RESEARCH INTO VIOLENT BEHAVIOR: OVERVIEW AND SEXUAL ASSAULTS

HEARINGS
BEFORE THE
SUBCOMMITTEE ON
DOMESTIC AND INTERNATIONAL SCIENTIFIC
PLANNING, ANALYSIS AND COOPERATION
OF THE
COMMITTEE ON
SCIENCE AND TECHNOLOGY
U.S. HOUSE OF REPRESENTATIVES
NINETY-FIFTH CONGRESS
SECOND SESSION

JANUARY 10, 11, 12, 1978

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Committee on Science and Technology

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RESEARCH INTO VIOLENT BEHAVIOR: OVERVIEW AND SEXUAL ASSAULTS

THURSDAY, JANUARY 12, 1978

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SCIENCE AND TECHNOLOGY,
SUBCOMMITTEE ON DOMESTIC AND INTERNATIONAL
SCIENTIFIC PLANNING ANALYSIS AND COOPERATION,
New York, N.Y.

The subcommittee met, pursuant to adjournment, at 10:24 a.m., in room 305, 26 Federal Plaza, New York, N.Y., Hon. James H. Scheuer, chairman of the subcommittee, presiding.

Also present: Hon. Robert Walker. Staff: Ms. Mountcastle, Mr. Shacknai, Dr. Wells, Mr. Gallagher.

Mr. SCHEUER. The third and last day of hearings at this point of the DISPAC Subcommittee on Violent Crime will come to order.

Today we're researching into the question of sexual assault. We will have further hearings on wife battering and child abuse.

I'm happy to have with us here today for the third day Congressman Robert Walker of Pennsylvania, who is one of the outstanding members of this committee, a hard-working, diligent, highly professional, and intelligent member of the subcommittee.

Our first witness will be Dr. Nicholas Groth, director of the Forensic Mental Health Department of Harrington Memorial Hospital in Southbridge, Mass.

We're happy to have you here this morning, Dr. Groth. Your testimony will be printed in its entirety at this point in the record, so if you wish you may just talk to us informally and give us the highlights of your testimony, plus any other matters that you would care to dwell on, and then I'm sure we'll be asking you some questions.

[The prepared testimony of Dr. Nicholas Groth follows:]

COMMITTEE ON SCIENCE AND TECHNOLOGY

U.S. House of Representatives

Washington, D.C. 20515

Domestic and International Scientific Planning, Analysis, and Cooperation

"Research into Violent Behavior"
New York City Field Hearings
January 12, 1978
Research into Sexual Assault
26 Federal Plaza, Room 305
10:00 a.m. New York, New York

TOPIC: TREATMENT OF OFFENDERS

WITNESS: A. Nicholas Groth, Ph.D.
Director
Forensic Mental Health Department
Harrington Memorial Hospital
Southbridge, Massachusetts 01550

The treatment or rehabilitation of the dangerous sexual offender (the rapist or child molester) constitutes a new frontier in the medical and behavioral sciences. The current state of the art is more one of search than research.

Since sexual offenders do not characteristically self-refer to mental health agencies or seek out professional help for their problems they do not come to the attention of clinicians or other behavioral scientists. As a result, such personnel do not have the opportunity to develop skill and expertise in the diagnosis and treatment of these offenders and, in term, they become reluctant to accept professional responsibility for such clients. Instead, to a large extent, mental health agencies have been content to let the criminal justice system alone deal with the dangerous offender. "Treatment" then for the great majority of apprehended sexual offenders, is some form of penalty: fine, probation, prison sentence, and the like.

Fortunately there appears to be a growing realization that penalty alone is insufficient to rehabilitate dangerous offenders. Unfortunately, too often such realization is the result of some tragic event. In Massachusetts, for example, serious attention to developing a program for the diagnosis and treatment of sexually dangerous persons came about only after the sexual homocide of two preadolescent children by an offender who, but a few weeks earlier, had been released from a correctional institution following the expiration of his sentence for an almost identical prior offense. With the increasing recognition that sexual assault

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is not only an offense but also a symptom a demand has been placed on the clinician to bring to bear whatever his science, his theories, and his experience teach him to assist society in identifying and treating such assailents.

Treatment is dependent upon careful and accurate diagnosis. However, researchers are only in the early stages of developing a conceptual/theoretical framework which will encompass the wide variety of behaviors, both qualitatively and quantitatively, which are encompassed by the term "sex offense." Sexual assault cuts across all conventional diagnostic categories. It maybe symptomatic of situational stress, psychotic decompensation, characterological defect, intellectual limitation, or some combination of these and other factors. To state it simply, not all sexual aggressors are alike. They do not all do the same thing. Even when they commit similar offenses, they do not all do it in the same fashion or for the same reason, What deters one offender encourages another. And the development of theoretical--empirical frameworks from which implications for treatment, prevention, and program development can be drawn is at best rudimentary.

We do not know what creates a rapist or a child molester, the specific pattern of life experiences, situational factors, and precipitating events that combine produce a dangerous sexual offender. The question as to how to effectively rehabilitate such an offender is no less easy to answer.

Predicated on the belief that there are offenders for whom imprisonment through criminal law alone would not substantially diminish their

dangerous potential, a number of treatment programs have evolved to make psychological and medical services available in the hope of minimizing the likelihood that the offender will repeat his offense following release. These programs operate in correctional institutions (e.g. Connecticut Correctional Institution at Somers), mental hospitals (e.g. South Florida State Hospital in Hollywood) or special facilities for sexual offenders (such as the Adult Diagnostic and Treatment Center in Avenel, New Jersey). For sex offenders released from institutions or for whom imprisonment seems counter-indicated a number of specifically--designed community based programs such as Alternative House in Albuquerque, New Mexico and the program run by Dr. Abel and his collegues at the Memphis Mental Health Institute have been created. In addition, treatment services are being developed for offenders as a component of local mental health clinics and agencies. For example, I am currently Director of the Forensic Mental Health Department of Harrington Memorial Hospital in Southbridge, Massachusetts, and we offer diagnostic and treatment services to both offenders and victims at a local community level. To date there are about ten (10) formal institutional programs nationwide which offer rehabilitation services specifically for the dangerous sexual offender, and another ten (10) community based programs specially designed to service this client population. Clearly this is only a token effort, and a small token at that!

What is the nature of these rehabilitation efforts? We can divide these treatment efforts into three broad categories: (1) physical, (2) psychological, and (3) behavioral. Under physical treatment we would

include ongoing research on the effects of psychosurgery, and surgical and chemical (hormonal) castration as techniques of rehabilitation. The surgical procedures raise a number of ethical issues but chemical castration which is reversible may be an adjunct or offer an alternative for cases that are not responsive to other treatment modalities. The pioneering work in psychohormonal research began at the Phipps Clinic at John Hopkins Hospital, Baltimore, MD and is still in its preliminary stages.

Psychological treatment modalities encompass all forms of psychotherapy and range from individual counseling to milieu therapy. Practically every form of interaction, individual, family, group, self-help, and milieu, in every style (supportive, confrontational, marathon, consciousness-raising, analytical, etc.), has been incorporated in the rehabilitation efforts of the institutional programs. Such programs offer the opportunity to evaluate therapy procedures and outcomes but unfortunately most of the staff's time is usually committed to providing direct services rather than research. Although the data are not unambiguous, some preliminary studies, do suggest, that security-treatment programs can prove effective in reducing the recidivism rate of dangerous sexual offenders. For example, based on almost twenty (20) years of experience working with convicted sexual offenders, my colleagues and I found that about 15% of the men sent to us were unresponsive to any of the psychosocial treatment modalities we could offer; for another, somewhat larger group of about 25% treatment had a very modest effect in regard to their maladaptive life styles although it did serve to reduce their dangerousness; and for the remaining

60% a total treatment effort of individual and group psychotherapy, socialization experiences, occupational educational and recreational therapy, pre-release planning and post-release treatment and supportive aftercare had a significant effect on their lives and on successful societal adaptation.

Behavioral treatments seek to eliminate the inappropriate sexual responses of offenders and to replace them with more acceptible and adaptive behaviors. To simplify the comparison to psychological rehabilitation--behavioral approaches focus on the symptom whereas psychological approaches focus on personality characteristics or traits of the offender. The term "adversive conditioning" is frequently used to describe the behavioral rehabilitation technique. Essentially the undersirable sexual responses are extinguished by pairing them with noxious stimulation and more appropriate responses are reinforced by pairing them with pleasurable/rewarding stimulation. Dr. Abel will be describing his work at length before the Committee and with more eloquence than I can. Again the limited research on this rehabilitation technique is encouraging.

This then, very briefly, sums up the types of efforts that are being made, currently on a very small scale, to rehabilitate the convicted offender. It is really too soon to know how successful such efforts will prove to be. The preliminary studies are encouraging, but clearly research components are, for the most part, sadly lacking in practically all the available programs. Also it must be kept in mind that the work being done here is a pioneering effort and the treatment programs and procedures

are in a state of evolution with new and innovative approaches still being developed. In a very real sense the work has just begun.

There is a major need for research both into the nature of sexual assault and procedures to remedy such behavior. The work that is being done appears promising but the task of evaluating its effectiveness is a complex and difficult one. There is no clear indisputable evidence that any program is in fact effective in reducing recidivism, but there is the strong impression that they do help to address this problem. A decision at this point in regard to any treatment modality would be premature. Each approach has its advantages and disadvantages and no one progran can be expected to provide a solution to all the multiple bio-psycho-social problems and issues encompassed under the term "sexual offender."

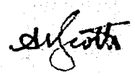
From my own experiences in dealing with this complex and multi-determined form of sexual pathology I would like to argue for what I consider to be three key issues that need support: First, specialized treatment programs for the dangerous offender (sexual and non-sexual) needs to be provided. What is needed are forensic mental health programs and institutes in the full sense of the word--that is, programs or facilities that not only provide direct services in the form of diagnosis and treatment, but also provide adequate supervision of its staff together with an active teaching and training program to help its personnel increase their skills, that put a priority on research and study and actively support and encourage such enterprises. Obviously the wider the range of treatment modalities that can be offered (chemotherapy, psychotherapy, sociotherapy,

behavior modification, and related educational, and vocational programs) the better equipped the program is to address the problem of rehabilitation. Especially lacking, at this time, are effective programs of intervention for adolescent offenders.

Second, a number of us have labored in the field, so to speak, for a period of years. It is important, in effect, to go out and spread the word, that the skills and knowledge we have developed be shared with others who are facing this serious and frustrating social issue for the first time. To achieve this, I would put an emphasis on consultation and education in the form of lectures, workshops and training seminars much in the fashion that were provided to assist people who worked with victims. On a more long-range basis I would encourage the development of graduate education courses in medicine, nursing, social work, psychology, etc. that focus on the diagnosis, assessment, and treatment of dangerousness and on the clinical needs and dynamics of both offenders and victims of violence.

Finally, any approach to be effective, must be inter-agency and multi-disciplinary in nature. Rape is not the province of any one group or profession be it law-enforcement, medicine, sociology, psychology, or the like. Each has something to contribute to the understanding and amelioration of this serious social problem and it is important to abandon professional conceit and territorial possessiveness and to find ways of working together cooperatively.

Thank you.



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