Crime

A Special Program For Sex Offenders

By Nikki Meredith

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■ In the mile-high, main corridor at Atascadero, where the men file to meals in platoon formation, the sex offenders are easy to pick out. Unlike the others who shuffle along, heavily drugged or generally spaced out, the sex offenders seek direct eye contact and, except for the uniforms, look like the people in your neighborhood. In fact, it is their normal appearance which contributes to their status as perhaps the most controversial group of offenders currently processed by the courts and confined in state institutions. There is a raging dispute in both law and psychiatry about whether these sex offenders are mentally ill or just criminally dangerous men with weird habits who belong in prison. Proponents of the latter belief are increasing and this year Assemblyman Tom Bates (D-Oakland) has introduced a bill which would abolish the present treatment program for sex offenders.

Atascadero is a maximum security state hospital located midway between San Francisco and Los Angeles. The sex offenders who end up in Atascadero instead of prison are the ones designated "mentally disordered" by the courts. Based on psychiatric examinations, judges confer "MDSO" status on men who stand to benefit from psychiatric treatment. There are about 450 of them, and they make up half the hospital's population. The other half consists of the "criminally insane" — men who have committed crimes, but have been adjudged not guilty by reason of insanity — and men who have been arrested for crimes but whose mental state renders them incompetent to stand trial.

At dinner, sitting sandwiched between a child molester and an exhibitionist, I listen as they talk about their "offenses." The exhibitionist is a handsome man — boyish, deep dimples, big smile. His muscular, athletic body is confined to a wheelchair. I wonder if he might be exposing himself because his disability makes him feel impotent. Not so, the ensuing conversation reveals. He was flashing before he was injured. In fact, he was shot and paralyzed as the result of flashing. (The police caught him, he ran, they shot.) But he still does it. I am astounded. He smiles and shrugs his shoulders. The absurdity makes us both laugh.

I'm sitting with a group of six men: two rapists and four child molesters. The subject of discussion is the behavior some patients use to keep others at a distance. I watch the most outspoken and articulate of the lot — a good-looking black man who is pointing out the defensiveness of one of his fellow group members. His bleached white tee-shirt under his khakis sets off his sweet, open face. I try to imagine him jumping out from behind a car or breaking into a house and raping. It doesn't compute.

I shift the topic to victims, to guilt.

One man, a child molestor with blown-dry hair, who manages to look like a dandy in spite of the uniform, replies, "I feel very badly about my victim. I would try to help the family out with money, but the state won't permit any contact. So, I pay my dues to society by being in here and working on my problems and by being the best father to my own children that I can." He says he feels guilty, but I'm not sure I believe him. He's just too smooth.

The black man adds, "The way I'm going to deal with my guilt is by never raping again." He says he's been at Atascadero four years and it was at least two before he was able to feel guilty about his victim. The social worker sitting with the group says she was with him when the full impact of what he had done first hit him. "He broke down and sobbed and sobbed." I believe him. I believe her. A staff member on another ward later tells me he's seen guys who are crying and remorseful at Atascadero go out and murder children.

One man at Atascadero for rape describes the event almost as if it had been a play, with the victim not portraying her role according to the script. "I was acting out what had been a fantasy in my mind for years," he says. "When I got into it, I wasn't getting the response I had imagined, so I escalated and became more violent. I knew the bottom line — I wouldn't kill her — but I kept trying to get the feeling I had fantasized. Of course, I never did, never could, that way." Social worker John Taylor says he believes some men who rape confuse terror with passion. "These guys get a rush from being frightened and in some screwed up way they believe their victims do, too."

An air of detachment descends on many of the men at Atascadero when they talk about their victims. The "offense" seems easy for them to discuss, the victim is harder. Some of the rationalizations are ludicrous; a favorite with child molesters is, "I know it was wrong but she [a four-year-old] asked for it." Rapists frequently employ the standard, "She hung around with a fast crowd and I knew she slept around." One staff member talks about guys who come to group with the "big breakthrough": "Well, yeah, now I realize I put the victim through some changes." One of the methods the staff uses to cut through this absurdity is "role playing," which gives the men an opportunity to play victim. Social worker Grenda Ernst says the technique enables the patients to go beyond their excuses and to understand the anguish of their victims. Is guilt essential to the treatment process? "Guilt held onto is not productive," she replies, "but it's a starting point."

"We get the passive fellow who takes it and takes it and then violently explodes," says psychologist Charlotte Brown. "We also get the guy who is inappropriately aggressive all the time."

The assertive skills training program has one of the best defined therapy models, complete with diagrams and flow charts. According to Brown, the goal is to reconstruct a whole life style, starting with the basics.

The therapy model guiding the sexual identification program is not so well defined, but the surroundings are more colorful. Hanging above the desk of assistant program director Jim Baron is a collage of naked women in various erotic poses. Mutually consenting sex with adults is the theme pushed here, so there's

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an emphasis on sex education, acquiring sexual skills and partner appreciation.

"A lot of these guys have the idea that sex is a seventy-second quickie," says Baron. "One of our goals is to help these men come to grips with their sexuality," adds social worker Marilyn Jones. "It is not an expression of anger or aggression."

A second goal is to get pedophiles to raise the age of their sexual objects. With boy-child molesters, this means talking a lot about homosexuality. "I have never worked with an adjusted homosexual who was a pedophile," Jones says. "Frequently, a man who molests little boys is married and superficially leading a heterosexual life."

At a party sponsored by AGE, Atascadero Gay Encounter, one of the members explains to me that the purpose of the group is to help men accept their homosexuality so they will quit bothering children. "If I had been able to get my needs met on Castro Street, I never would have molested little boys."

"I want the patients to remember forever what it was like to be a sex deviate and what it feels like not to be in control. Self-control is going to be an every-day event for the rest of their lives," says Dr. Richard Laws.

While the other treatment programs are talking about feelings, Dr. Laws is measuring them. When patients are referred from the wards for evaluation and/or treatment, the staff in the sex lab hooks the guy up to a "penile transducer" which is placed on the penis and measures arousal. The patient, in the privacy of his own booth, is exposed to deviant sexual material (slides, audio and video tapes) as well as non-deviant and his arousal is measured and compared. If he is highly aroused by deviant material and not so aroused by non-deviant, he is considered a good subject. If he is aroused by both, he is not as good, and if he is aroused by neither, he is not considered for treatment.

Once he has been accepted for treatment, he is then introduced to what is called "masturbatory conditioning." The patient is first instructed (again in the privacy of his own viewing booth) to respond to his favorite deviant erotic material; then he is instructed to respond to non-deviant sexual material. (For rapists or female-child molesters, this would be sex with consenting female adults; to male-child molesters, this would most likely be sex between consenting male adults.) At some point, if the treatment is successful, the patient shows a "crossover." His arousal to deviant material decreases while his arousal to non-deviant material increases.

Dr. Laws discounts most of the theories about overriding hatred of women and terrible family backgrounds — he even refuses to characterize sex offenders as mentally ill. "Sex offenders learn to be sex offenders. They learn that behavior in the same way other behavior is learned: trial and error, direct instruction, reading, and films," he says. "If I can take a sex offender and increase his arousal to adults and decrease his arousal to children, then the opposite must be possible."

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In keeping with this approach, Laws and his staff never listen to a patient "whining" about his background or his problems. "We say, 'The way to change your behavior is to change your behavior.' "

Laws says when a patient has successfully completed treatment at the sex lab, he's still basically the same person. "We haven't changed a guy into a non-deviant, we've just given him another option." The sex lab message to patients is that it is possible to control behavior. Laws criticizes "talk" therapies which explore the patient's feelings of inadequacy. "Giving the individual a sense of control is what raises self-esteem."

Well, is it effective? One patient I talked to who is in Atascadero for rape told me the treatment is working so well for him that he now dreads going in for his sessions. "Now that deviant stuff makes me sick. I hate it."

What happens when the patients are released is not altogether clear. Upon discharge, Atascadero patients return to communities throughout the state. While most are followed by local mental health centers, follow-up statistics are not refined enough to demonstrate whether sex lab patients repeat offenses at a lower rate than other Atascadero patients. One out of three sex offenders released from Atascadero repeat their offenses.

"The therapist's unconditional positive regard for the client ... means that the therapist communicates to his client a deep and genuine regard for him as a person with potentialities, a regard which is uncontaminated by evaluations of his thoughts, feelings or behavior." — Carl Rogers, 1967.

Some of the staff just can't do it. After they work at Atascadero for a while, read history after history of the murder of children, rape, torture — they get out. "I understand it," says Paul Burkhardt, program director of the sexual identification program and a twenty-year veteran on the staff. "It's really hard to be positive about rapists and child molesters. How the hell do you deal therapeutically when you know what these guys have done?"

Grenda Ernst is a social worker who has worked at Atascadero for six years. In her thirties, tall and slim with deep blue eyes, Grenda radiates unconditional positive regard for the men with whom she works. Like many of the female staff I interviewed, she manages to be warm, even affectionate, without being seductive. There's something solid, reassuring about her. She says sometimes when she reads the history of a new patient, she questions her ability to form a therapeutic relationship. "I say to myself, 'Oh, my God, how am I ever going to work with this man?' What he did was so disgusting and I feel so sorry for the victims. But then I get to know the man, and he's someone with problems. There's work to be done."

Psychiatric technician Elaine Klearman is trusted by her patients and considered a good therapist by her co-workers. She's young and pretty, dedicated and serious — almost deadpan.

In working with the men, she gives the impression that she is on their side, rooting for their team, but she confronts them honestly and does not appear to be a soft touch. She is committed to the therapeutic community model and believes prisons should be operated the same way. She doesn't think the hospital is coddling criminals because she sees it as hard work for the patients. "It's not easy to expose yourself. It's a frightening experience. They have to do that here." The amazing thing about Elaine Klearman is that over a year ago her mother and her pregnant sister were murdered by a man who had once been a patient at Atascadero. (Her working there was not connected to the murders.) The experience left her pained, but not bitter. She believes in her work and she believes it helps.

John Taylor, director of the admissions and discharge unit, has worked at Atascadero for ten years. His attitude has changed dramatically during his tenure. "When I came here, I was a bleeding-heart liberal. Now I sit on admissions and I hear the stories but I don't really get to know the men. All I hear are the gruesome details. Now I'm totally law-and-order."

The staff working at Atascadero reflects the full range of attitudes held by the commu-

nity outside toward these men — everything from Grenda Ernst's positive regard to the security officer who, when I asked about his relationships with the men, responded, "I don't believe in becoming personally involved with child molesters."

Whatever else it is, Atascadero is an effective facility for containing people "benignly." On the outside, the community is protected — there are few escapes — and on the inside, the patients are not brutalized. It is a clean institution. There is a minimum of illicit drug use; there are no gangs, no rapes and only episodic, individual violence. There appears to be little "them and us" divisiveness between inmates and staff and "snitching" to the group is considered part of the therapeutic process, an opportunity to work on oneself. In addition, the patients are indoctrinated with a humanistic value system, given educational opportunities and exposed, some of them for the first time in their lives, to kindness, warmth and caring.

Of course, the state pays more for this kind of containment — armed guards are cheaper. At Atascadero, there are 1,175 staff members for 1,000 patients and it costs about $28,000 per year per man. At San Quentin, there are 900 staff members for 2,940 inmates, and it costs $13,000 per year per man.

From all indications, Atascadero patients repeat their offenses at a lower rate than prisoners convicted of the same offenses, but it is a faulty comparison because the prison population may be a more "hardened" sample. According to John Taylor, it is impossible to do a scientific study of the effectiveness of treatment because to do so would involve randomly assigning sex offenders to a hospital, to a prison or immediately releasing them to the community. "It would be unacceptable to randomly release convicted sex offenders to society." Statistics do show, however, that crime categories make the biggest difference in who reoffends, regardless of where the men are confined. Rapists and girl-child molesters have the highest rate of recidivism; boy-child molesters have the lowest.

The effectiveness of psychotherapy with these men is subject to considerable debate, even within Atascadero. The hope, of course, is that the new behavior acquired in the hospital, and reinforced by treatment in the community, will continue once the patient is released.

But the gaps are obvious. Some counties don't provide careful supervision, and the availability of drugs and alcohol, substances which are heavily implicated in the crimes and lifestyles of these men, will be a constant temptation. Joining Alcoholics Anonymous may be a condition of discharge, but will that be a sufficient deterrent? Will the arousal states reduced by the sex lab stay that way after a few drinks, after a few Quaaludes? What about the guys who were criminals for years before coming to Atascadero?

Taylor is not optimistic about the rehabilitation of sex offenders who have a history of other criminal activity as well as sex offenses

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(about 60 percent of those in Atascadero do). "A lot of sex offenders don't have this one little kinky sex problem, which is all that prevents them from being normal citizens," he says. Typical of this group is a guy who does burglaries and then one time finds the woman home and he rapes her. He decides he likes it, and so he adds one more crime to his repertoire.

"On the outside, this guy gets high status by selling dope and ripping off and raping people," Taylor says. "The equivalent to that course in the non-criminal world is a middle-management position. No matter how much psychotherapy you do with this guy at Atascadero, he's not going to get a high status middle-management position when he gets out.

"But there are some people who believe that the circle-of-chairs model of psychotherapy reshapes the whole personality; it doesn't. We can only do so much, and it's too bad we're expected to do more than we have the knowledge or the capability of doing." After some thought, he adds, "I think there are some people who should stay here forever."

And upon release, there may be some patients who wish they had. The level of camaraderie and caring among the men is so intense and the atmosphere of some of the programs so nurturing, I asked patients how they would adjust to the lonely world outside. After all, few men have a wide circle of intimate friends, let alone a psychiatric staff, available to them twenty-four hours a day. Most of the guys I talked to have such high expectations about life on the outside, they dismiss such concerns with, "I have my family," or "I'll have my work," but some acknowledge that the fear of loneliness, added to the prospect of facing society affixed with the sex offender label, terrifies them at times.

"Atascadero State Hospital deserves all the condemnation in the world and something should be done about it. Something should be done about legislation to protect children from the Theodore Franks of the world." — Ventura Deputy District Attorney, Irving Prager, 1979.

Theodore Frank is one of Atascadero's most embarrassing and tragic failures. He was sent there in 1974 for molesting one little girl, but while he was hospitalized he admitted committing 100 to 150 child molestations in the previous seventeen years. Atascadero released him in 1978. Last year he was convicted of killing a two-and-a-half-year-old girl just six weeks after his release from the hospital. He had been a model patient and had convinced a majority of the staff on his program that he had changed. He now lives on death row at San Quentin.

The issue of discharge is a touchy subject at Atascadero. Whenever a patient leaves the institution and reoffends, especially if it's a case which draws public attention, the press swarms, the district attorneys condemn, and the community gets that much more nervous about crime on the streets. Reoffending Atascadero patients tend to get much more media play than reoffending prisoners and that's partly because the hospital staff plays such a big part in discharge decisions.

The responsibility is awesome and some of the staff at Atascadero respond defensively with, "Blame the courts, blame the system — don't blame us." Paul Burkhardt, on the other hand, says, "It's true the judge makes the final decision, but our recommendations are followed most of the time."

After a patient has been in the hospital for treatment and evaluation, he is sent back to court with one of several recommendations: release to the community, retain in the hospital for further treatment, transfer to prison.

While considering a recommendation for discharge, one of the questions Charlotte Brown asks her staff is: "Would you want to live next to the guy?" "We take their entire history into account," she says. "There are never just a few second thoughts. We do a lot of odds playing and soul searching." Currently, Burkhardt's program is recommending release for only 40 percent of their patients, returning to court for review. "When it comes to discharge, I'm as conservative as hell. My patients have the longest stay in the hospital. It's better to overreact and to keep them longer because when they act out, the damage is severe."

In reviewing a patient's readiness for release, the staff does a total evaluation which includes the length of criminal activity, the severity of the offense, day-to-day behavior on the ward. Most staff will admit, however — and this is borne out statistically — that the best predictor is the patient's past criminal

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activity and not his behavior in the hospital. According to the latest follow-up study, 20 percent of the patients who are recommended for release and then discharged by the court repeat their crimes. (Thirty percent of those the hospital recommends against and are released anyway or are sent to prison and later released repeat their crimes.) "The positive way of putting that is that we are accurate 80 percent of the time," says Taylor, whose program conducted the study. "In most areas, those odds wouldn't be so bad except that we are talking about very bad crimes."

Taylor believes that the biggest problem with the present system is linking hospital treatment to length of sentence. "When the responsibility for release is on the treatment staff, it contaminates the treatment process. Besides, why should a guy get out sooner because he's sent to Atascadero?" Taylor would like to see the law changed so that sex offenders all do the same amount of time, regardless of whether they are hospitalized or imprisoned. State Senator Omer Rains (D-Ventura) has introduced a bill this year that would make such a change. Under the present law, rapists going to prison are getting an average sentence of twelve years — most will serve about eight. The average treatment time for rapists at Atascadero is three years.

While a sex offender may serve less time if he goes to Atascadero instead of prison, he may not serve more time. According to the law, an MDSO cannot be hospitalized for a period which exceeds the maximum sentence prescribed for the offense he committed. That is, unless he is still considered dangerous. If the hospital convincingly demonstrates that the man's current behavior (not his history of violence) presents a "clear and substantial" danger, the court can extend the maximum term by two-year increments.

Predicting dangerousness, however, is still a guessing game. Men like Theodore Frank are not dangerous until they hit the streets. In the hospital, they are often congenial, cooperative fellows. Without crystal ball capabilities, the only tool available is longer incarceration, particularly for men with extensive criminal histories. Clearly, the longer the confinement, the longer potential victims are protected. But what then? If Theodore Frank had been kept for the maximum term possible for child molesting (seven years), would that have prevented him from molesting and murdering a child once he was released? Unfortunately, no one yet has the answer to that question. □