would like to offer Depo-Provera as an option, others frown on the use of the drug. For instance, Richard Seely, who in 1971 made a study of Depo-Provera at the Minnesota Security Hospital's former BEAD sex-offender treatment program, says,

> The Intensive Treatment Program for Sexual Aggressives (ITPSA)[14] has not used Depo-Provera or any other antiandrogens in its treatment of the sexual aggressives here. Philosophically, the ITPSA maintains that attitudes, values, and behaviors are learned and, beyond the fact that the behaviors must be stopped, there is a need to develop a systematic process wherein the offender learns new ways to manage his/her feeling states and needs. The majority of our work has concentrated on the significant cognitive handicaps of the offenders which have allowed them to: (1) not consider the rights and feelings of others before they act; (2) not consider the consequences of their behavior; and (3) not be able to delay their need for immediate gratification.
>
> We have developed a continuum where both hypersexuality and hyposexuality are labeled as major social and sexual dysfunctions, as contrasted to the integrated sexuality in the middle of that continuum. Diagnosis of offenders within two ends of this continuum does not appear to be related to the level of androgens present. Although a few of the offenders we have seen have been characterized as having an overwhelming sexual drive and labeled hypersexual, the ITPSA's therapeutic environment has been quite successful in helping those persons control and integrate their sexual behavior.
>
> Depo-Provera has not been considered for use [at the ITPSA] since the double-blind study was completed in 1971, for several reasons: (1) the ITPSA staff labels the use of Depo-Provera as intrusive therapy, for which it would be impossible to obtain informed consent from an incarcerated

14. For a description of ITPSA, see Chapter 11 of this book.

> population; (2) we are concerned about the carcinogenic risk of Depo-Provera, especially at the dose necessary for significant reduction of sexual drive; (3) our experience suggests concern regarding the noted side-effect of depression while using the drug, in that one person in confinement committed suicide while taking the drug, and another, in outpatient therapy, made a serious suicide attempt; and (4) our work with women sexual offenders and the findings that their motivation, behavior, and cognition are similar to the male offenders has reduced our interest in this approach. We continue to be concerned about any approach to therapy that minimizes the assaultive, manipulative, predatory, and aggressive components of the offender's behavior. [Seely, 1984]

The Depo-Provera Drug Therapy Committee, convened by the Connecticut Department of Correction in June 1983 to consider the drug for use with male sex offenders committed to their custody, concluded in their report of October 4, 1983 (Brooks, 1983), that "the Department of Correction should not now embark upon a program of Depo-Provera hormonal therapy with sex offenders within its system." The recommendation was predicated upon very real concerns about the safety of the drug. A second consideration was the lack of community-based clinics to continue treatment that might be begun if the drug were accepted. Reservations also were expressed about sufficient personnel and hospital safeguards, which do not presently exist in the Connecticut correctional system.

Other treatment specialists would recommend Depo-Provera as a last resort. "If a person has failed other treatments and is faced with incarceration or medication," says Judith Becker (1984), Director of the Sexual Behavior Clinic at the New York State Psychiatric Institute, "I might consider advising him to try the drug."

With one exception, the programs or treatment providers administering Depo-Provera[15] depend upon self-reports of the client's deviant fantasies while under the drug. The Sex Offender Unit (SOU) at Oregon State Hospital is the only identified treatment program where the penile plethysmograph is used to measure the client's response to deviant sexual or other stimuli while he is receiving the drug. Initial monitoring of three paraphiliacs in their treatment program indicates that

> The drug does not eliminate deviant sexual arousal, nor does it prevent deviant arousal from occurring when the client is exposed to sexual

15. PREAP has identified 11 programs administering Depo-Provera. The community-based programs include KaCor Associates and Paul A. Walker, Ph.D. (California); Isaac Ray Center (Illinois); Biosexual Psychohormonal Clinic (Maryland); David Barry, M.D. (New York); Barry M. Maletzky, M.D. (Oregon); the Rosenberg Clinic (Texas); and Northwest Treatment Associates (Washington). The residential programs include the Maryland Penitentiary, New Hampshire State Hospital, and the Sex Offender Unit, Oregon State Hospital.

> stimuli.... While the client may candidly report deviant fantasies or lack thereof, he may not be aware of his potential to become aroused to multiple deviant stimuli, either in the community or in a clinical environment. Assessment is therefore necessary in order to demonstrate the subject's potential for deviant sexual arousal. Therefore, it is our contention that MPA therapy be delivered in conjunction with physiological assessment and behavioral treatment with the plethysmograph. [Freeman-Longo, Smith, & Wall, 1984]

SOU's initial impression was that Depo-Provera would eliminate sexual arousal, thoughts, and fantasies, along with the decrease in sexual drive; however, the sexual apathy they expected to see among these clients is not apparent. Thus the writers warn, "These findings should temper many of the overly optimistic and unrealistic expectations which have been embraced by the criminal justice system and the public, and place this modality in its proper perspective as a useful treatment tool and not as a panacea for eliminating sexually aggressive behavior."

Philip Kanter, former Parole Information Senior Agent with the Division of Parole and Probation in Baltimore and a former co-therapist in that city's Special Offenders Clinic serving sex offenders, has great faith in the Johns Hopkins' program. "The reason I have so much confidence in it," he says, "is because all five people who I have referred there have stayed with the program, taken the Depo-Provera, and not had any more problems" (1982). Kanter cites the case of a highly compulsive exhibitionist:

> He has five or six full FBI rap sheets of nothing but indecent exposure. He has done it everywhere--in planes where he ejaculated on a woman's coat--everywhere. He is from a lovely family, a consummate musician, popular and well known. He started as a teenager, has this problem, and cannot stop it--it is totally compulsive. It took him a long time to get into the Provera program, not because they didn't want him, but because he could not come to grips with taking the drug. He wanted to do it without it, and this is a common thing among the clients who go into this program. It wasn't until it was either jail or take Depo-Provera that he took the treatment. He had always received probation or fines. He had two previous prison sentences and served about two and one-half years and was out on parole. So when it came to having his parole revoked or going to prison, he took the Depo-Provera. He has not repeated and is functioning fine. For two weeks when he stopped taking the Depo-Provera he exhibited once. That was two years ago and he hasn't had the problem since. And this was a person who exhibited--no, was caught exhibiting--at least 24 times a year. A great many of them express relief that they can finally stop obsessing about it and think about something else. To me, it is the greatest thing since the wheel. [Kanter, 1982] 16

16. Berlin (1984b) reports that this client is still doing well. "He has on a few occasions exposed himself even while taking medication. The decrease in frequency, however, has been dramatic and he has never caused others any harm."

In Berlin's view (1982), the program's mission is to try to gather a great deal of descriptive information about the offender at the same time that they are helping the offender suppress his appetite in order to facilitate self-control:

> Since there is no scientific base for why some people are paraphiliacs and some are not, there exist a great many theories. Sometimes behaviorists get too narrow in looking only at the behavior and forgetting about the company it keeps and therefore can miss out on an important means of intervention that has been proven to be helpful for a particular person. Other times, we see rapists who have been contaminated by psychiatric theories that have been indoctrinated into them. I have seen rapists, for instance, who are clearly raping in response to sexual urges, even though they have been persuaded that rape is not a sexual act but that it has to do with aggression or hating women. I am not suggesting rape is never due to motivations other than sexual. It is an assaultive act from the point of view of the victim and a horror to experience. I am not saying it is never a family issue or a matter of life experiences. I am just saying one should not feel that everybody is going to fit into the same mold. And you have to have results. If you are going to say that you have a program to help men not be able to rape or become involved with children, you have to show that they do that with a much diminished frequency, compared to how they had been behaving before, compared to doing nothing, compared to other kinds of treatment interventions.

GOAL FOUR

> *Each sex offender needs to engage in a re-education and resocialization process in order to (a) replace antisocial thoughts and behaviors with prosocial ones, (b) acquire a positive self-concept and new attitudes and expectations for himself, and (c) learn new social and sexual skills to help cultivate positive, satisfying, pleasurable, and nonthreatening relationships with others.*

The re-education and resocialization agendas in sex-offender treatment programs are implemented through a wide array of restorative interventions that can be called upon to meet the offender's individual needs and deficits. These re-socialization opportunities include (1) changing culturally rooted stereotypic notions about the roles of women and men in our society; (2) overcoming myths and misperceptions about human sexuality, and increasing positive sexuality; (3) learning how to increase nondeviant sexual arousal; (4) dealing with sexual, physical, and emotional victimizations the offender may have suffered personally as a youth; (5) learning how to become empathic persons and build caring relationships with others; (6) learning how to become assertive people

who can appropriately manage and express anger, aggression, and other negative or positive feelings; (7) learning family and caretaking skills; (8) learning how to increase self-esteem; (9) increasing living, educational, and vocational skills; and (10) learning strategies for controlling alcohol and drug abuse.

Addressing Gender-role Behavior

Like the majority of people in our society, sex offenders hold certain stereotypic notions about the roles of women and men. Says Saylor (1981),

> One of the things that seems to be fairly consistent with most of the men in our program is they have bought whole-heartedly what I would call the masculine mystique in this culture that says men are strong, they don't cry, they don't get upset, they're powerful, they get what they want, etcetera. When they compare themselves to that image, they fall very short. A lot of their energies are directed toward somehow trying to live up to this image in their head of how men should behave. Sometimes I think that the issue really isn't so much how they relate to women but how they feel about themselves relative to other men, and their difficulty with women seems to come as a result of that. I see this with both rapists and child molesters--this feeling that they just are not very good men.

In addition to perceiving women in subservient roles, as men grow up they rarely experience other men as sources of assistance, affection, or validation, but as persons who would abandon, abuse, or both (Knopp, 1982, pp. 36-37). According to Seely (1981), "We have yet to find any sex offender who has a warm, gentle relationship with his father. We have yet to find a sex offender whose relationship with his father was meaningful to him or fulfilling to him or who had any kind of intimacy in that relationship." Thus, if one is to find any sense of being cared about, says Groth (1983),

> one will find that from a female. As a result the offender overinvests in women, and because he has not developed much of a range of emotional expression, he puts a great deal of emphasis on sexuality as an expression of acceptance and approval. If a woman has sex with him, that means she cares about him, and if she refuses sex, it means she does not care about him or devalues him in some way.... That is seen as the bottom line, especially with rapists. They feel devastated by any kind of what they perceive to be rejection by women, because that leaves them totally abandoned, with no alternatives for any sense of ego enhancement or personal worth.
>
> When we work with these issues in prison settings, most of our volunteers are, interestingly, women. They still get the message by and large that anyone that is going to care is going to be a woman. They say things like, "I can cry in front of a woman. She will understand, but I can't cry in front of a man." They live in a very exaggerated macho world in the prison, where you don't cry, where you don't get sad, you get mad;

> or you don't get mad, you get even; or you are never polite or affectionate because that will be seen as weakness or perversion or something of that nature. So there is a real sense of isolation from men in their lives in any positive way.
>
> In descriptions of offender treatment programs, it often seems like there is an overemphasis on the offenders' attitudes toward women, perceptions of women, relating to women. Although that is necessary, I think it is equally necessary that some attention be given in terms of how they relate to men. That is the hardest thing to address, because, if there has been a relationship to a woman and it has been problematical, it is something concrete that you can address. However, in relationships to men, here is something that is not as tangible. In their relationships to men, they wanted or needed something that was not provided to them, and it is harder to address neglect than abuse; harder to address those areas that you needed in your life that you didn't have and to which you have no reference, but you need to work on and develop. So we changed our treatment module from relating to women exclusively, to relating to persons or interpersonal relationships.

Discussion groups focus on gender-role behavior, address macho image perspectives, and examine attitudes toward the role of women and men in society, with an emphasis on redefining traditional roles. Some programs provide structure to the learning approach by using films, small group discussions, structured exercises including a modified version of Bem's Androgyny Scale, and a 28-item questionnaire designed to assess beliefs about sex roles before and after these educational efforts.

Female volunteers and staff bring in women's points of view to counter male/female role stereotyping; female staff members model these new perspectives; and female (as well as male) staff are provided with assertiveness and self-defense training as an integral part of their orientation.

Human Sexuality

Every sex-offender treatment program provides some module or opportunity for correcting the lack of knowledge about human sexuality. Nancy Steele, Director of the Transitional Sex Offender Program at Minnesota's Lino Lakes Prison, describes sex offenders in her program:

> On the whole, they are ashamed of sex. They see it in a pretty negative light. It runs the gamut from being thought of as "bad" or "dirty" to being something men do for fun or with "bad girls." You don't really do it with anybody you respect--not with your wife except to have children. You get real traditional ideas about "good" women on the pedestal and then the women you go out and have fun with, but of course they are "bad" women, so what you do to them doesn't really count--these kinds

> of women know what it is all about so they deserve whatever happens to them. They project their own negative feelings about sex onto women, then punish them for being seductive. Rapists, particularly, read seduction into women. [Steele, 1981]

Groth (1984) sees aggression being expressed sexually by some rapists because "sex is seen as something degrading, something dirty in our culture. So if we devalue sex as we seem to do, then it is something that can be used to degrade a person, and sex becomes the means or expression of nonsexual needs."

Offenders, like many people in our society, believe a great many myths and hold misconceptions about information as simple as anatomical structure and function of the genitals. Some programs are limited to this type of sex education, but others include information on sexual development, sexual skills, birth control, and sexually transmitted diseases. These courses sometimes are conducted by staff but more often by outside specialists such as Planned Parenthood.

In some programs, excellent modules and seminars are available that encourage and stimulate positive and appropriate sexuality. These programs may include dealing with sexual dysfunction, desensitizing sexual phobias, learning sexual communication skills, examining sexual behavior and values, and viewing and discussion of sexually explicit audiovisual materials. A few programs offer final written examinations and award certificates to those who have completed the module.

Sexual Attitude Reassessment (SAR) seminars are offered in a few programs. These are intense learning experiences for residents, families, and staff and are unique ways for gaining an understanding of *positive* sexuality, which can replace the negative and aggressive sexual patterns of some offenders.

Finally, some residential programs offer the opportunity for conjugal visits by spouses or close women friends.

Increasing Nondeviant Sexuality

Laws (1981) contends that the biggest need sex offenders have is to change their sexual behavior. "I tell them, 'You may have a lot of mental problems, you may have deficits in social skills, you may not be as well educated or as employable as you might like to be, but the thing that regularly gets you in trouble is your sexual behavior.' No one was ever put in jail for lack of social skills or

lack of empathy, but people are regularly put in jail for offending other people with their sexual organs."

While the first goal of behavioral treatment always is to reduce deviant sexual behavior, the second, which we will deal with here, is to build up nondeviant sexual arousal if it doesn't exist, or maintain it and strengthen it if it does. One treatment approach Laws has used to build up nondeviant arousal is orgasmic conditioning, also referred to as masturbatory conditioning or masturbatory reconditioning. This involves rearranging a person's habits of masturbation, in order to break the pattern of deviant sexual arousal.

> One thing you can be almost certain of with sex offenders is, if they masturbate, and almost all of them do, they are masturbating to deviant sexual fantasies that had a role in creating the behavior in the first place and certainly a central role in maintaining it. You can lock a person up for 15 years, and if you allow him to masturbate to deviant sexual fantasies, he is going to come out just as hot on his fantasies as when he went in. Prison has no effect whatsoever on changing the deviant sexual interests of sex offenders, and this is true whether they get traditional group therapy or not. You have to intervene in the behavior itself, and that is exactly what this procedure does. It is incredibly simple and produces very dramatic results. [Laws, 1981]

Laws first chooses a deviant sexual behavior that is already in the person's fantasy/masturbatory repertoire and brings him into the lab but does not hook him up to the penile plethysmograph. Through a headset, he is asked to masturbate to the selected deviant fantasy until he ejaculates or 20 minutes elapse, whichever comes first. (Most of them ejaculate within five to 10 minutes). He is asked to speak the deviant sexual fantasy aloud, for two reasons: "First," says Laws (1981), "I want him to hear how repulsive and ridiculous it is for him to talk about a 12-year-old child as a desirable sexual object. There is no way a 12-year-old child is a desirable sexual partner for an adult male. Second, we want to make sure that the fantasy is deviant, that he is not just sitting in there going doodelly-doodelly-doo, which some of them do."

The second week, the offender is brought back into the lab and asked to masturbate to a nondeviant fantasy, using the same process as the previous week. "Usually" Laws (1981) says, "he tells us, 'I haven't masturbated to a nondeviant sexual fantasy since I was 15 years old.' And we say, 'Beginning today, you are going to do it.' And sure enough, within a couple of sessions, if not the first session, he is quite able to masturbate to a nondeviant sexual fantasy and ejaculate. Older men (aged 50 to 60) are less able to make this cross-over

than younger ones."

During the third week, the person is asked once again to masturbate to a deviant fantasy arousal, the fourth week a nondeviant fantasy arousal, and so on, alternating between the two types of fantasies for about 40 treatment sessions, three days a week. Treatment may last about six months or sometimes up to a period as long as eight months. He is asked to use the assigned theme for that particular week if he masturbates outside the lab. One day each week he is brought into the lab for comparative measurement of his erection response to either pictures or descriptions of deviant and nondeviant activities that ordinarily are to his liking.

When the procedure starts out, the person has a high level of deviant arousal and a low level of nondeviant arousal. If the goal is accomplished, at the end of this treatment there is a cross-over effect; deviant arousal sinks down to zero level and nondeviant arousal increases, generally to the level of 60 to 80 percent.

Laws uses orgasmic conditioning with every variety of sex offender and has achieved the effects described with the majority of offenders. Treatment gains usually last from six to 12 months and must be maintained through self-management for long-range efficacy.

Personal Victimization and Trauma

Many sex-offender treatment programs have reported on the incidence of sexual abuse in the lives of sex offenders during their developmental years. The rates reported vary from a low of 20 percent to a high of 100 percent, with such incidents seemingly higher among some types of offenders. Most treatment specialists agree, however, that, while early victimization may be an important single contributing factor to later sexual aggression, it is probably not the sole cause.

In a preliminary survey of sex offenders at the Massachusetts Treatment Center, a maximum-security institution catering to very serious offenders, 23 percent of the rapists and 59 percent of the child molesters had been sexually abused as children (average age, nine years). Thus, victimization rates for pedophiles were more than 2.5 times those for rapists, and the victimizer of the pedophile was four times more likely to have been a person outside the nuclear family than in the case of the rapist. Seghorn, Boucher, and Cohen (1983) conclude that "it would appear, based on these and additional data, that sexual

abuse in childhood predisposes to repetition of that behavior in adulthood."

Groth (1983) found that about 82 percent of the imprisoned sex offenders in treatment at the Connecticut Correctional Institution had experienced sexual victimization as children, as compared to about 29 percent of the offenders who were incarcerated for offenses that did not involve sexual assault.

> Perhaps, since we think of this in terms of the dynamics of aggression, it is comparable to the battered child who becomes the battering parent. And when the victimization goes unrecognized and goes unaddressed with no intervention, perhaps, for the male, one way of moving from being the helpless victim is to become the more powerful victimizer. The sexually abused boy, less likely to be identified than the sexually abused girl, is therefore less likely to gain any kind of intervention or assistance in coping with this experience and may be at higher risk of becoming a victimizer sexually at some point in his life.

Data gathered by Abel and his colleagues (Abel, 1984) indicate that, in a sample of heterosexual pedophiles, the incidence of child sexual abuse while young was 20 percent. In a group of same-sex child molesters who targeted young boys, the incidence of their early child sexual abuse was 40 percent--a significant difference. "What that means," says Abel, "is that these early experiences serve as an example for the child, who eventually becomes an adult, to conceptualize sexual violence as part of the way of life."

Programs use a variety of victim counseling skills to help the offender work through the problems associated with his own sexual abuse. In one program, for offenders who have highly repressed traumatic sexual experiences, a Freudian insight-oriented cathartic group experience is available. Also, the negative childhood sexual abuse experience may be used in behavioral approaches, to help an offender destroy his current arousal. For example, during covert sensitization, where aversive thoughts are paired with a deviant fantasy in order to control it:

> When he switches to an aversive scene, we might use the very experience he had as a youngster. For instance, he might say, "I see myself, I see my uncle. He is holding me down. He is going to force himself on me. He is going to force himself on me just like I was going to force myself on the young boy. He is grabbing hold of my hand. He is holding me down, tearing my clothes off. I am really terrified and frightened." Switch. "I am looking over at the curb, looking at the young boy, just looking at his legs, thinking about him, wondering if I should get involved sexually with him." Switch. "I see my uncle, he is coming at me. He is going to get sexually involved with me. He is going to do whatever he wants and there is nothing I can do about it. He is going to control and humiliate me." In other words, we tie together the urges to involve the individual in the

> deviant behavior with the previous very aversive experiences, so that an individual can teach himself the consequences to others about doing this kind of behavior and cut off the early fantasies that lead toward involving oneself in the behavior. If you control your fantasy, you will control your behavior. [Abel, 1984]

All programs, while helping the sex offender to deal with his own personal victimization trauma, insist that he take responsibility for his behavior and realize that these early experiences cannot be "blamed" for his victimization of others. Taking responsibility also can be taught through a module, "Understanding Sexual Assault," which includes such topics as the dynamics of rape and child molestation, patterns of assault, the psychology of the offender, self-deceptions, and rationalizations used to avoid recognizing responsibility for the behavior.

Empathic Skills

Characteristically, rapists and many other sex offenders feel little empathy for their victims, are uncaring of other human beings, and unconcerned about the problems their actions cause them. Groups, special modules, individual counseling, role plays, and outside consultants and resource materials help the offenders to gain the ability to feel empathy for their victims and understand the effects of their actions on others. They also teach the kinds of skills needed to build meaningful relationships. Peer-group methods provide multiple opportunities for learning and demonstrating care and concern for others.

In order to experience some of the feelings of victims, the offender may be asked to reconstruct the victim scene and cast himself or significant others in the role of victim. Groups of survivors of sexual assaults and victim counselors may come in to the program to confront or talk with rapists about the long-range effects of victimization. Adults who were molested as children and the parents of children who have been sexually abused may meet face to face with child molesters in some programs, and offenders may be asked to read books and articles written by victims of sexual assault.

Assertiveness Training and Resocialization Skills

Many sex offenders have been found to be deficient in social skills. These include basic assertive skills such as refusing and making requests, expressing negative emotions, solving problems, and resolving conflicts; broader communications skills such as expressing positive and tender feelings and accepting

compliments; and interpersonal and heterosocial or homosocial skills, including initiating conversations and dating.

Programs focus on getting needs met in an appropriate way. The techniques range from highly developed 12-week semesters involving structured learning approaches such as modeling, role playing, and behavior rehearsal with sophisticated audiovisual feedbacks, to short-term, informal, one-hour modules.

A number of programs have either separate modules or special-focus, guided peer groups on anger and aggression management. Through didactics and role plays or other techniques, offenders are trained to keep anger at an appropriate level and express it nonviolently. In therapeutic communities, "emotive groups" sometimes are convened on the spur of the moment, to deal with the offender's suppressed anger and help him to express it. Values- and attitudes-clarification modules also relate to the issues raised in assertiveness and resocialization skills training.

Family Skills

Where appropriate, family skills may be taught through family therapy groups and marital counseling with spouses. If such counseling is not available within programs, when needed, families are referred to appropriate agencies for counseling.

Some residential programs offer protracted family visiting and, in later stages of the program, the opportunity for a family to spend time together alone before the offender is released from the program. In addition to easing the postrelease transition, the family sessions are used to encourage members to express care for one another and to share hitherto concealed experiences:

> As issues of sexual abuse are opened up and talked about in the family sessions, we are finding with increasing frequency that other members of the families have been involved as offenders and victims, often much of it unknown and hidden from each other in years of secrecy. Mothers and sisters have been raped or molested, wives and their parents have been abused or raped by relatives and strangers. Two men in the program learned recently that, while they were in prison, their three- and seven-year-old daughters had been abused by other men. [Steele, 1982]

Raising Self-Esteem

Sex offenders, particularly pedophiles, often harbor feelings of inadequacy and inferiority. Many treatment specialists contend that families, particularly

fathers, contribute significantly to the offenders' feelings of low self-esteem:

> I find that the fathers are uninvolved, unemotional, rejecting, critical and uncaring. The boy in that situation (the boy who is now the adult that we see as the sex offender) is looking, striving, and yearning for this love and acceptance and doesn't get it and goes off with tremendous feelings of inadequacy, inferiority, and a sense that "I am no good." [Rosow, 1981]

A variety of remedial interventions are employed to rebuild self-esteem, including some mentioned already in this section. The guided therapy groups, for example, though confrontive, are also extremely supportive. In therapeutic communities, "endorsement" groups may be convened to provide positive feedback for especially good behaviors. Formal "steps of progress" provide rewards in the form of extra privileges and benefits, thus encouraging good behavior as well as raising pride and self-confidence in the offender. Self-esteem and the person's sense of worth also are enhanced by programs that provide opportunities to serve others. One program, located in a hospital setting, permits selected offenders to work in helping relationships in other locations in the institution; another provides an opportunity for sex offenders to meet and educate community people who deal with sexual assaults, thereby contributing to community safety. Groth (1983) calls these interactions a form of "community restitution for their assaultive behaviors" when offenders work with law enforcement, probation, parole, victim, and child-protection workers.

Living, Educational, and Vocational Skills

Residential programs try to provide everyday living skills to sex offenders who have such needs. Budgeting, cooking, skills in seeking employment, auto and appliance maintenance, manners, and maintenance of clothes may be included. Educational opportunities may range from individual tutoring to Adult Basic Education (ABE), from General Educational Development (GED) to college courses. Arts and crafts, sophisticated vocational skills, recreational activities, or religious and civic programs are offered in some programs.

Chemical Use and Abuse Groups

Many outpatient programs will not accept sex offenders who are chemically dependent, preferring that they deal with that addiction before entering sex-offender treatment. Most residential programs offer assessment, education, and strategies for dealing with such problems. Single-focus peer groups led by paraprofessional residents trained and supervised by treatment staff also may focus on chemical

dependency. By far, Alcoholics Anonymous (AA) formats are the most popular. Some programs permit community-based AA groups to come in on a volunteer level to work with chemically dependent sex offenders.

GOAL FIVE

Each residential sex offender needs a prolonged period during his treatment when he can begin to test safely his newly acquired insights and control mechanisms, in the community, without the potential for affronting or harming members of the wider community.

Some residential programs have no mechanism for the gradual release of sex offenders into the community. Unless there happens to be a community-based specialized sex-offender treatment program in the area where he is released (and there are few such programs available), the sex offender comes directly from the unreal environment of the prison or asylum program to the reality of the community.

The period after release into the community is the most challenging and crucial to the sex offender who does not wish to reoffend. Over 70 percent of the persons who reoffended in one residential program did so during the work-release or outpatient phase. The postrelease phase, therefore, should be considered a separate and important component of the total treatment program.

Programs that incorporate gradual release strategies into the treatment agenda provide the opportunity for the "shaky" offender to be pulled back into the program when he begins to exhibit early warning signals or old preoffense patterns.

A variety of formats are used to integrate the offender gradually into the community. One prison program bridges the gap between incarceration and community release by providing a one-year transitional sex-offender treatment program that incorporates an opportunity to attend a specialized sex-offender outpatient group in the community six weeks prior to release. Some programs offer short-term prerelease groups that focus on the various skills needed to readjust to the community, such as vocational planning, job hunting and interviews, dating or family expectations, and apartment hunting. Others provide opportunities for offenders to spend up to 18 months in intensive outpatient treatment after completing the residential portion of the program. One program involves almost one quarter of its entire sex-offender population in a long-term, carefully monitored release procedure that can take two to three years to complete.

GOAL SIX

Each sex offender needs (a) a post-treatment support, peer, or "rap" group and (b) continual postrelease access to therapeutic treatment so he can maintain permanently a safe lifestyle.

Most programs, with the exception of those prisons that cannot accommodate a sex offender re-entering the institution, offer the offender therapeutic post-treatment support, (1) through a hotline where he can call in and talk with program people, (2) by providing the opportunity for him to attend his former inpatient group, or (3) by making provisions for him to meet with the program therapist on an individual basis. Where offenders have been treated in the community, an ongoing support group for veterans or "graduates" of the program may be offered, or, if needed, it may be suggested that the person come back into treatment for a short period of time.

Post-treatment peer support groups are a tremendous area of need, according to treatment specialists and offenders, and crucial to the offender's ability to maintain control over his aggressive behaviors.

TREATMENT OUTCOMES AND POTENTIALS

There exists a lack of standardized measures of treatment outcomes, because outcome research is still in its infancy in the field of mental health in general and has barely begun in the field of sex-offender treatment (Greer, 1983, p. x). Where treatment data are collected by sex-offender treatment programs, they are informal and focused largely on the reported repetition of previous behaviors or the commission of new crimes. Where these data have been made available, they are included in the descriptions of the various programs in Sections II and III of this book. Many programs report encouraging results.

Until longitudinal research is completed[17] and standardized measures of treatment outcome are established, it will be difficult to assess the treatment variables that enable sex offenders to control and manage their sexually aggressive behaviors. At this point, the types of treatment provided generally are determined by the philosophies or prior training of the program designers or

17. At least two program efforts are under way to track treatment effects: the Massachusetts Treatment Center is following 260 persons committed for sex-offender treatment and released during a 25-year period (see Chapter 12, footnote 15), and the New York State Psychiatric Institute's Sexual Behavior Clinic is tracking 194 men who have been treated and/or dropped out of the program since 1981.

therapists or by the restraints of settings or funding, rather than by scientific data on the efficacy of various types of treatment for specific categories of offenders and their behaviors.

An examination of the literature on the assessment and treatment of sexual aggressives leaves the reader with the impression that there are "behavioral" assessment and treatment methods and "the other kind." The fact that behavioral, rather than psychodynamic, sex-offender assessment and treatment approaches dominate the literature reflects in part the results of the funneling of federal funding into the research and development of the more precise and measurable behavioral techniques and strategies. Though these monies have been well spent and have enabled behaviorists to make an inestimable contribution to the state of the art, site visits to the programs reveal that "the other kind" of treatments actually dominate practice in the field. With few exceptions, research efforts are lagging in the psychodynamic programs, a lack that must be remedied by federal funding agencies.[18]

At this time, it generally is agreed that (1) early intervention in these habituating patterns is the most important and useful (Abel, 1984; Groth, 1983; Jackson, 1984; Knopp, 1982); (2) offenders who have been exposed to programs that provide the skills and tools for them to control and manage their sexually aggressive behaviors have a better chance of exerting such controls over impulses and leading nonassaultive lives than those who have not had such treatment; and (3) sex-offender treatment is a steadily evolving and important new discipline.

Treatment providers are candid about the evolving nature of the new discipline:

> [Sex-offender treatment] is not an area of human behavior that has been well studied. We are still in a frontier of knowledge here and I share with you some of the impressions and ideas I have derived from my work. Please take it at that level, not as something cast in bronze. Maybe it is something written in pencil with an eraser at the end of that pencil because we do not know everything and what we know today is very incomplete. Maybe five years from now I might say about some of the things I am sharing at this time, "Well, here is another myth." In that perspective, please apply these approaches to your work and see if they are useful. Adapt them in a way that makes them more useful and communicate your own knowledge and your own experience and share them. [Groth, 1983]

18. A two-year planning grant for evaluating sex-offender treatment programs was awarded to the Evaluation Research Group in 1979, but the proposal actually to do the study was not funded by the National Center for the Prevention and Control of Rape, part of the National Institute of Mental Health.

Treatment providers also are outspoken about the specific goals of the new discipline and the chronic and often volatile nature of many of its clients:

> I have no illusions that any treatment is going to give a chronic sex offender what might be called an emotional grease job and oil change. That is not going to happen. What we might be able to do is to restore them to the point where they are no longer a danger to other people. And if we have accomplished that, we have accomplished what we need to do. If we can do a real social rehabilitation, help the person begin to learn a new set of values, it is fine and nice, but those are secondary goals. We are not running a civics class here. We are running a class with some highly dangerous people who need to learn something about bringing that behavior under control; that is what our business is. [Laws, 1981]

Finally, treatment providers are convinced that clinicians have a social as well as professional responsibility to become involved in helping the sex offender overcome his assaultive behaviors:

> Assessment and treatment of paraphiliacs presents unique problems to the clinician. Therapists have traditionally dealt with paraphiliacs by identifying them as poorly motivated and subsequently writing them off as inappropriate treatment candidates. Under such circumstances the therapist feels better (since he or she no longer has to deal with a difficult patient), the offender feels better (since he does not have to reveal the difficult, perplexing problem that he is attempting to control), and generally those around him (family, the courts) feel better because "something was done." In actuality, this approach is harmful to all those involved. Most damaged are the potential new victims who will be offended upon and whose victimization could have been prevented by appropriate treatment. On recommission of the crime the offender is harmed since in general he is no longer afforded the luxury of receiving treatment, but is simply incarcerated. The disruption of his life, the disruption of his family, the reduction of the family income, and the extra burden on society of housing him in prison are all negative consequences of the offender not receiving treatment. In addition, the emotional impact of incarceration on the lives of everyone involved with the offender is tremendous.
>
> Finally, clinicians themselves will inevitably be harmed by not attending to such offenders. The courts, the families of offenders and offenders will continue to view the psychological helping professions as ineffective in dealing with the more severe problems of our society, and this need not be the case. The clinical strategies for assessment and treatment are well documented in the literature and clearly accessible to all clinicians. Prevention of sexual assaults and sexual victimization rests, in part, in the therapist's hands. [Abel, in press]

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Abood wants sex offenders to register

JUNEAU — Sen. Mitch Abood wants people convicted of sexual offenses against children to register with local police when they are released from prison. The Anchorage Republican on Tuesday introduced a bill that would require a person convicted of a sexual offense against a minor to register with the nearest law enforcement agency within 14 days after being released from jail. Registration would include the person's fingerprints and photograph. Any change of address would have to be reported within 10 days, under Abood's bill (SB467). The registration would be confidential, except for law enforcement work, and would be removed from police and state files within 5 to 20 years, depending on the crime.