A HISTORY OF THE WESTERN STATE HOSPITAL SEXUAL OFFENDER TREATMENT PROGRAM

by

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Western State Hospital is a mental hospital in Steilacoom, Washington. In 1951, on the order of the Washington State Legislature, Western State Hospital began accepting sex offenders as inpatients. In 1958, a treatment program was developed. The program used an iconoclastic form of group therapy, wherein the offenders led their own group sessions without staff present. The program considered sexual offense the most prominent symptom of the offender's social maladjustment and self-isolation. Therapy sought to have the offenders "teach" each other interpersonal skills, as well as to elucidate individual problems. Under the leadership of Dr. George MacDonald and Robinson Williams, M.S.W., the program developed to a multi-component modality that included work release and couples' therapy. The program received an increasingly large percentage of the state's sex offenders through 1975, with little corresponding oversight from the state or the wider academic world. The professional field shifted rapidly toward conditioning therapies in the late 1970's. The program adopted these new methods slowly. Treatment costs ballooned as staff levels increased to handle the large patient population and the new methods. The public's fears of escapes, despite their rarity, led to numerous demands that the program be closed to protect the local

community. The state eventually sided with the public as costs continued to rise, and the program was formally ended in 1986. Washington replaced the program with the strictest sex-offender laws in the nation.

Acknowledgements

Writing this paper has been as much a test of my character as a test of my scholarship. I repeatedly impeded my own efforts to finish the paper by hiding from responsibility and pretending that the assorted preliminary steps to the project would complete themselves if left alone. My advisor, Professor James Mohr, did not let me sabotage myself. Even when I had failed to make meaningful progress in months, he assisted my writing process, completed a host of steps to grant the project IRB approval, and directed the research down meaningful, relevant paths. Most importantly, he underlined to me that my handling of the project was poor, but not the aim. With effort, I could deliver on the subject's promise. This final project is the result of his prescription. I thank him immensely for his refusal to take excuses, and I hope he enjoys the results. I also thank Professor Steven Beda for serving as my Secondary Reader.

The Honors College Faculty and Staff have made me into the student and historian I am. Any positives in my writing, method, or analysis are the legacy of their excellent instruction. I give special mention to Michael Pexioto, Casey Shoop, Shelise Zumwalt, and Miriam Jordan who have been wonderful mentors in the fine art of living. Rebecca Lindner was exceptional in her role as CHC Representative and provided much needed emotional support throughout the writing process. I cannot thank her enough.

My friends – Andrew, David, Jackson, Sam, Mo, Cody, Nathan, Devin, and more – were essential throughout the process. On the nights where I sat in my bedroom, surrounded by loose-leaf photocopies, staring at the wall, they gave me comfort and perspective.

Much of this program was described in summary, in top-down reports. From these sources alone, it was difficult to visualize the ward and determine its operation on a personal, day-to-day basis. My interviews helped to dispel some of those unknowns, and I thank my interview participants for their time and for their knowledge.

My last acknowledge demands some background, and I implore your patience. In my Junior year at the Honors College, I took an "Inside-Out" course, in which college students join a class of students who are serving time at Oregon State Penitentiary. During that course, I came to understand the extent to which prison is distanced from everyday life. The prison was a function and portion of society, but the reticence from most parties about the topic made it seem a concrete island. No one wanted to discuss anything about it, to maintain their own separation from the institution. Studying the history of this program, I noticed a similar trend. Few people, then or today, talk about what is done with sex offenders after they are caught. Several the sources I read couched their therapeutic approaches wholly within clinical language, to avoid describing the day-to-day realities of treatment. For residential programs, the rest of the prisoner's life as a prisoner was not described in any capacity, even in how the program impacted them. Almost no papers discussed what they did to sexual offenders within recent, broader movements in mental health. The changing social atmosphere surrounding sexual crime is given lip service in introductions, then the topic is dropped entirely. The offender cannot, even in text, be integrated in any capacity to society.

This paper seeks to challenge this norm. The prosecution and rehabilitation of sexual criminals cannot be considered something totally separable from or unrelated to

our social norms and practices. Without my experience in “Inside-Out”, I could not have made this realization. I extend my greatest thanks to Prof. Cohen and to his assistant (and my friend) Keene Corbin for helping me come to this realization. This paper would never have begun without them.

This paper was written in the hope that historians may take a greater interest in this under-researched field, and it is dedicated to those researchers who have come before me in researching this program and others on a more detail-oriented scale. Society may yet confront its problems with rampant sexual abuse if it is willing to learn what it is doing with the perpetrators and the victims of those crimes.

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Introduction

The public does not like to think about rapists and pedophiles. Spectacular murderers, skilled thieves, and desperate robbers taking hostages can attract a sort of grudging empathy, or even admiration. Serial rapists earn total scorn and are largely absent from entertainment media. The lack of public discussion is not because the crime is rare. The Federal Bureau of Investigation's official estimate of the number of rapes reported in the United States for 2017 was 135,755. That same year, police made an estimated total of 18,289 arrests on charges of rape.[1] Sexual crimes against children in the United States have historically been severely punished, with public approval. The public's disdain of sexual offenders and love of strong sentences, however, has not stopped attempts at treating them, both in the past and today. One in five defendants convicted of rape charge entered a treatment program as part of their sentence.[2] This is only a portion of the number of offenders who go through treatment, as the majority of rehabilitation is undertaken as part of an offender's probation or parole.[3] In 2008, the *Safer Society*, a group devoted to sex offender treatment policy research and outreach, conducted their most recent survey of the over 2,200 known sexual offender rehabilitation programs in the United States. 1,307, or 57%, of the programs responded,

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[1] Crime Statistics Management Unit, "Summary Reporting System Estimates 1995-2017", Federal Bureau of Investigation, https://crime-data-explorer.fr.cloud.gov/downloads-and-docs. "Rape" here means all sexual offenses committed without the other person's consent or with someone unable to given consent. Child sexual abuse and child molestation are tallied under this definition. The figure is an "estimate" because it includes averages and approximations from police departments that did not keep a full year's records.

[2] Matthew Durose, Donald Farole, Jr., and Sean Rosenmerkel, "Felony Sentences in State Courts, 2006 – Statistical Tables", Bureau of Justice Statistics, U.S. Department of Justice, NCJ 226846 (December 2009), 2.

[3] Marcus Nieto, "Community Treatment and Supervision of Sex Offenders: How It's Done Across the Country and in California", California Research Bureau, California State Library, Sacramento, CA (2004), 3, 11-14, 46-49.

and reported they collectively gave treatment to 53,811 offenders over the 2008 calendar year. 81.6% of these programs were community-based, outpatient programs who overwhelmingly serve offenders released from prison.[4] Sexual offender rehabilitation has become a major facet of the criminal justice system.

The adoption of rehabilitation for sex offenders in the American justice system happened slowly, over decades. The initial effort was by and large abortive. In the 1930's, a wave of "sexual psychopath" laws were created in response to a wave of fear of "sexual deviants" from the public. These laws allowed the indefinite confinement of certain sexual offenders in mental hospitals. They justified themselves on the premise that these offenses were due to an underlying psychological disorder, which, if not treated, would lead to recidivism. The goals of the program, therefore, were to advance public safety as well as provide more humane treatment. If successful, the program would benefit the state with a lower recidivism rate and give its "patients" a pathway to reintegration into society. In practice, these goals were not seriously attempted in most states. Few treatment programs were created of any size or duration. Rehabilitation for sexual offenders instead began on different grounds in the middle of the 1970's, building slowly in size and prevalence through the end of the century.

Washington, however, took a different course. The legislature passed a sexual psychopath law in 1947, but in contrast to other states, Washington's justice system steadily committed offenders to the state mental hospitals for a decade. After some hesitation, one of those hospitals, Western State Hospital in Steilacoom, established a

[4] R.J. McGrath et. al., *Current Practices and Emerging Trends in Sexual Abuser Management: The Safer Society 2009 North American Survey*, Safer Society Press, Brandon, VT (2010), vii, 15, 23-25. This is the most recent such survey available.

treatment program in 1958. For the majority of its lifespan, the state and the program held different but nonconflicting goals. The program staff focused on developing its treatment model, while the state focused on cost containment. The program earned increasing support from the justice system and the legislature. In 1966, the hospital was designated the state's official Treatment Center for Sex Offenders, and the program's population increased massively. By the middle of the 1970's, the program evaluated 80% of all sexual offenders convicted of an offense in Washington.[5] Costs remained low, so the state let the program continue with little oversight. Only the public outcry caused by major failures, such as the 1974 escape of a rapist who then killed two girls in Seattle, brought any attempt by the state to monitor the effectiveness of the program. The state was satisfied so long as the program kept cost low and didn't raise hell.

As the 1970's wore on, the state's expectation of low cost was increasingly joined by demands for higher security. The treatment model that the program had developed was predicated on a degree of freedom for the offender. Significant change from this principle was not possible without changing the program entirely. The program and government were increasingly at odds. Meanwhile, the crimes of child molestation and rape became a source of greater public concern and disdain, putting pressure on the government to enforce its security demands. The conflict between the two was eventually irreconcilable. As sex offenders became increasingly vilified, the program's existence and policy became dependent on local headlines and public opinion, rather than medical science or measurable efficacy. By 1985, the state was no

[5] R.V. Denenberg, "Sex Offenders Treat Themselves", *Corrections Magazine* 1 no. 2 (November/December 1974), 55.

longer interested in a treatment program, no matter the cost, no matter its success. The escape of a nationally infamous rapist that same year was the last straw. Politicians listened to a furious public and closed the program to admissions the next year. The Washington Department of Corrections has received custody of all legally competent sex offenders since.

The Western State program was unique for both its long life and for its iconoclastic approach to the offender's role in his treatment. The program's first incarnation, established by Dr. Giulio di Furia in 1958, was heavily influenced by milieu therapy and by the group techniques developed in Alcoholics Anonymous. Its approach was predicated on offenders intervening in and correcting the mindset and behavior of their fellows. The offender was thought to be self-isolating and unable to interact with others. Group sessions centered on constant, full disclosure of present feelings to develop honesty and socialization skills. The program's residents lived on the same ward and met in a therapeutic "group" throughout the week. They led themselves in their therapy, which they conducted on their own. Staff supervised their progress but allowed them to "manage" themselves, which included setting certain restrictions for individuals and establishing a group code. Under the direction of residents who had been appointed leaders, the offenders analyzed each other's behavior and gave updates on their individual progress. It was like no other sex offender treatment program at the time.

With the arrival of Dr. George MacDonald in 1965, the "therapeutic group" became increasingly prominent in and of itself. The ward was hypothesized to be a miniature community. In the program, the offender had the opportunity not only to seek

help from his group, but to help his fellows and contribute to the therapeutic environment. The groups became more "democratic" to encourage broad participation. Simultaneously, they became more structured to make individual leaders less "distinct" from the general group population. MacDonald, working with Robinson Williams, dramatically expanded the program's practices and services. They sought to effect a wide-ranging change in the life of the offender that would help them transition from the institution to everyday life, and from offender to law-abiding citizen. Their initiative earned the program professional acclaim, and other hospitals across the country, most notably Oregon State Hospital in Salem, adopted the approach for themselves.[6] Their changes, however, began to rack up major increases in per-capita costs. The staff wrote reports on their method, but rarely engaged with the wider academic literature and were less than scientific in their self-analysis. The program's methodology seemed increasingly a response to the program's high resident population, rather than a modality justified by reduction of sexual misconduct.

As the program maintained course, it fell out of step with developments in the field. di Furia and MacDonald had broken with the psychiatric majority in their disinterest in treating subconscious motivating factors and by giving the group so much control. By the start of the 1980's, however, the "self-guided group" approach was seen as "old fashioned" by other professionals. A new model of the sexual offender had surfaced that took sexual offense to be deeper-rooted in an individualistic sexual

[6] Edward M. Brecher, *Treatment Programs for Sex Offenders*, Department of Justice, Law Enforcement Assistance Administration, U.S. Government Printing Office, Washington D.C. (1978), 5; Robert Krell, *Sex Offender Programs at Western and Eastern State Hospitals (Department of Social and Health Services): A Report to the Washington State Legislature,* No. 85-16, Legislative Budget Committee, Olympia, WA (1985), 13.

attitude, rather than a response to a low self-perception. Assorted conditioning methods, combined with cognitive-behavioral therapy, became the new standard in an attempt o stamp out this toxic desire directly. At the program's closure, it was one of the last using the method it had pioneered.

When the last residents left in 1992, the program and its model disappeared from the secondary literature. In a few short years, it had effectively never existed. Today, it only has a handful of mentions in scattered documents describing past approaches to sexual offender rehabilitation. A slightly larger clutch of contemporary evaluations exist, rarely cited. Little of this material is readily accessible. The overwhelming majority of information on the program only exists in the Washington State Archives. To the contemporary observer, this program never existed. This paper seeks to remedy this absence.

The Western State Hospital Sexual Offender Treatment program was a pioneering program in sex offender treatment. It emerged out of a hospital in crisis adopting a new psychiatric philosophy that emphasized group therapy, with little research into its efforts. With time, staff developed its understanding of sexual offenders beyond these original principles to a much more coherent and practical conceptualization. The residents led their own groups, which resulted in a highly combative form of group therapy to emerge. Residents were engaged, but rapid growth threatened the program's ability to maintain this participation. High confidence among the staff and the program's reliance on the offenders to lead therapy meant the program was able to maintain course, even as the number of offenders it saw reached near two hundred. The program attracted little notice outside of the immediate area from any

observer. As time wore on, the program proved more successful in remaining stable than in remaining effective. The field of ex offender treatment changed around the program, not only in method but in principle, and staff struggled to keep up. A decline in funding and in experienced staff resulted in decay of the therapeutic environment. However, these concerns were of little interest to the public, who were instead fearful of the program's relatively rare escapes, and it was this fear that signed the program's death warrant in 1986. To put the program in a wider context, its history will be contrasted with the history two nearby residential programs, one in Oregon State Hospital, the other in California's Atascadero State Hospital, and compared to national developments in sex offender treatment as necessary.

Background: The Prehistory of the Sexual Psychopath

In 1947, Washington legislators passed the state's first sexual psychopath law. However, the Western State program did not officially begin until 1958. This gap between the commitment of sexual offenders and the creation of a treatment program for them formed because the two efforts were carried out by different groups with much different objectives. This "prehistory" will attempt to summarize the national movement of sexual psychopath legislation, then show the path Western State took as it created a coherent treatment program meet the law's expectation.

The sexual psychopath laws were born in a confluence of public fear, professional confidence, and legislative interest.[7] The first factor was born of a

[7] Estelle B. Freedman, "'Uncontrolled Desires': The Response to the Sexual Psychopath, 1920-1960", The Journal of American History 74, no. 1 (1987): 85-92; Joanna Bourke, *Rape: Sex, Violence, History*, Shoemaker & Hoard, Emeryville, CA (2007); Philip Jenkins, *Moral Panic: Changing Concepts of the Child Molester in Modern America*, Yale University Press, New Haven, CT (1998);, Simon A. Cole,

combination of increasing availability of information and wider societal upheaval. The public was made aware of the phenomenon of sexual murder with the proliferation of the sensational press. Starting at the beginning of the century, newspapers printed more and more "shocking" stories and photographs to gain the attention of the public. Crime, particularly gruesome or bizarre sex murders, became a mainstay.[8] Newspaper teams, particularly in smaller states, such as Vermont began publishing about horrible crimes outside their own locale to attract readers.[9] In short order, a serial killer of children went from a local horror to national news. This coverage dramatically increased at the end of the 1920's, and the increasing number of child murderers in the press suggested to the public that sexual crime was on the rise.[10] One woman was based in the crisis and change society was undergoing in the Great Depression. The wage-earning father in the city could no longer find work and feed his family, and the government seemed unable to meet the needs of the people.[11] The Great Migration of African-Americans to the North and the Midwest was met with fear by the white majority, due to a number of old prejudices.[12] These fears resulted, however, in little long-term action by citizens. Instead, law enforcement and legislatures received public approbation and some pressure to enact stronger and more expensive measures against sexual crime.[13]

"From the Sexual Psychopath Statute to "Megan's Law": Psychiatric Knowledge in the Diagnosis, Treatment, and Adjudication of Sex Criminals in New Jersey, 1949–1999", Journal of the History of Medicine and Allied Sciences 55 no. 3 (2000): 292-314.

[8] Freedman, "Uncontrolled Desires", 89-90; Jenkins, *Moral Panic,* 36-37, 55.

[9] Galliher and Tyree, "Edwin Sutherland's Research", 106-107.

[10] Freedman, "Uncontrolled Desires", 92-93.

[11] Freedman, "Uncontrolled Desires", 89;

[12] John F. Galliher and Cheryl Tyree, "Edwin Sutherland's Research on the Origins of Sexual Psychopath Laws: An Early Case Study of the Medicalization of Deviance", *Social Problems* 33 no. 2 (1985), 109-110. The 22 states with the most new black residents all passed sexual psychopath laws.

[13] Freedman, "Uncontrolled Desires", 94, 96; Jenkins, *Moral Panic,* 72-73; Galliher and Tyree, "Edwin Sutherland's Research", 106-107 Simon A. Cole, "From the Sexual Psychopath Statute to "Megan's

This demand surfaced shortly after psychology had established itself as a legitimate field of study in America. Analysis promised a greater understanding of the unconscious drives that were postulated to be the seat of the compulsion. By determining what kind of criminals were frequent recidivists, their psychological characteristics and behavioral habits could be checked for patterns. With time, diagnosis could be replaced with treatment, and society could truly be safe. Psychologists began their efforts to analyze the sexual offender before the first panic got underway. By the time the panic broke, professionals had several observations they were happy to share with the press.[14] In aggregate, they distinguished between certain sex offenders and the "common criminal". Criminal offenders acted out of an intent to harm a specific party, or due to a sexual concern of a different nature, instead. The "different", "psychopathic" offender suffered from problems of attachment that emerged from childhood trauma and resulted in a number of personality deficits. While everyone had unacceptable fantasies, in the sexual psychopath, their internal fantasies made up the primary element of their offenses. These fantasies came from disrupted psychosexual development that stunted their emotional and social growth and left them alienated from adult society.[15] This internal conflict was chalked up, almost always, to an overbearing mother and an absent father.[16] The end result was the offender was unable to address their emotional

Law": Psychiatric Knowledge in the Diagnosis, Treatment, and Adjudication of Sex Criminals in New Jersey, 1949–1999", *Journal of the History of Medicine and Allied Sciences* 55 no. 3 (2000), 298-299.

[14] Freedman, "Uncontrolled Desires", 89-90.

[15] Karl M. Bowman and Bernice Engle, "Sexual Psychopath Laws", in *Sexual Behavior and the Law*, ed. Ralph Slovenko, Charles C. Thomas, Springfield, Ill (1965), 769; Cole, "From The Sexual Psychopath Statute to "Megan's Law"", 298-299; Kittrie, *Right To Be Different*, 182; John Pratt, et. al, "The Rise and Fall of Homophobia and Sexual Psychopath Legislation in Postwar Society", *Psychology, Public Policy, and Law* 4 no. 1-2 (1998), 26-27.

[16] Pratt, et. al, "The Rise and Fall of Homophobia", 36.

needs in a healthy way, leading them to isolate themselves even more. The spiral continued until they offended, relieving the pressure.[17] Symptomatically, the condition of sexual psychopathy was described as a sexual deviance that was not accompanied by or a symptom of a grander psychopathic illness, such as severe bipolar disorder or schizophrenia. The term "psychopathy" applied loosely. The man in question was "sane", insofar as he knew what was and wasn't reality, could articulate his thoughts, and look after himself.[18] His "psychopathy", in the analyst's view, was specified, and lay in his inability to control his sexual desires despite its obvious negative effects on others.[19] The group "suitable for diagnosis" was fairly large, and included exhibitionists, serial rapists, child molesters, and sexually abusive parents among other "paraphiliacs".[20] Joanna Bourke sums up the condition as it appeared to the analyst: "…[Sexual] Psychopaths realized 'only too well the implications of their various acts' but were 'impelled… by a desire or passion against which they struggle[d] in vain'".[21]

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[17] Karpman, "The Sexual Psychopath", 185, 191; Larry Hendricks, *Some Effective Change Inducing Mechanisms in Operation in the Specialized Treatment Program for the Sex Offender,* Dept. of Social and Health Services, Olympia, WA (April 1973), 1-2, 8.

[18] Patients with developmental disabilities were considered "sexual psychopaths" in a majority of cases, but if their disability was severe enough to impede basic speech or personal attention, their offenses were attributed to the disability rather than a different illness.
This essay genders the sexual psychopath as a "he" intentionally, to mirror the language of the sources. Women were, with a handful of exceptions, excluded from the classification. While women rapists were occasionally mentioned, with the exception of mother-son incest they were never discussed.
Paul H Gebhard et. al., *Sex Offenders: An Analysis of Types*, Harper & Row, New York (1965).

[19] George, "The Harmless Psychopath", 232-233; Group for the Advancement of Psychiatry, *Psychiatry and Sex Psychopath Legislation, the 30s to the 80s, Group*… Publication No. 98, New York (1977), 855-859.

[20] Cole, "From the Sexual Psychopath Statue", 298; George, "The Harmless Psychopath", 231-232; Karpman, "The Sexual Psychopath", 187-188, 190.

[21] Joanna Bourke, *Rape: Sex, Violence, History*, Emeryville, CA: Shoemaker & Hoard (2007), 278.

Professionals gave a number of reasons why sexual psychopaths should be committed rather than imprisoned.[22] Firstly, sexual psychopaths were a questionable moral target of punitive control.[23] A person internally compelled to do something they abhorred should not be subjected to the same consequences the state brought against willing criminals.[24] As well as ethically proper, the offender was thought likely to reoffend until their internal problems were properly addressed. It was "responsible" to establish commitment based upon cure, rather than time served, for both the offender and their community. Their mental problem necessitated treatment for both their own sake and for society's safety.[25] Individual practitioners differed on the method of cure, but the possibility of meaningful treatment of the sexual psychopath by *some* psychiatric or therapeutic avenue was accepted by a vocal portion of the profession.[26] The assertion by mental health professionals that they understood sexual offenders and their crimes was accepted and disseminated by the popular press. Newspaper articles featured interviews with psychiatrists and government bureaucrats, while fictional media spun narratives about sex murderers whose motivations and actions matched the theories the professionals postulated.[27]

Whether legislatures truly accepted the validity of psychoanalysis or not, about half of the states in the Union decided to delegate the handling of the "psychopaths" to

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[22] Freedman, "Uncontrolled Desires", 91, 96; Jenkins, *Moral Panic,* 45, 59; Kittrie, *Right To Be Different,* 183.
[23] Kittrie, *Right To Be Different,* 183; Tappan, "The Sexual Psychopath", 371; California Department of Mental Hygiene and Langley Porter Neuropsychiatric Institute, *Final Report,* 21-22, 42-43.
[24] Jenkins, *Moral Panic,* 21.
[25] Frym and Hacker, "The Sexual Psychopath Act", 766-767; Bourke, *Rape,* 188, 193-194.
[26] Cole, "From the Sexual Psychopath Statue", 293-294; Jenkins, *Moral Panic,* 61, 73, 89-90; Bourke, *Rape,* 280, 284-285.
[27] Jenkins, *Moral Panic,* 54-56, 60, 62-63.

its practitioners. In some cases, the laws were joined with a dedication of funds to "research" at a particular institution, or in a few instances, toward the construction of a new psychiatric facility.[28] For legislators, these bills killed two birds with one stone. The offender was not leaving the institution for quite some time, and while inside, people with training and interest could provide him treatment that might stop his negative behavior for good.[29] The handoff was accomplished with a series of highly formulaic "sexual psychopath" laws. These laws established the "sexual psychopath" as a separate class of sex offender, definable by the criterion of uncontrollable impulses that emerged from internal psychological problems. These offenders were to be committed to a mental institution indefinitely.[30] While the general character and intent of the law was remarkably consistent from state to state, the hearing's conditions and process varied greatly.[31] Washington's law fell into what was termed the "preconviction" type of statue, a type it shared with Iowa, California and many others.[32] The law allowed the indefinite commitment of a "sexual psychopath" in a civil hearing, without a corresponding criminal conviction. These laws were not amended to previous insanity clauses, on the grounds that they described a fundamentally new condition to the court. The gray area that psychologists proposed of "uncontrollable urges", whether in this specific instance of sexual conduct or of another crime, lay between legal sanity

[28] Freedman, "Uncontrolled Desires", 98-99; Jenkins, *Moral Panic,* 83-84.
[29] Bourke, *Rape,* 285-286.
[30] Jenkins, *Moral Panic,* 79-80, 83.
[31] California Department of Mental Hygiene and Langley Porter Neuropsychiatric Institute, *Final Report,* 16-20.
[32] Slovenko, *Sexual Behavior,* 758.

and insanity as previously defined.[33] This legally justified a new form of civil commitment that otherwise bordered on detention without trial.

By 1935, the sexual psychopath had been "identified", the alarm had been raised, and a particular legal niche had been dug. However, the follow-through by legislatures took time. A first wave of sexual psychopath laws passed in a burst from 1937 to 1941. The start of World War II diverted public and legislative interest in crime at home. At the war's end, legislators in a number of states, including Washington, returned to drafting laws combating and committing the "sexual psychopath", as a "second panic" regarding child molestation kicked up.[34] This wave ran from around 1948 to the "mid-fifties". By that time, twenty-four states had passed sexual psychopath statues, a number that would eventually reach twenty-eight.[35]

The sex psychopath statues had been passed, ostensibly, to target dangerous sex offenders. In many states, however, it was primarily homosexual men and lesser offenders, such as voyeurs, who were committed under them. [36] From state to state, the crimes which were covered under commitment varied. Often they were not listed explicitly, and it was the perceived "dangerousness" of the offense that made someone eligible for commitment.[37] The 1951 Washington statue was one of these, which stated

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[33] Slovenko, *Sexual Behavior,* 758; Sol Rubin, *Psychiatry and Criminal Law; Illusions, Fictions, and Myths*, Oceana Publications, Dobbs Ferry, NY (1965), 2-3, 88-90.
[34] Cole, "From the Sexual Psychopath Statute….", 294-295; Freedman, "Uncontrolled Desires", 96-97; Jenkins, *Moral Panic,* 82-83.
[35] California Department of Mental Hygiene and Langley Porter Neuropsychiatric Institute, *Final Report,* 41; Cole, "From the Sexual Psychopath Statute….", 293-294.
[36] Bourke, *Rape,* 291; Freedman, "Uncontrolled Desires", 97-98; Bernard C. Glueck Jr., "An Evaluation of the Homosexual Offender", *Minnesota Law Review* 41 no. 2 (January 1957): 191; George, "The Harmless Psychopath", 225-227; William N. Eskridge, *Gaylaw: Challenging the Apartheid of the Closet*, Harvard University Press, Cambridge, MA (1999), 60-61.
[37] George, "The Harmless Psychopath", 225-227; Jenkins, *Moral Panic,* 81-82, 88.

that "any person who is affected in a form of psychoneurosis or in a form of psychopathic personality which… predisposes such person to the commission of sexual offenses in a degree constituting him a menace…." could be committed.[38] In contrast, the "sexual psychopath" statue in New Jersey, passed in 1949, defined sexual psychopathy as "abnormal mental illness resulting in commission of *enumerated* sexual offenses", which included possession of "obscene literature or pictures", "homosexuality", "indecent exposure" and "indecent communications to females", among many others which were decidedly nonviolent.[39] The result of this was that some states, such as Iowa, used their statue almost exclusively to round up gay men. One panic in Sioux City resulted in twenty-one men being committed to a ward set aside for them alone in the Mount Pleasant Hospital.[40] The majority of California's commitments to Atascadero in the 1950's were gay men and gay prostitutes, earning it the nickname "Gay Dachau."[41] Dangerous offenders continued to be sent to jail, as before.

Mental health at this time was predicated on institutional care, in the form of large inpatient mental hospitals. When legislators sought a psychiatric answer for the problem of "sexual psychopaths", they sought an institutional treatment situation. Outpatient care for most patients was not given much consideration. In Washington, this mainstream of institutional care was centered in Western State Hospital, often abbreviated to Western State. Western State Hospital was the state's oldest mental

[38] Kenneth H. Kato and James H. Hardisty, *The Sexual Psychopath and the Incompetent to Stand Trial: Peas in a Pod?*, Student Papers, University of Washington School of Law, Seattle (1975), 18.
[39] P W. Tappan, "The Sexual Psychopath; a Civic-social Responsibility", *Journal of Social Hygiene* 35 no. 8 (1949), 371.
[40] Neil Miller, *Sex-Crime Panic: A Journey to the Paranoid Heart of the 1950s*, Alyson Books, Los Angeles (2002): 82-84, 121-123.
[41] Jackson, "Dachau for Queers", 42-50.

health facility, and its largest. It was established in 1871 on the ruins of old Fort Steilacoom. It was the primary mental hospital for the Pacific Northwest from its founding through the period under discussion. It grew massively in size over the decades, and bought a large portion of nearby land for patients to farm as occupational therapy and to lower costs.[42] By 1950, two additional hospitals had been built in the state: Eastern State Hospital in Medicine Lake, near Spokane, and Northern State Hospital in Sedro-Wooley, about an hour north of Seattle. Western State remained the "most advanced" of the facilities, boasting the first geriatric care facility in the nation in 1945.[43] A few other mental health facilities existed, most notably at the University of Washington, but the three state hospitals provided the clear majority of psychiatric care at this time. It was almost certain that any sexual psychopath statue in Washington would send its commitments to one of the three.

Washington stepped into this environment in 1947 when passed its first sexual psychopath law. Like the other countries began its efforts at sexual offender treatment. The real goal of this legislation, however, was the creation of a legal means of indefinite incarceration. Portions of the psychiatric field strongly advocated that, on both ethical and practical grounds, the care of sex offenders be shifted to the mental hospital. States were eager for a simple response to the public fear of sexual crime. Making mental hospitals into jails that offenders had no right to leave was perfect in their eyes. If treatment proved effective, then all the better, but assisting institutions in making

[42] Hilda Skott, *From Camas Lilies to Prilly Blossom: Fort Steilacoom Becomes Western State Hospital*, Fort Steilacoom Monograph Series, Steilacoom, Wash (1999), 8-14; "Western State Hospital is State's Largest", *Mt. Adams Sun*, Bingen, WA (January 2nd, 1948), 6.
[43] "Western State Hospital is State's Largest", 6.

effective treatment was not a serious consideration. The state accordingly created the category of the "sexual psychopath", whose defining psychological trouble was an inability to conform to the dictates of society, and whose treatment had to be conducted while incarcerated.

The Sexual Psychopath in Washington, 1947-1957

Washington was a part of the "second wave" of sexual psychopath legislation. The three laws that passed muster suggested the legislature was primarily concerned with the legal procedure, seeking to balance power between the court and the hospital. The sessions sped to unanimous votes. However, a deeper conflict of understanding and interest between law enforcement and mental health institutions led to halfhearted treatment attempts. When Western State Hospital began receiving commitments from these laws in 1949, the staff did not know what to do with them. The psychiatric profession's brief fiery passion for reforming criminal minds with civilian methods had cooled rapidly over the 1930's. The profession accordingly allowed the subject to fade from the literature, leaving little besides a flurry of theoretical arguments and rebuttals on the amenability of sex offenders to treatment. Once in the care of the psychiatric hospital, however, the staff's belief in their ability to help was a moot point. Washington state's courts, unlike many other states, continued sentencing offenders to Western State Hospital. It had to house them, and live with them, somehow. Being forced to deal with the offenders for the better part of a decade, however, was not enough to push the hospital to focus its efforts or cohere its approach. Public and legislative disinterest meant that the sorry state of affairs was given little attention or criticism. Western State Hospital's first ten years of sex offender rehabilitation saw the

institution of a handful of initiatives predicated around group therapy for sex offenders, combined with what was effectively incarceration on locked wards, with little focus, theorization, progress or success. It was not until a cascade of events in 1957-1958 that sex offender rehabilitation achieved any meaningful progress at Western State.

Washington States first piece of legislation regarding sexual psychopaths was Senate Bill 179. It defined the sexual psychopath as anyone who was "convicted at least once as a sexual offender", was suffering from a mental illness, and was "not insane or feeble-minded" as a "criminal sexual psychopathic person".[44] The defendant, on the petition of the prosecuting attorney, would be made the subject of a "sexual psychopath" hearing following their conviction.[45] The hearing would accept or deny this classification. If the offender was found a "sexual psychopath", two major changes to their sentence occurred. During their prison term, the offender was entitled to care by a psychiatrist within their institution.[46] Then, following either the end of their sentence or their release on parole, the offender was subject to a second hearing for their discharge "as a criminal sexual psychopath".[47] If they were found "unsafe to be at large" in this hearing, they would be committed to an institution which offered treatment for sexual psychopaths until found “safe to be at large” by the institution’s administration.[48] The offender deemed "unsafe to be at large" could file for discharge from their institution once a year, which would be reviewed by the committing Court.[49] While this was the

[44] Washington State Legislature, *Session Laws of the State of Washington: Thirtieth Session, Olympia, WA (1947),* 1161.
[45] Washington State Legislature, *Session Laws…Thirtieth Session,* 1162.
[46] Washington State Legislature, *Session Laws…Thirtieth Session,* 1164.
[47] ibid, 1165.
[48] ibid.
[49] ibid, 1167.

first proposed law of its kind in Washington State, the bill received minimal discussion, and was only amended in one instance to clarify all psychiatrists and physicians needed to be licensed.[50] It was passed near-unanimously by both houses, and signed into law by the Governor on March 21st, 1947.[51]

This law was significantly altered by State Senate Bill 87, introduced and passed in 1949. This bill was concerned with the "care and treatment of the mentally ill" broadly.[52] Sections 25 through 39 amended the "sexual psychopath" procedure specifically. Two or three psychiatrists were now required to examine the defendant.[53] If the defendant was found to be a sexual psychopath, the offender's criminal proceedings could be suspended at the court's discretion. The offender was committed to "a state hospital...according to the provisions for the commitment of the mentally ill."[54] They no longer had to be convicted to be classified a sexual psychopath, and their time in prison could be effectively replaced by a hospital stay. The committed offenders could no longer file for discharge. Their release was at the discretion of the hospital superintendent and the committing court.[55] The bill was signed into law by the Governor on March 19th, 1949. In a strange choice, all commitments were ordered to Eastern State Hospital.[56] Why Eastern State was specified is unclear. This point was

[50] Washington State Senate, *Senate Journal of the Thirtieth Legislature of the State of Washington*, Olympia, WA (1947): 320, 365, 754.
[51] Washington State Legislature, *Session Laws…Thirtieth Session*, 1167.
[52] Washington State Legislature, *Session Laws of the State of Washington: Thirty-Second Session*, Olympia, WA (1949): 606.
[53] Washington State Legislature, *Session Laws of the State of Washington: Thirty-Second Session*, 616.
[54] Washington State Legislature, *Session Laws of the State of Washington: Thirty-Second Session*, 614.
[55] ibid, 615.
[56] ibid, 617.

seemingly disregarded, as Western State Hospital received its first sexual psychopath commitments following the bill's passage.[57]

In 1951, House Bill 436, a significant expansion and refinement of the 1949 bill, again revised "sexual psychopath" commitment. It proved satisfactory, and its general approach would stand for the rest of the law's life. The law added a new chapter to Title 71 of the Revised Code of Washington and repealed the previous statue.[58] The primary change was the addition of an observation period. Following the primary hearing and the classification of the offender as a sexual psychopath, the offender was confined at "the nearest state hospital" for a period "not to exceed ninety days".[59] The hospital superintendent was then to report to the committing court the hospital's opinion on the condition of the offender. Another hearing would follow.[60] If the court affirmed the classification, the sexual psychopath was "retained by the superintendent of the institution" until they were deemed "safe to be large" by the superintendent. When certified "safe to be at large", those who had been convicted of a crime took a different path than those who had not. Those offenders who had not been convicted would be returned to their committing court, who could press the charge or set terms of release, at their preference.[61] A convicted offender had their sentence suspended while they were committed to the institution. Upon the offender's certification as "safe to be at large", two things could happen. If they had been committed in the hospital for a period less

[57] "Western State Hospital 1957 - Progress and Problems", Memorandum, 1957, 4.
[58] Washington State Legislature, *Session Laws of the State of Washington: Thirty-Fourth Session*, Olympia, WA (1951): 669, 678.
[59] ibid, 671.
[60] ibid.
[61] Washington State Legislature, *Session Laws of the State of Washington: Thirty-Fourth Session*, 672.

than the length of their sentence, they would be referred to the parole board to negotiate the remaining length of their bid or the terms of their release. If they had completed the length of the sentence in the hospital, then the parole board was irrelevant, and the hospital superintendent decided release terms.[62] The only other significant change to the law was in Section 25, which eliminated the designation of Eastern State as the sole provider of Sexual Psychopath treatment. Instead, it opened any institution to accept sexual psychopath commitments, so long as they "provide[d] psychiatric care and treatment" in some capacity.[63] Again, the debate on the bill was minimal. It was introduced, read, and referred to committee in the House, amended for clarity and a more precise definition of "psychopathy", and passed with none opposed.[64] It was read two days later in the Senate and referred to the Committee on Institutions.[65] The next day, it was recommended to pass without amendment, and the day after it passed without debate, and with only two of forty-six senators opposed.[66] It was signed into law eleven days later.[67]

Legislators had greeted the opportunity of institutionalizing sexual offenders with enthusiasm. The majority of the bills received unanimous support, with only a handful of no votes in the state Senate. They ran through the legislature quickly. The 1949 bill was passed by both the House and the Senate in the same day.[68] The term

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[62] ibid, 671-672.
[63] Washington State Legislature, *Session Laws of the State of Washington: Thirty-Fourth Session,* 677.
[64] Washington State House of Representatives. *House Journal of the Thirty-Fourth Legislature of the State of Washington,* Olympia, WA (1951): 260, 622-623.
[65] Washington State Senate. *Senate Journal of the Thirty-Fourth Legislature of the State of Washington,* Olympia, WA (1951): 542.
[66] ibid, 598, 663.
[67] Washington State Legislature, *Session Laws of the State of Washington: Thirty-Fourth Session,* 678.
[68] Washington State Legislature, *Session Laws…Thirtieth Session,* 1167.

"debate ensued" was absent from the Record for both the 1949 and the 1951 bills, which in this context means the bills me with no questioning or discussion of import. The legislature, having enabled the justice system and the state hospitals to pursue an alternative to prison, took no further action. They did not monitor sexual psychopath commitment in any serious capacity for two decades. Later, they would modify what the actors in the process could do, most notably in 1967, but the process itself was changed little. The Washington justice system seemed satisfied with their conclusions. The 1951 law buffeted a number challenges in Washington courts, including State V. Wilmoth in 1979.[69] The new system of civil commitment for sexual offenders lasted almost forty years.

The enthusiasm shown by the legislature was not initially met by Washington's mental hospitals. This disinterest was grounded in a larger decline of psychiatric interest in treating criminals. In the 1930's, the psychiatric profession and its institutions had attempted to treat the new "sexual psychopath" commitments with the same therapies it used with the "civilian" population. The institutional staff found their methods had less effect on the sexual offender than they had hoped.[70] As professionals attempted to engineer new methods, they investigated the offender to try and determine what about them exactly was different from others. Psychologists were doubtful whether the classification of "sexual psychopath" meant anything.[71] Their primary objection was the

[69] State V. Wilmoth, 22 Wn. App. 419, 589 P.2d 1270 (1979).
[70] Galliher and Tyree, "Edwin Sutherland's Research", 106-107; Jenkins, *Moral Panic,* 67-68, 73, 89-91; Bourke, *Rape,* 197-199.
[71] Rubin, *Psychiatry and Criminal Law*, 90-91; Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 11-12; Edward Sagarin and Donald E. J. MacNamara, *Problems of Sex Behavior*: *Selected Studies in Social Problems*, Crowell, New York (1968), 239-240; Gebhard, *Sex Offenders,* 866-867.

use of the term "psychopathic": while the offender's crimes were greatly upsetting to most, this was not proof of a classifiable mental illness or a reality-distorting psychosis.[72] An 1949 article by Paul Tappan, enthusiastic about the possibilities of treatment, debated the term's meaning of the term for three pages. He argued that the term's definition differed widely. As doctors could not agree on what symptoms besides a criminal sexual impulse existed, it was effectively a criminal charge masquerading as a medical diagnosis. The offender likely had personality problems, but not a distinct disease from other maladjusted, antisocial people, and not a distinct ailment from other criminals.[73] With time, even longstanding advocates bowed to the pressure. Dr. Karpman, a tireless devotee to "psychopath" as a label, capitulated in a 1954 paper and stated, "the terms 'sexual psychopath' and 'sexual psychopathy' have no legitimate place in psychiatric nosology or dynamic classification." He stated that the illegality of their behavior was, effectively, the reason for the "psychopath's" distinction, which wasn't evidence of a psychological difference.[74] The disease that the laws had sought to "treat" was now widely discredited as an overspecification of a complicated problem. The term soon disappeared from clinical usage altogether. In most of the Western State documents, and almost all academic works written after 1965, the term itself was not

[72] Frym and Hacker, "The Sexual Psychopath Act", 770; Marie-Amelie George, "The Harmless Psychopath: Legal Debates Promoting the Decriminalization of Sodomy in the United States", *Journal of the History of Sexuality* 24 no. 2 (2015), 239-240; California Department of Mental Hygiene and Langley Porter Neuropsychiatric Institute, *Final Report*, 20-21.
[73] Tappan, "The Sexual Psychopath", 355-357.
[74] Benjamin Karpman, "The Sexual Psychopath", *The Journal of Criminal Law, Criminology, and Police Science* 42 no. 2 (1951), 185-186.

used at all. The authors couched it in quotation marks, to show they are referring to the offender's legal classification, then shift to a term they find more appropriate.[75]

In the first decade of the panic, psychiatrists had asked state legislatures for funds for research. A handful had gotten funding to either for research or build another hospital. The majority of mental health institutions got no additional funding and were expected by their state legislatures to educate themselves on the cutting edge of sex offender diagnosis and treatment. At the same time, mental hospital populations were rapidly increasing across the country, "from 160,000 in 1910 to 270,000 by 1930…[peaking at] about 550,000 in the mid-1950's, a rate of growth far higher than that of the population at large".[76] All of these new patients demanded the hospital's attention and resources. Unsurprisingly, most hospitals did little to nothing to "treat" the sex offenders who came alongside the new patients. Those hospitals that did attempt to find treatment methods found literature on the topic sparse. What little existed was predicated on critique or praise of legal statues. Accordingly, the establishment of a "proper" procedure for sex offender treatment by the mental health profession, the logical second step of sexual psychopath laws, never came to pass. To prevent escapes, the majority hospitals simply locked up commitments as best they could, most often in their highest security ward. The superintendent discharged them whenever the it was thought appropriate, or if the patient population was getting too high.[77] The hospital's

[75] Marcel Frym and Frederick Hacker, "The Sexual Psychopath Act in Practice: A Critical Discussion", *California Law Review* 43 (1955), 766; Gebhard, *Sex Offenders,* 846.
[76] Jenkins, *Moral Panic,* 84.
[77] Bourke, *Rape,* 289-291; Cole, "From the Sexual Psychopath Statute to "Megan's Law", 297, 299-300; Group for the Advancement of Psychiatry, *Sexual Psychopath Legislation*, 855-859; Freedman, "Uncontrolled Desires", 99-100; Jenkins, *Moral Panic,* 84-85,88-90; Giulio di Furia and Hayden L. Mees, "Legal and Psychiatric Problems in the Care and Treatment of Sexual Offenders (a National Survey)", *American Journal of Psychiatry* 120 no. 10 (1964): 980.

inaction was not challenged by judicial insistence. Before 1968, no involuntary commitment statue – sexual psychopath or otherwise – was successfully challenged in court because the hospital had failed to provide treatment.[78] This was partially because the problem of sexual psychopath commitments proved "temporary". Many of the sexual psychopath laws arrived stillborn, seeing little use. Minnesota passed its law in 1939, but commitments trickled down to roughly ten a year by 1950. Illinois "committed only sixteen" sexual psychopaths through the decade of the 1940's.[79] Indiana, through the '50's and 60's, annually committed a number Dr. Gebhard said "[you could count] with the fingers of one hand."[80] Without a legal challenge, and with no pressure from the public or legislature, there was no impetus for mental hospitals to attempt treatment on a tiny portion of their patients.

Western State Hospital, however, faced a steady, if small, commitment of offenders as 'sexual psychopaths" through the first decade of the law's passage. The first court commitments as of suspected sexual psychopaths began after the second law's passage in 1949.[81] Commitments continued steadily for a decade. The hospital accepted for treatment a little under half of the offenders referred by the courts. For example, between July 1952 and June 1954, 56 people were admitted to Western State for observation as sexual psychopaths. Of these, 20 were certified sexual psychopaths and retained for treatment.[82] The Division of Mental Health report for 1957 stated that over

[78] Group for the Advancement of Psychiatry, *Sexual Psychopath Legislation*, 930-931; Nason v. Superintendent, 353 Mass. 604, 233 N.E.2d 908 (1968).
[79] Bourke, *Rape*, 287; Jenkins, *Moral Panic*, 88; Kittrie, *Right To Be Different*, 191-192.
[80] Gebhard et. al, *Sex Offenders*, 847.
[81] "Western State Hospital 1957 - Progress and Problems", Memorandum, 1957, 4.
[82] Shovlain, *Seventeenth Biennial Report*, 14.

the year, 68 people were admitted under observation for sexual psychopathy and 31 were committed.[83] All told, there were a total of 222 "referrals" and over 100 commitments by the courts from 1949 to 1957.[84] The number of these committed offenders who were later successfully discharged as "safe to be at large" was very small. From July 1952 and June 1954, only five residents were "returned to society…on a five-year parole".[85] In 1957, only four more had been returned to the parole board for release. Putting the two intervals together, this made a total of only nine graduates for the same interval's fifty-one commitments, a graduation rate of just over 17.6%. The sexual psychopath was a constant, difficult-to-discharge presence at Western State Hospital through the 1950's. Even after eight years of minimal "treatment", there was no sign that the justice system would stop referring offenders.

Washington's sexual psychopaths were *not* homosexual men. As previously discussed, in most states, sexual psychopath law became a means of institutionalizing gay men convicted of a minor charge. Washington's law itself had the same language and provisions as most others had. Consensual homosexual intercourse of any kind was explicitly defined as a crime, falling under a wider "Sodomy" charge. "Sodomy" was one of the charges which "qualified" an offender as sufficiently dangerous for a "sexual psychopath" classification.[86] However, review of the hospital's letters to the court showed that, in at least two instances, Western State did not classify a man sent to them on charges of sodomy a "sexual psychopath." The first, [Richards], was a prostitute who

[83] "1957 Annual Report", Washington Department of Institutions, Division of Mental Health, Olympia, WA (1957), 8.
[84] "Western State Hospital 1957 - Progress and Problems", Memorandum, 1957.
[85] Shovlain, *Seventeenth Biennial Report,* 14.
[86] Glueck Jr., "An Evaluation of the Homosexual Offender", 190.

only engaged with male clients. His homosexuality was noted dismissively, as an aspect of his immature, depressive personality. While the superintendent, Shovlain, considered [Richards] mentally ill, this illness was not sexual psychopathy. [Richards] was not perceived as a threat to the public at large, and his "problems" of same-sex attraction did not in his opinion demand institutionalization.[87] The second, [Brown], was in "the opinion of the majority of the staff… a homosexual." He was not "neurotic", could tell right from wrong, and "has adjusted in this way of life without any apparent difficulty". The last paragraph stated, again, that he was a "homosexual", not a sexual psychopath, and was best processed through the justice system.[88] "Homosexual" was referred to in a general sense, as a classification, and the last paragraph explicitly stated that the homosexual and the sexual psychopath were distinct classifications. To the staff of Western State, homosexuality was not in and of itself sexual psychopathy.

The treatment of sexual psychopaths was attested by the program founders to have begun only with Dr. di Furia's arrival in 1958. In his 1968 historical overview and report, Dr. MacDonald stated that no coherent treatment plan for sexual psychopaths was followed, and the majority of those committed were placed on locked or heavily restricted wards.[89] The new "offender-patients" were vastly different than the sort of patients that hospital staff had been trained to treat. Ward attendants believed they posed a serious risk to those inside and outside the facility. For security, the

[87] F.E. Shovlain to Judge H.G. Sutton, February 10th, 1953, "RE: [Richards]", Western State Hospital, Department of Institutions, 1-2.
[88] F.E. Shovlain to Judge H.G. Sutton, July 2nd, 1953, "RE: [Brown]", Western State Hospital, Department of Institutions, 1-2.
[89] George J. MacDonald, H. R, Nichols, and Robinson A, Williams, *Treatment of the Sex Offender: A Report on the First Ten Years of a Hospital Program*, Western State Hospital, Steilacoom, WA (1968): 1.

"psychopaths" were placed on maximum-security locked wards. Some of them were distributed among the solitary-cell unit housing uncontrollable psychotics.[90] This "punitive over-control" lead to "outbursts" of poor behavior and an average of twenty escape attempts a year.[91] Western State Hospital writ large was overcrowded and "badly understaffed", worsening matters.[92] A public outcry over the high escape rate was, according to di Furia, what ultimately pushed him to start the program.[93] MacDonald summarized the situation: "...for seven years following [the law's] passage... the mental hospitals treated sex offenders in essentially the same way as the prison."[94]

MacDonald and di Furia were correct in saying the sexual psychopath population was a major escape risk for the hospital. The 1957 "Progress and Problems" memo presented a hard figure for every other population attribute but sheepishly stated "some" sex offenders escaped. It hinted that major change was needed to keep the figure from rising.[95] Internally, there appears to have been a lot of pressure to stop the escapes. However, whatever "public outcry" surrounding the escape rate existed was quite muted. A wholly separate program concerning "psychopathic" juvenile delinquents existed at the hospital at the time, and a similarly high escape rate was the source of a lot of community and media concern. There were no mentions of "sexual psychopaths", however, in the numerous articles and editorials on the escapades of the psychopathic

[90] MacDonald et. al., *Treatment of the Sex Offender: Ten Years*, 1.
[91] ibid; Giulio di Furia, "On the Treatment and Disposition of Sexual Offenders", *Northwest Medicine* 65 no. 8 (1966): 629.
[92] MacDonald et. al., *Treatment of the Sex Offender*,, 1.
[93] ibid.
[94] MacDonald e. al., *Treatment of the Sex Offender*, 22.
[95] "Western State Hospital 1957 - Progress and Problems", Memorandum, 1957, 4.

delinquents.[96] Western State had little pressure from the public or the legislature to do something about the sexual psychopath. The motivating forces for developing treatment, to be discussed later, were in fact internal.

Similarly, MacDonald and di Furia's claims that sexual psychopath treatment began with the 1958 program appear inaccurate. A number of historical documents described attempts at treatment of the committed sexual psychopaths before di Furia's program. These efforts were inconsistent and lacked a long-term plan, but they did have one consistent point: a group approach. In a 1952 letter to J. Edgar Hoover, Robert Brown, the hospital's Clinical Director, asked Hoover about "the disposition" of an escaped patient, [Andrews]. [Andrews] was diagnosed as a Sexual Psychopath, but he escaped in November 1951 before he could be returned to court for a commitment hearing. The hospital sought his return for "further treatment", suggesting that someone at Western State was interested.[97] Later documents described explicit attempts at therapy. The 1954 Biennial Report stated that "[a] special sound-proof room, wired for tape recording [,] has been constructed for group therapy practice. At present time a special study is being conducted with a number of Sexual Psychopaths... When this series is completed, a number of Schizophrenics will be studied in like manner".[98] In Superintendent Shovlain's view, discharging the thirty-three "psychopaths" committed

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[96] "Steilacoomites Alarmed About Escaped Delinquents from W. State Hospital", *Suburban Times,* Lakewood, WA (January 17th, 1957); A.P. Wire, "Many Escapes at Steilacoom Draw Criticism", *Seattle Post-Intelligencer* (October 29th, 1959); Jack Pyle, "State Seeks Answers to Escapee Problems", *The News Tribune,* Tacoma, WA (June 23rd, 1963), A9.

[97] Robert Brown to J. Edgar Hoover, July 23rd, 1952, Western State Hospital, Department of Institutions, 1-2. [Andrews] is a pseudonym. All other sexual offender treatment program residents and figures contained in brackets are pseudonyms. Only those residents and staff who earned public renown or infamy are referred to by their real name.

[98] F.E. Shovlain, *Seventeenth Biennial Report, July 1st, 1952 to June 31st, 1954,* Western State Hospital, Steilacoom, WA (1954), 2.

to the hospital's care was an essential step to alleviating the hospital's overloaded inpatient units.[99] The other mentions of the "Sexual Psychopath Program" in the report gave no description of the "program" further than the word "treatment".[100] The study itself, or any other mention of it, sadly could not be located. The group approach, however tentative, persisted for the rest of the decade. A "progressive group therapy setting" was stated to be the "primary" treatment for Sexual Psychopath programs as of 1957. The same memo described the "formulation of a treatment program for sex psychopaths" that was sent to the Clinical Director for approval. Again, no description of the program is included. Observers inside the hospital took notice of the lack of progress in treating the sexual offender. Research into the treatment of sexual offenders was, in the Psychology Department's estimation, "the type [of research] needed most by the hospital at this time".[101] The memo is not dated, but its contents strongly suggest an end-of-year report from 1957. di Furia did not arrive at the hospital until 1958.[102] These treatment attempts, while only described in passing, do not suggest a common understanding of the sex offender. They do, however, strongly suggest that group therapy was the de facto approach before the innovation of any targeted approach to treatment. Before di Furia began a full-scale program, there were numerous scattered attempts at Western State, to provide some degree of treatment to sexual offenders, primarily involving group therapy. Di Furia's efforts were the birth of a long-term plan for sex offender treatment, not the beginning of treatment itself.

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[99] Shovlain, *Seventeenth Biennial Report*, 7.
[100] Shovlain, *Seventeenth Biennial Report*, 7, 14.
[101] "Western State Hospital 1957 - Progress and Problems", Memorandum, 1957, 4, 16.
[102] "Dr. Di Furia New Hospital Assistant", *Suburban Times*, Lakewood, WA (November 14th 1962); Dr. Edward A. Posell, "Medical Services", *Fort Reporter* 12 no. 11, Steilacoom, WA (November 1958), 1.

Washington's patchwork history of sexual psychopath treatment before di Furia's arrival was similar to how sex psychopath legislation played out in other states. Few other states developed a coherent approach to their "sexual psychopaths".[103] Those few that did primarily launched scattered pseudoscientific attempts to "cure" same-sex interest. California was, along with New Jersey, Wisconsin and New York, one of the most prominent states to embark on curing the sexual psychopath. The state passed its law in 1939 and steadily committed offenders in large numbers for the next thirty years. Like Washington, despite numerous commitments, California's first organized approach to treatment took a decade to arrive. This program was the Norwalk program, which began at Metropolitan State Hospital in Norwalk in 1948.[104] The program was minimally restrictive and used individual therapy alongside a group living situation.[105] By July 1953, the state had diagnosed and committed 1,163 "sexual psychopaths" to state mental hospitals.[106] Then, the program was abruptly ended by the legislature, and in an about-face in policy all "sexual psychopaths" were sent to the new twenty-million-dollar medium security Atascadero State Hospital.[107] Atascadero added chemical and surgical castration, lobotomies, electroshock treatment, and group therapy to previous psychoanalytical efforts.[108] At one of the most advanced psychiatric hospitals in the

[103] Bourke, *Rape*, 286, 292-292; Jenkins, *Moral Panic*, 88-90.
[104] Brecher, *Treatment Programs*, 39.
[105] Brecher, *Treatment Programs*, 39-40.
[106] California Department of Mental Hygiene and Langley Porter Neuropsychiatric Institute, *Final Report*, 88.
[107] ibid, 41.
[108] California Department of Mental Hygiene and Langley Porter Neuropsychiatric Institute, *Final Report*, 42; Eskridge, *Gaylaw*, 62; Don Jackson, "Dachau for Queers", in *The Gay Liberation Book*, ed. Len Richmond and Gary Noguera, Ramparts Press, San Francisco (1973), 42-50; John LaStala, "Atascadero: Dachau for Queers?", *The Advocate* (April 26th, 1972), 11-14.

nation, explicitly designed for "psychopathic offenders", little research was done on sex offender treatment distinct from wider psychiatric practice.

Washington's first ten years of sex offender treatment were, in sum, part of a larger effort to allow the indefinite detention of sexual offenders. The state felt obliged to respond to a public fear of sex offenders and saw psychiatry as a simple solution. It paid legal lip service to the possibility of rehabilitation as a means of accomplishing this end. The state did not give Western State or any other hospital a funding increase to handle its new residents, and made no initiative under a different agency, to investigate possibilities of treatment. The courts showed unusual tenacity in applying the law. "Sexual psychopaths" were committed in numbers uncommon elsewhere in the United States, and these commitments held steady for a full decade. This created a serious burden on the hospital's operation. The hospital made assorted tentative efforts at treatment which were by and large predicated around group therapy. They did not, however, extend these efforts to a program, and never stated why they pursued one approach over another. The staff instead fell back on punitive measures as a long-term management strategy. Their heavy-handed approach resulted in frequent escapes and high per-capita costs, but the hospital chose to turn its attention elsewhere, for reasons that will become clear in the next section. A lack of legislative oversight and public interest meant the hospital was under no pressure to resolve its problem.

The Institutional Milieu and the Foundation of the Program, 1959-1965

In 1958, Dr. Giulio di Furia was a newly-hired psychologist at Western State Hospital, serving as the Mens' Wards Supervisor. During his time there, his attention

turned to the sexual psychopaths committed to the hospital's care, and he decided to implement a series of group therapy sessions.[109] His efforts, and the efforts of his colleague Dr. Hayden Mees, were the foundation of a program for treatment which was later christened the Treatment Program for the Sexual Offender at Western State Hospital. Their sudden change from abortive one-off attempts to a cohesive program was a watershed development in the handling of sex offenders in Washington. The shift was later described by the program's founders as budget-minded innovations undertaken in the face of mounting escapes, mounting costs, and an angry public.[110] The reality was that a cascading series of events created a much different hospital environment which was conducive to major initiatives in sex offender treatment. This change precipitated from three primary factors. The hospital hired a large number of new staff after it faced major public scandal for mistreating patients. A movement in psychiatry emphasized the role of the patient's environment in their illness and in their treatment, and advocated the patient become the primary actor in their own cure. Lastly, issues with costs, patient population, and escapes encouraged clinicians to find a means of treating sex offenders so that they could be released. All of these factors gave the doctors an avenue of approach and depend their resolve. From their efforts, an initially tentative exercise in group therapy was made into a long-term program with a clear, innovative treatment method and an explicit philosophy of the offender and his problems. Their principles and approach would remain the program's bedrock for twenty-five years.

[109] di Furia, "On the Treatment and Disposition of Sexual Offenders", 629.
[110] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* Introduction.

In 1958, Western State Hospital was in the aftermath of a year of public scandal. It had begun in March 1957 with an investigative report in *the Seattle Post-Intelligencer*.[111] According to the report's findings, Western State Hospital psychologists had hundreds of patients assigned to their management each. A doctor could only review an individual's treatment progress every couple of months. Nurses were unofficially directing treatment of patients with rubberstamp approval from doctors, attempting to give some therapeutic attention. Supplies were chronically low, and on one occasion, the hospital ran out of Thorazine for three weeks.[112] Conditions were so poor that the Joint Commission on Accreditation of Hospitals had pulled its accreditation of the hospital in 1953, and ordered the suspension of resident training in the hospital in the coming June.[113] This meant that the hospital's low accredited staff level, which the staff stated was the primary problem, dropped even further.[114]

Meanwhile, the newly-elected Governor Rossellini was involved in a minor controversy. He had changed staff hiring and qualification requirements, which had resulted in eight support staff being fired from Western State. They argued it was due to their union ties, not their behavior.[115] While the state was investigating, a released patient, who had not been committed as a sexual psychopath, was arrested on child molestation charges. It was discovered he had been paroled from the hospital to go

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[111] Lucille Cohen, "Western State Hospital Needs Everything – Except Patients", *Seattle Post-Intelligencer* (March 10, 1957), B-2; Lucille Cohen, "Only One Doctor For 215 Patients at Western State", *Seattle Post-Intelligencer* (March 11th, 1957), B-3; Lucille Cohen, "Time Lack Curbs Real Patient Aid", *Seattle Post-Intelligencer* (March 12th, 1957).
[112] Cohen, "Time Lack".
[113] A.P. Wire, "WSH Wins Accreditation by Joint Body", *Tacoma Tribune* (June 15th, 1962); Cohen, "Western State Hospital Needs Everything", B-2.
[114] Cohen, "Western State Hospital Needs Everything", B-2.
[115] "State Firings for Cause Only Says Rossellini", *Tacoma Tribune*, Tacoma, WA (May 29th, 1957).

work for a fish hatchery, making only three dollars a week plus room and board. No medical reason was given for his discharge, and his condition was not described as cured in any capacity. Rossellini ordered an evaluation of the hospital.[116] During this initial review, it emerged that three ward aides were stealing barbiturates and selling them to outside parties. They were arrested.[117] Other cases emerged of patients being prematurely "released" to employers, who hired them at below market wages. The hospital's Business Manager, Phil Lelli, began hearing testimony from "more than a dozen women nurses and attendants" to gauge what they'd known about the situation. Their testimony quickly went beyond the cases at hand and spoke of larger, systemic abuses of the patients. Lelli telephoned the state prosecutor, and a "probe" began immediately.[118] Its findings were, in general, the same problems that the *Post-Intelligencer* had discovered, but worse. Most shockingly, patients were malnourished. Some were fed less than 1,000 calories a day. Nurses had begun bringing food from home on a rotating schedule to get their patients enough to eat. This burden of low food was not shared: the staff got larger and heartier meals than the patients.[119] Neglect was endemic. Patients went unspoken to for days at a time. Incontinent patients were strapped to furniture to make management easier.[120] Child and adult patients were kept on the same ward with no special supervision for the children. Other abuses were also investigated, which had largely to do with employee theft. The hospital's response to

[116] AP Wire, "Institution Probe Ordered By Governor", *Tacoma Tribune,* Tacoma, WA (June 7, 1957).
[117] Jack Pyle, "Full Hospital Probe Ordered", *The News Tribune,* Tacoma, WA (July 19th, 1957), A1.
[118] Pyle, "Full Hospital Probe Ordered", A1.
[119] ibid. The average preparation cost of a patient's meal was 11 cents; staff meals ranged from 25 to 30 cents.
[120] Pyle, "Full Hospital Probe Ordered", A1.

the probe was silence. The administration claimed it had not been informed of these problems, and non-medical staff claimed they were being scapegoated for budgetary problems.[121] Newspapers and taxpayers called for reform, and Rossellini positioned himself as their champion. The union dispute was forgotten.

The affair broke quickly, but there had been numerous warning signs. First, there was the hospital's loss of accreditation. Then, Dr. Richard Hartley, the hospital's chief clinical psychologist, quit the job in 1955. He wrote a public letter that lambasted the hospital's low pay, understaffing, and lack of a coherent "theory" or "policy of treatment". He blamed the size of the institution as the primary cause of its problems. The hospital could not sustainably hire enough staff with as many patients as it then had, and no management could effectively "monitor" that many people. [122] In 1956, a routine Legislative Budget Committee audit was done to compare the hospital to APA standards. The hospital was certified to hold 2513 patients. It held 3091.[123] Northern State and Eastern State Hospital were similarly overcrowded, to the extent that the APA recommended the construction of a fourth hospital.[124] A detailed follow-up focused on accounting issues. It found a number of disturbing financial practices and trends in patient demographics. One was representative: "a number of physicians [who] performed various services [between] 1953-1955..." were only paid in the month before the report.[125] Western State was, in short, desperately parlaying its minimal complement

[121] Ed Guthman, "Workers Voice Complaints on Medical Care", *The Seattle Times* (July 19th, 1957), Page 1; Ed Guthman, "Kahin Schedules Report on Probe at State Hospital", *The Seattle Times* (July 20th, 1957), B-6.
[122] "Mental Hospital Doctor Quits -- Hits Program", *News Tribune*, Tacoma, WA (Nov. 15th, 1955): 1.
[123] Legislative Budget Committee, "Progress Report of Examination at Western State Hospital", Washington State Legislature, Olympia, WA (July 31st, 1956), 1.
[124] Legislative Budget Committee, "Progress Report", 2.
[125] Legislative Budget Committee, "Progress Report", 7.

of funds and staff into a workable hospital. A rising patient population and rampant abuses over the last decade had only accelerated an inevitable breakdown in management and care.[126]

The tumult led to a major change in the direction of patient care at the hospital. The immediate result was the dismissal of a portion of the backline staff and the hiring of a new dietician. The superintendent and most administrative staff survived.[127] It emerged later that Lelli himself was involved in assorted theft, and he was handed a five-year sentence for larceny.[128] The government by and large accepted the hospital's argument that money and staff deficits had caused the problems. Governor Rossellini sought, and received, a three-million-dollar biennial budget increase, which gave Western State Hospital a thirteen-million-dollar budget for the 1960-1961 biennium.[129] The hospital hired a slate of new staff over 1958 and 1959, now assured that it could pay their salaries. Dr. Giulio di Furia was hired in the midst of this drive in 1958.[130] His first position was Supervisor of the Men's Wards of the Hospital, and it put him in close contact with sexual psychopaths.[131] He had "limited" experience and no background knowledge with managing or treating sex offenders.[132] His primary goal was ending the flood of escapes and freeing staff from what was effectively "guard duty".[133] To this

[126] ibid, 12, 14-16.
[127] Jack Pyle, "Conditions Improving at Western", *The News Tribune,* Tacoma, WA (November 3rd, 1957), Front Page.
[128] Jack Pyle, "Lelli Pleads Guilty to Larceny", *The News Tribune,* Tacoma, WA (May 19th, 1960).
[129] "Western State Increase set at 3 million", *Tacoma Tribune,* Tacoma, WA (January 16th 1959).
[130] "Dr. di Furia New Hospital Assistant", *Suburban Times,* Lakewood, WA (November 14th, 1962); Robert Cour, "Many Emerge From Dark Shadows, Gain New Hope at State Mental Hospital", *Seattle Post-Intelligencer* (October 19th, 1963), 9; Posell, "Medical Services", 1.
[131] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 1-2; Posell, "Medical Services", 1.
[132] di Furia, "On the Treatment and Disposition of Sexual Offenders", 629.
[133] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 1, 8.

end, he assigned a staff psychologist, Dr. Hayden L. Mees, to oversee once-a-week group therapy sessions with the offenders. These "nonspecific" sessions were led by the psychologist and centered around developing "insight" into the offender's psychological problems generally.[134] Patients with comorbid psychotic disorders were admitted alongside the regular offenders, a practice that would end almost entirely within the year.[135]

The program proper started on the offenders' initiative. di Furia hoped that the sessions would be meaningfully therapeutic for the offenders but did not have high expectations. The offenders, however, were enthusiastic about the sessions, and wished to hold them more regularly. Dr. Mees was too busy, and there were no other qualified staff available to lead the proposed new sessions. The state was extremely unlikely to allocate staff and funding resources necessary to intensify the standing mode of treatment would be allocated to this program.[136] Dr. di Furia and Dr. Mees decided to allow the offenders to lead the sessions themselves.[137] Dr. Mees still sat in with the offenders once a week. At the new sessions, however, the residents were left to themselves. There were no attendants in the room with them. They were not given instruction or an agenda.

Placing residents in a direct leadership role was a dramatic departure from the previous therapeutic interventions at Western State. The concept of group therapy for

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[134] Brecher, *Treatment Programs,* 17; di Furia, "On the Treatment and Disposition of Sexual Offenders", 629; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2.
[135] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 13.
[136] Brecher, *Treatment Programs,* 17; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2; MacDonald and Williams, *The Washington State Sexual Psychopath Law,* 2; Schwartz, "Overview", 364.
[137] Brecher, *Treatment Programs,* 17; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2; Joe Rigert, "Group Therapy Program At WSH Aids Patients", *The News Tribune,* Tacoma, WA (July 14th, 1963).

sex offenders was not new. It had already been attempted at Western State numerous times. Nationally, it had been attempted in at least one instance in American psychiatry.[138] This new effort sought to make residents interact with each other on their own terms. Di Furia sought the patient's use of his firsthand knowledge of his offenses in a productive way, by critiquing the actions of their fellows and offering insight into how they could change.[139] If this proved not to be the case, the sessions would at least give the offenders something to do, and cut back on cagey, restless "acting out".[140] The gamble paid off. These initial offender-led meetings were so successful in terms of offender engagement that the pair began designing a program of "self-guided" rehabilitation around it.

The Sexual Offender Treatment Program started in earnest in 1959. It is unclear if di Furia and Mees came to their conclusions about the psychology of the sex offender before or after they started the residential program. Most information on the program's development from '58 to '63 was written retrospectively. These papers described the program as though it emerged with both its policies and its theoretical underpinnings fully formed. Much of this theory was adapted from milieu therapy, a point which will be explored later. The extrapolation of these principles to sex offenders, however, and some of the conclusions di Furia and Mees derived from the extension were novel. Considering di Furia and Mees' lack of experience in the field, it was unlikely they

[138] Raymond Corsini, "Group Psychotherapy with a Hostile Group", *Group Psychotherapy and Psychodrama* 6 no. 4 (1954): 168-73.
[139] *01* Interview Transcript, 19; Denenberg, "Sex Offenders Treat Themselves", 54; MacDonald et. al., *Treatment of the Sex Offender: Ten Years*, Introduction.
[140] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 1; Rigert, "Group Therapy Program At WSH Aids Patients".

began with these understandings. One paper by Mees, from ’62, was written within the “development era”, but it could not be located.[141] For the sake of simplicity, this paper will first describe the program’s understanding of the sexual offender, then explain how those principles informed the Program’s initial form. The reader is advised that most likely, the program’s philosophy was slowly built out from preexisting considerations when it proved “successful”.

The program considered sexual offenders a group needing present help. Dr. di Furia and Dr. Mees did not establish in writing a full conception of the sexual offender’s internal drama and its origins. They admitted that the "etiology of aberrant sexual behavior is not known", and they did not attempt to differentiate between different “sorts” of offenders.[142] It was not considered necessary for treatment. In di Furia’s view, the assorted hypothesized causes -"unconscious motives, symbolism, regression..." – did not need to be known to attempt to stop the offender’s wrongdoing.[143] The primary driving cause of offenses laid in the offender’s everyday behavior and emotional malcontentment.[144] The program was “behavior-oriented”, and followed a “learning theory” approach to human interaction.[145] People learned by reinforcement, and the sexual offender had reinforced in himself a cruel means of coping with his stresses and his internal problems. He had to learn how to cope with the

[141] Hayden L. Mees, “A Therapy Program for Sexual Offenders”, *Bulletin VI*, Division of Mental Health, Washington Department of Institutions, Olympia, WA (1962), 65-69. Only a handful of sources cite the paper, which appears to have stated simple points of program practice and theory available elsewhere.
[142] di Furia, "On the Treatment and Disposition of Sexual Offenders", 629; Denenberg, “Sex Offenders Treat Themselves”, 60.
[143] di Furia, "On the Treatment and Disposition of Sexual Offenders", 630.
[144] ibid; MacDonald et. al., *Treatment of the Sex Offender: Ten Years*, 4.
[145] di Furia, "On the Treatment and Disposition of Sexual Offenders", 630.

stresses of life without sexual violence.[146] While his offenses may well have emerged because of past trauma or an underlying adjustment problem, it was the offender's present state of mind and present life that pushed him to offend. Therefore, the program did not investigate the past of the newly-admitted offender beyond what he attested to in an autobiography.[147] If the offender proved cooperative with and amenable to treatment, the events in the past that mattered would be revealed in the group sessions, and could be dealt with there.[148] The sex psychopath, in the program's view, was not defined by a case history but by his present condition and his underlying personality problems.

The offender's present condition was simultaneously the cause and the result of the offender's sexual violations of others. Surmised, sexual violence was a "self-defeating, self-reinforcing" cycle of isolation, denial and fantasy.[149] It varied in the specifics, but at its core, the pattern of thinking and action were the same among all offenders.[150] Despite being legally considered psychopaths, most sexual offenders were not psychopathic.[151] He was sane enough to know right from wrong, and did not desire to hurt people with his assaults, but did so because of blocks relating to other people. The man, for any number of reasons, had come to see himself as "inadequate and inferior".[152] He considered himself unworthy of attention and love.[153] His ability to

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[146] Robert J. Kelly, "The Cycle", in *Handbook for Volunteers,* ed. Robert J. Kelly, Western State Hospital, Steilacoom, WA (1972?), 4.
[147] *01,* Interview Transcript, 19.
[148] Hendricks, *Some Effective Change Inducing Mechanisms,* 13-14.
[149] Hendricks, *Some Effective Change Inducing Mechanisms,* 2.
[150] Kelly, "The Cycle", 2-3, in *Handbook for Volunteers.*
[151] Giulio di Furia and Hayden L. Mees, "Dangerous to Be at Large--A Constructive Critique of Washington's Sexual Psychopath Law," *Washington Law Review* 38, no. 3 (Autumn 1963): 531, 533.
[152] Kelly, "The Cycle", in *Handbook for Volunteers,* 7.
[153] Hendricks, *Some Effective Change Inducing Mechanisms,* 13-14; Kelly, "The Cycle", 5-6 in *Handbook for Volunteers*.

socialize with others was hampered by his reservations about himself, and he met his rejection or disappointment with further withdrawal and self-isolation. He still nursed the same need for human attachment and affection that most people have. To meet them, he turned to "solitary and socially aberrant sexual behavior" – rape, exhibitionism, or whatever else – as a means of fulfilling that desire. Many offenders had a wife or a long-term lover, but because they refused to invest themselves emotionally in their relationships, they were unsatisfied in that relationship as well. Their turn to crime, however, didn't make up for their dissatisfaction elsewhere. The offender knew they hurt others.[154]

The offender couldn't accept this reality. He believed he had no other avenue of gaining affection from others. To avoid confronting his own failure, he denied reality. He replaced the actual offense with a fantasy in his mind and blocked out the feelings and responses of his victims.[155] Most offender's fantasies recreated the situation as a consensual, socially permitted encounter with someone who accepted them. One offender, for example, pretended his exhibitionism was lovemaking with an imaginary "cheerleader". The woman he was exposing to was, according to him, not of interest besides her literal presence, and he did not look at her during the offense.[156] Child molesters claimed that the children they raped loved them, and enjoyed the assault, not simply to defend their actions but because that was what they wanted to believe was

[154] di Furia, "On the Treatment and Disposition of Sexual Offenders", 630; Robinson A. Williams, *Community Adjustment of Treated Sexual Offenders*, Western State Hospital, Steilacoom, WA (1971), 2; H.R. Nichols, "Effect of treatment of the habitual sexual offender as measured by the Minnesota Multiphasic Personality Inventory", Western State Hospital, Steilacoom, WA (1971), 19-20.
[155] Hendricks, *Some Effective Change Inducing Mechanisms,* 11-13.
[156] Paul Henderson, "A pothole in psychopath's long road", *Seattle Times* (April 20th, 1974); Kelly, "The Cycle", in *Handbook for Volunteers,* 8-9.

true.[157] Despite their attempts to distance themselves, the truth lingered in the offender. After his first assault, the offender saw himself, rightly, as a criminal, and he internalized this role. He believed he was unable to pursue any other course to satisfy themselves. The mental gymnastics he performed drove the offender even further within themselves and made the task of change and reconnection seem impossible. He'd repeat his offenses, entrenching them with habit.[158] Eventually, he would stop trying to restrain himself, because he believed there was no way out. His offenses almost always continued unless he got caught, died, or grew so guilty he turned himself in.[159] In short, the offender's crimes were crimes of need for emotional fulfillment far more than sexual contact. They were an immediate means of meeting needs for self-worth and control which they felt others would never consensually provide.[160]

The sexual offender's crimes were founded in self-doubt and isolation. di Furia and Mees believed this mindset would be apparent in the rest of the offender's life.[161] The pattern between different offenders was less clear in this part of their lives. Not all offenders were "failures" in life, and not all were wholly antisocial.[162] Rather, the offenders writ large would have dysfunctional relationships and be unable to communicate their needs in general. The most prominent of these traits was constant

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[157] Don Hannula, "Roots of Sex Wrongs Found in Reticence", *The News Tribune*, Tacoma, WA (April 23rd, 1965).
[158] di Furia, "On the Treatment and Disposition of Sexual Offenders", 629-30; MacDonald et. al., *Treatment of the Sex Offender: Ten Years*, 2.
[159] Denenberg, "Sex Offenders Treat Themselves", 54; Robert H. Mottram, "The story of a child molester", *The News Tribune*, Tacoma, WA (August 11th, 1974).
[160] Kelly, "The Cycle", in *Handbook for Volunteers*, 8.
[161] Brecher, *Treatment Programs*, 18; di Furia, "On the Treatment and Disposition of Sexual Offenders", 630; Rigert, "Group Therapy Program At WSH Aids Patients"; Williams, *Characteristics and Management*, 22.
[162] AP Wire, "The average sex offender may be the guy next door", *The News Tribune*, Tacoma, WA (November 25th, 1976), A-5; *The Sexual Offender: Safe to Be At Large?* Produced by Robert Davy, KWSC-TV, for National Educational Television, 1966; Williams, *Characteristics and Management*, 22.

"deceit and dishonesty".[163] Offenders lied about their feelings to everyone, going beyond their sexual desires to habitually lie about anything of importance. The need to lie emerged out of the offender's feelings of inferiority. He thought that no one would love him if spoke his mind. He shut himself up or put on a "mask" of machismo or disaffection to distance himself from his feelings.[164] Their withdrawal intensified as the offender began committing crimes he could not talk about without severe consequences.[165] With time, it hardened into a deeper, internal denial of his feelings, and of the victim's feelings.[166] It was essential to him that the reality of his violation was blotted out, at least partially, to make the assault satisfying. By the time he arrived in the program, the fact that his offenses hurt others had become "a very foreign concept", not because he didn't feel for the victim, but because he had rewritten in his head what actually happened during the offense.[167] The offender was, at this time, not thought to enjoy the sensation of power over another, but to be actively denying to himself that was what he was seeking and "achieving" through rape. Another common trait was irresponsibility. The offender felt they were "out of control", and internally dismissed his breaches of contract and expectation with others as an aspect of himself he could not change.[168] The offender retreated further from society to avoid the confrontations and rejections his behavior incurred. He manifested his feelings of

[163] Hendricks, *Some Effective Change Inducing Mechanisms,* 11-12; Louise Wojtech, "The Unmasking of a Sexual Psychopath", *The Daily Olympian,* Olympia, WA (October 20th, 1970), 2.
[164] Wojtech, "The Unmasking of a Sexual Psychopath", 2.
[165] di Furia, "On the Treatment and Disposition of Sexual Offenders", 631.
[166] ibid; Hendricks, *Some Effective Change Inducing Mechanisms,* 11-12; Kelly, "The Cycle", in *Handbook for Volunteers,* 8.
[167] Denenberg, "Sex Offenders Treat Themselves", 64.
[168] Kelly, "The Cycle", 8, in *Handbook for Volunteers*; Hendricks, *Some Effective Change Inducing Mechanisms,* 2, 11-12.

helplessness in irresponsible behavior. He made few friends and spent much of his time alone. He had trouble keeping jobs due to absenteeism.[169] Alcoholism and divorce were considered the statistical evidence of these wider discipline, and satisfaction, problems, and fueled the offender's negative self-image.[170] The program emphasized that most offenders did not fit the pattern exactly. A fair number of offenders maintained a successful marriage, and the majority had managed to provide for themselves without unusual support.[171] However, all offenders, regardless of their social or fiscal success, were believed to be nursing the same negative conception of themselves. This negative self-image was the primary cause of their offenses, and the cause of more individualized negative coping mechanisms in other aspects of their life. They kept silent on their problems in fear of rejection and retribution, allowing them to fester and worsen. The offender had to learn another way of seeing themselves and the world before their behavior could change.

"Our contemporary way of looking at the sex offender leads us more and more to the conclusion that…we're dealing with a problem that arises from the way in which individuals have learned to be human…"

- George MacDonald, in *The Sexual Offender: Safe To Be At Large?*

Di Furia and Mees thought the impulse to violate another person was greatly similar in all offenders, regardless of their differences in "target" and method.[172] A

[169] Robinson Williams, *Characteristics and Management of Committed Sexual Offenders in the State of Washington,* Western State Hospital, Steilacoom, WA (1971), 22-23.
[170] Williams, *Characteristics and Management,* 22; Hannula, "Roots of Sex Wrongs".
[171] *The Sex Offender: Safe to Be At Large?* KWSC-TV; Emily Hitchen, "Denial: an identified theme in the martial relationship of sex offenders", *Perspectives in Psychiatric Care* 10 no. 4 (1972), 152.
[172] Denenberg, "Sex Offenders Treat Themselves", 64; di Furia, "On the Treatment and Disposition of Sexual Offenders", 631; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 11; Williams, *Characteristics and Management,* 19.

mindset problem plagued the sexual offender. Both the exhibitionist and the child molester shared this mindset. Therefore, the program did not need to vary its approach between different sorts of offenders. Child molesters, violent rapists, voyeurs and incestual fathers were all admitted, and all treated with the same self-guided group method.[173] The program also subscribed to the theory that sexual offenders generally went through an escalating cycle of offenses. "Minor" sexual offenders, such as exhibitionists, turned to more assaultive offenses over time. The line between sexual misbehavior and sexual assault was thought of as a downward "slope", not a categorical distinction.[174] Once a man began assaulting others, he would not return to voyeurism alone.[175] His offense "target" or "targets", however, were thought to remain the same. If the offender exhibited himself to adult women, he would likely continue to only target adult women if he progressed to assault.[176] The program did not classify how far an offender had "slid" on a scale of offenses. The point was moot. The ability of the offender to slide from one kind of offense to another was support, in di Furia's view, for his generalization of sex offender maladjustment. One offender, without treatment, was ultimately as dangerous to the community as any other. Only stress and time separated the voyeur from the violator. All offenders needed a run in treatment to face their impulses.[177]

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[173] *01,* Interview Transcript, 14-15; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 11-12.
[174] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 12; Williams, *Characteristics and Management,* 19.
[175] *The Sex Offender: Safe to Be At Large?* KWSC-TV; Williams, *Characteristics and Management,* 19.
[176] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 12; Williams, *Characteristics and Management,* 19, 26.
[177] *The Sex Offender: Safe to Be At Large?* KWSC-TV; Williams, *Characteristics and Management,* 19.

This theory of the mutable offender also supported the program's choice to target the offender's self-image and sociability, rather than his desires. Desire was, following its logic, a dependent variable. The offender was thought to be seeking affection and acceptance when he raped others. The changing offense showed that the act of rape or exhibition was little satisfying in-of-itself. Addressing the particular crimes the offender committed was necessary, as his offense eventually became habit and had to be confronted as such. This habit, however, manifested out of and was reinforced by a wholly different need. The desire would change more effectively by targeting, in the main, its source. Elucidating the stress causing these offenses was the most important piece in stopping the cycle of sexual violence.[178]

Di Furia and Mees' offender inclusivity was sharply limited to sexual crime. No sexual murderers were admitted to the program. While di Furia, MacDonald and Williams speculated a number of nonsexual criminals had the same sexual/interpersonal frustrations as sexual offenders, the program did not attempt to treat them.[179] A few offenders convicted of burglary charges entered the program, but they were committed for sexual crimes that had not been prosecuted, or which had bargained down to a nonsexual charge.[180] It was another decade until the program's approach was broadened beyond sexual offenders to other types of convicts.

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[178] di Furia, "On the Treatment and Disposition of Sexual Offenders", 629-630; *The Sex Offender: Safe to Be At Large?* KWSC-TV.
[179] di Furia and Mees, "Legal and Psychiatric Problems", 980; Williams, *Characteristics and Management,* 5; Louise Wojtech, "Volunteers play role in rehabilitation", *The Daily Olympian,* Olympia, WA (October 22nd, 1970).
[180] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 11-12.

In sum, a "larger pattern of socially deviant behavior" in all aspects of life, accompanied by major stresses, was thought to push the offender to recourse to sexual offense.[181] To end the offender's assaults, the offender had to fix his flawed capacity to relate to others. Before the program, the offender, according to di Furia and Mees, had bottled up his emotions because of his mindset of inferiority. He created an artificial emotional distance between himself and the world. Carrying out his offenses in secret was the furthest extension of this distance. To rehabilitate himself, the offender had to purge their mindset and accept their emotions. That mission was totally in his hands. The program did not believe an offender could be "changed" without his active involvement. Instead, di Furia and Mees sought to create an environment where the offender would be repeatedly forced to handle the consequences of their actions, day in and day out. This would challenge how the offender viewed themselves and how they accordingly lived their life. Confrontation in the present was thought to best engage the offender and entrench more positive habits and attitudes.[182] By forcing the offender to face the reality of their situation and their actions, di Furia and Mees sought to establish to the offender how they hurt others and the connection between their self-image, their fantasies, and their wrongdoing.[183] By creating a self-critical group, the doctors sought to create a space where offenders would confront and analyze each other's denial, shame, and fear. It was essential that the offender *wanted* to be free from his impulses.

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[181] Brecher, *Treatment Programs,* 14; di Furia, "On the Treatment and Disposition of Sexual Offenders", 630-631; Rigert, "Group Therapy Program At WSH Aids Patients".
[182] Denenberg, "Sex Offenders Treat Themselves", 60; di Furia, "On the Treatment and Disposition of Sexual Offenders", 630; MacDonald et. al., *Treatment of the Se\x Offender: Ten Years,* 1, 7.
[183] Brecher, *Treatment Programs,* 18; di Furia, "On the Treatment and Disposition of Sexual Offenders", 630.

The program would not work if the offender did not invest himself in treatment, and it therefore rejected offenders referred by the court who continued to deny their crimes and who explicitly stated they did not want to enter treatment.[184]

di Furia surmised the program's treatment objectives as:

"1. Recognition of his hurtful behavior patterns,
2. Understanding of the origin and operation of these patterns;
3. Acceptance of responsibility for change; and
4. Application of new patterns of responsible behavior in dealing with people."[185]

The chosen approach to meet these goals was the aforementioned group sessions, described by the program as "self-guided group therapy". The offenders met in two-hour sessions. The number of sessions increased over the first few years from two, to five, to ten. When the program reached ten sessions, it began holding them twice a day, one at midday and the other in the evening. The sessions were straightforward. The residents of a group convened at a scheduled time in a dayroom. They circled chairs around large, freestanding ashtrays. There was no "podium" for speakers The senior and junior group leaders led proceedings from behind a desk. They used the desk to take notes and, as a stand for the tape recorder. If a new "observation man" had joined the group recently, the group went in a circle, introducing themselves and their sexual offenses to the new arrival. The "observation man" then introduced himself and his crimes. Following this, or on a day without a new member, the group began going over any immediate inter-hospital announcements and concerns. From there, sessions took

[184] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 4; Williams, *Characteristics and Management,* 4.
[185] Wayne Kilbourne, "Editorial Comment on Program", KIRO-7 (November 24th, 1970); Williams, *Characteristics and Management,* 5.

off on whatever avenue the participants thought appropriate for analyzing each other's behavior.[186] The therapeutic group's mission was to correct their collective mindset, and the group was free to pursue any line of inquiry they thought would achieve that end.[187]

The sessions became, under the leadership of the offenders, no-holds-barred, verbal arenas. The therapy was largely freeform analysis of the day's events, used by the group to probe an individual's temperament and problems.[188] The ward's everyday happenings, such as arguments, work assignments, were very prominent topics in therapy. The group examined these "pedestrian" events closely. Residents had to describe what they did from day to day in detail and discuss the feelings he had that day. Emotional disclosure was not voluntary. The offender had to be candid, even about things he knew were petty. [189] The group also discussed the circumstances of an offender's crimes, but the goal was to frame present emotions and avenues for change. It encouraged the residents to discover how their daily activities were tied to their self-image, their emotions, and their larger "personality"-based habit patterns.[190] It emphasized the thing in his life that he could control and change – his present – over his nonnegotiably criminal past.

Program residents needed to be honest in all of their descriptions, even if it cost them respect or suggested that their treatment was not going well. If an offender was

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[186] di Furia, "On the Treatment and Disposition of Sexual Offenders", 630; di Furia and Mees, "Legal and Psychiatric Problems", 980; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2; *The Sex Offender: Safe to Be At Large?* KWSC-TV.
[187] di Furia and Mees, "Legal and Psychiatric Problems", 985.
[188] *01,* Interview Transcript, 10-11; di Furia, "On the Treatment and Disposition of Sexual Offenders", 630; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* Introduction, 2.
[189] Denenberg, "Sex Offenders Treat Themselves", 58, 62; Williams, *Community Adjustment,* "Program Profile".
[190] Denenberg, "Sex Offenders Treat Themselves", 58; Hendricks, *Some Effective Change Inducing Mechanisms,* 2; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* Introduction, 2.

plagued by recurrent fantasies, he needed to tell the group. If he believed he was getting the worst work assignments because the other group members disliked him, he needed to tell the group.[191] Failing to disclose something like a telephone call was, in the program's view, an attempt to create a private sphere outside the group's oversight. Maintaining private conversations with people outside the program and keeping private hobbies allowed the resident to hide their thoughts and emotions from others. The offender had to live in the open. Being quiet opened a resident to accusations they were hiding something.[192] The group climate became so demanding and inquisitive that the program administration made an explicit policy that communications between the offender and their lawyer could remain confidential.[193]

To counteract a life of reticence and deceit, the group had to be open and honest about their feelings, concerns and judgements. All offenders, from the leader down to the trial member, were intended to be equals. Anyone could theoretically criticize anyone else. Honesty opened the offender to criticism. The individual might lose some dignity, but only through other's critique of his actions and words. The offender had to be willing to chance their censure in the pursuit of correcting their errors in thought and action.[194] Their actions were condemned, but their personal pain was validated.[195] The group could reject his actions, but not him, and their feedback gave him an opportunity to reflect. By opening himself to the judgement of others, the offender was beginning to

[191] Hannula, "Roots of Sex Wrongs".
[192] *The Sex Offender: Safe to Be At Large?* KWSC-TV.
[193] Denenberg, "Sex Offenders Treat Themselves", 60.
[194] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* Introduction, 8; *The Sex Offender: Safe to Be At Large?* KWSC-TV; Williams, *Characteristics and Management,* 4.
[195] Hendricks, *Some Effective Change Inducing Mechanisms,* 7, 11.

rebuild the social connections that the program architects believed he was too scared to build before. The exposure of the offender to social pressure and control gave him the opportunity to internalize some of those pressures, and build the offender's confidence that he could function under them, if he tried. [196]

The approach took some practical adjustments to function. Initially, the offenders were scattered around the hospital. To cut down on transit time, the offenders were brought on to the same ward a short time after the self-guided group began.[197] The ward was a "standard" ward. It was locked at night, like a handful of other wards, but it had no added security "features" or additional attendant staff.[198] Once the offenders were on their own ward, they were cut off from their previous ward's schedule and activities. To occupy their time, the administration entered the offenders into work assignments throughout the hospital. Work assignments were primarily housekeeping, but also included positions in the barbershop, the hospital kitchen and in various maintenance capacities, depending on their skills.[199] The offenders were paid for their time, with different wages for different positions. By the turn of the decade, the offenders, lived a very regimented life on weekdays, going to work, then lunch, then therapy. The "sexual psychopath" was no longer confined to a locked ward, awaiting another ambitious psychiatrist's stab at treatment. On the contrary, they were now given a specific goal in their treatment and made to understand they were responsible for its accomplishment.

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[196] di Furia, "On the Treatment and Disposition of Sexual Offenders", 631.
[197] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2.
[198] ibid; *01* Interview Transcript, 7-8.
[199] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 4.

At this stage, the group as a unit was not considered outside of the therapy sessions. The group was a means to the end of group therapy, rather than a therapeutic environment in and of itself. As a group, the residents had little power. The group's primary privilege was the ability to "recommend" to senior staff whether or not a group member under observation should be accepted. In general, however, the self-guided group sessions were a means of providing group therapy, rather than the creation of a semi-autonomous self-help group. The most telling demonstration of this was that Mees and di Furia did not believe the group could lead itself. Even with no professional present, a specific person or persons was still through necessary to chair the proceedings. "Thus evolved the role of Senior Leader". [200] The Senior Leader was fittingly chosen by seniority of stay. There was no gradation at this time of program progress at this time; seniority was thought best to allow the most experienced offender to lead the group's procedures. The Senior Leader "moderated" the meetings – a duty which di Furia and Mees never bothered to describe in any detail – and gave oral and written progress reports on resident progress to staff. As a reward for their progress and for their additional duties, the Senior Leader was afforded numerous privileges, including living quarters on a separate, open ward and grounds leave.[201] When the number of sessions proliferated to include both mornings and evenings, the Senior Leader was given exemption to miss evening meetings. Their residence on a different ward was thought to make their attendance of the evening sessions an undue hassle for

[200] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2.
[201] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2; di Furia and Mees, "Legal and Psychiatric Problems", 980.

them.[202] To run these evening sessions, the program staff developed the position of Junior Leader. This figure was also made responsible for any issues that arose on the ward in the Senior Leader's absence.[203] Resident leadership of therapy remained, therefore, predicated on a figure of authority and guidance.

The residents responded well to this independent discussion format. They became proactive and inquisitive in their sessions with each other. Men who entered the group denying wrongdoing or refusing to talk at all began to accept the pain they caused others. di Furia and Mees considered the group's engagement proof the program was at least somewhat effective.[204] The residents' open communication with one another showed they were taking the first steps in opening themselves to others. Their hard work in their occupations was proof they wanted to be accepted by the hospital generally, which meant they were beginning to internalize a concern for their society's values. While the two doctors stated repeatedly that this did not prove the treatment effective, they did not state any plans to evaluate the program by more definite means.[205]

[202] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2.
[203] ibid.
[204] di Furia and Mees, "Legal and Psychiatric Problems", 980.
[205] di Furia, "On the Treatment and Disposition of Sexual Offenders", 632.

Figure 1: A meeting of Milieu Therapy patients and staff.
The man on the far right holding a pair of glasses is Giulio di Furia. Taken from "New Treatment Proves Valuable by Statistics", an article by Larry Spears in the The News Tribune which ran on October 2nd, 1961.

In di Furia and MacDonald's later account, the Sexual Offender program emerged from Mees and di Furia's impulse creation of a self-accountable group, modeled on Alcoholics Anonymous and other self-help groups, and their wise efforts to cultivate it further after it proved engaging. This was an oversimplification. di Furia and Mees came to the problem of sex offender treatment with a different understanding of mental health and the possibilities of institutional care than that of their forbearers. Their new perspective on mental illness was shared nationally by many psychiatrists. It

was diffusely identified and did not receive an all-encompassing name.[206] The therapeutic approach it suggested to practitioners, however, was much more clearly delineated. It was variously called the "therapeutic milieu", "milieu therapy", and "community therapy". Its principles and methodology greatly informed the creation, mission, and structure of the Sexual Offender Treatment Program and of therapy generally within the hospital.

The model emerged as the dominant therapeutic model at Western State rapidly. Dr. Arville Davis, chief psychologist, Leon Tibbets, chief ward attendant, and di Furia himself established a pilot program in 1959 for "Milieu Therapy".[207] The "group leadership" concept was imported from self-help groups among civilian populations, such as Alcoholics Anonymous and Synanon.[208] Under the new model, the Freudian psychodynamic understanding of the causes of mental illness remained much the same, and illness was categorized in the same way as before. There were two major changes. The modes of expression and perpetuation of the patient's disease were considered an aspect of daily life as much as past trauma. Alongside this, the role of the "environment", or the institution's physical and social apparatus, in furthering the

[206] Patricia McBroom, "Psychiatry without Doctors", *Science News* 94 no. 14 (1968), 345-46; Donald R. Morton and James A. King, "Changes in a Mental Hospital's Treatment Milieu", *Social Science* 50 no. 2 (1975): 94-100; Larry Spears, "New Treatment Proves Valuable by Statistics", *The News Tribune,* Tacoma, WA (October 2nd 1961).
[207] Larry Spears, "Milieu Therapy at Western State Gives Patients Strength to Cope with Reality", *The News Tribune*, Tacoma, WA (Oct. 1st, 1961), B-12.
[208] Brecher, *Treatment Programs*, 20; MacDonald and di Furia, "A Guided Self-Help Approach to the Treatment of the Habitual Sex Offender", 311; George MacDonald and Robinson Williams, *The Washington State Sexual Psychopath Law: A Review of Twenty Years' Experience*, Western State Hospital, Steilacoom, WA (1971), 2.

patient's negative behaviors and entrenching their illness took on paramount importance.[209]

The approach sought to create an environment where the patient "learn[ed] the techniques of living" in an environment of their peers.[210] For the non-psychotic or mildly psychotic mentally ill, chief psychologist Davis explained, the patient's primary problem was maladaptation.[211] They had a grasp of themselves and the world, but their ability to handle either had deteriorated due to external pressure, such as changes at their job or a divorce. Their worsening problems of day-to-day living threw their early trauma into sharp relief. As their problems worsened, they became isolated from their loved ones their career, and themselves. When they lost those anchors, they lost the ability to account for their desires, their fears and their needs in a sensible way.[212] Mental illness flared as a stress response in most nonacute cases and cultivating the patient's ability to handle stress was the most effective cure. The everyday had inflicted a psychic wound upon the patient, not a past of trauma.[213] Accordingly, an institutional treatment program predicated on fundamentally different terms than life outside would not treat the depression as it manifested in everyday life. It would only treat the patient's mindset and feelings while in the institution.

This understanding of mental illness demanded patient initiative in their treatment, as well as involvement.[214] A tight schedule of staff-orchestrated activities

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[209] John and Elaine Cumming, *Ego & Milieu: Theory and Practice of Environmental Therapy*, New York, Atherton Press (1963), 32-33, 60-62, 89-91, 176-177.
[210] Spears, "Milieu Therapy at Western State…", B-12.
[211] ibid.
[212] ibid; Spears, "New Treatment".
[213] ibid, John and Elaine Cumming, *Ego & Milieu*, 28-29, 74-76, 247-248.
[214] Spears, "Milieu Therapy at Western State…", B-12.

were not therapeutic, as they took the patient's agency and disregarded their individual desires. The institution's everyday structure and activities could not be disconnected from the activities demarcated as therapy. Too little attention to the patient's interests and desires led to the same alienation and withdrawal that typified the patient before admission. Too much regulation of the patient's life would nurture an unhealthy reliance on outside moderation.[215] Patient leadership of their own care, in the form of limited self-determination over their activities, elegantly met both demands. It mirrored the responsibility the patient would shoulder outside the hospital. The patient could choose who they would speak with and what they would do, and when, with their core therapy group and its designated staff leader meeting with each other to discuss why they made those choices.[216] To complement this direction, the patient needed individual as well as group autonomy, and the patient had to identify as an individual to act as one. The group would help each other evaluate their problems, and rebuild themselves, while reacclimating the patient to the demands of everyday social life. What this practically entailed were major changes to hospital policy. A mixed-gender dorm was established, a then-first for Western State. Uniforms were discarded. Patients were allowed to keep their personal effects with them in their room, rather than keeping them uniform as before.[217] Most importantly, an "open door" policy was instituted: patients were to be free to wander around the wards and dayroom as they chose, and explore the

[215] John and Elaine Cumming, *Ego & Milieu*, 70-71, 155-157; McBroom, "Psychiatry without Doctors", 346.
[216] John and Elaine Cumming, *Ego & Milieu*, 120-122; Spears, "Milieu Therapy at Western State…", B-12.
[217] McBroom, "Psychiatry without Doctors", 346; Spears, "New Treatment".

surrounding community by signing in and out.[218] "Unauthorized" leaves were considered a sign of recovery. It was taken to mean that the patient sought to "[restrengthen their] ties with… family and community".[219] According to the philosophy of milieu therapy, patients had to be conscious actors in their own treatment. They had to establish and shoulder their own routines and activities to ready themselves for the world outside.[220] By creating a smaller-scale social experience within the hospital, the patient could be reintroduced to socialization in steps. This, more than internal self-discovery, was the key to treating their condition. The patient had to learn how to live under their own power, a day at a time. Any other therapeutic goal was ultimately a distraction from this fundamental need.[221]

The Sexual Offender Treatment Program was an outcropping of this new stream of thought. Most of the program's principles were derived from this wider reconsideration of the psychiatric approach, rather than consideration of the treatment needs of sexual offenders as a specific population. An example of the practice of the "therapeutic milieu" makes the internal similarities clear. One woman, appearing before the admissions board, described her paranoiac fears that her husband was unfaithful. The entrance board identified a flaw in her logic and asked she explain it to them. "She admitted she didn't know, [and] she felt guilty. She was taking the first step to recovery - recognizing that she had a problem..."[222] The woman's paranoia was something to be

[218] " 'Open Door' at Western State is Defended", *The News-Tribune* (December 1st, 1962), 1.
[219] " 'Open Door' at Western State is Defended", 1.
[220] Spears, "New Treatment".
[221] John and Elaine Cumming, *Ego & Milieu*, 71-73; McBroom, "Psychiatry without Doctors", 346; Spears, "Milieu Therapy at Western State…", B-12; Spears, "New Treatment".
[222] Spears, "Milieu Therapy at Western State…", B-12.

confronted like a drug addiction, as a flawed coping mechanism, an "unsuccessful way of life".[223]

Milieu was an attempt to change a mindset and a lifestyle, just like the Sexual Offender Treatment Program. The two programs were not identical approaches with different populations to be treated. To better suit the perceived needs of their different populations, they altered the treatment approach and modality within group therapy. "Confrontation" was a core piece of the sexual offender program, and it was directed from the "outside in" to foster within the offender intense self-questioning. It would be as vicious, petty, and insistent as the group decided it ought to be.[224] In milieu, confrontation in group was intentionally much more delicate. A heavy-handed lecture about character failings was obviously not appropriate for a suicidal person. Therapists emphasized creating an environment where the patient would question the way they viewed things, rather than "themselves" per se. Their independence, rather than group accountability, was sought.[225] Individually, the patient in milieu was granted time to "de-isolate" themselves on their own terms. Sexual offenders were not; a fundamental component of their internal problems had been self-imposed secrecy.[226] In the Sexual Offender program, cultivating "responsibility" was a major goal. Milieu emphasized a return to "harmony" and engagement with the patient's social and personal life. The resumption of responsibility as a part of this return was soft-pedaled.[227] These

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[223] ibid.
[224] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2; *The Sexual Offender: Safe to Be At Large?,* KWSC-TV.
[225] McBroom, "Psychiatry without Doctors", 346; Spears, "Milieu Therapy at Western State…", B-12.
[226] Kelly, "The Cycle", in *Handbook for Volunteers,* 7.
[227] John and Elaine Cumming, *Ego & Milieu*, 75-77, 222-223; Spears, "Milieu Therapy at Western State…", B-12.

differences made significant differences in the group environment. The preservation of institutional regimentation of life in the Sexual Offender program, under the guise of maintaining group responsibility, was avoided whenever possible in the "milieu". The offenders had much less contact with their assigned therapist. The milieu did not "promote" anyone through leadership positions. These differences, however, summed to adaptations based on the same theoretical consideration of mental illness. Society and the self were at odds for both the depressive and the assaultive. The mental hospital's job was not to "fix" them, but to develop the person's ability to help themselves, whether their problem was personal or social.

By 1963, the year of the program's first public mention, the program's tentative measures had become its policy. The Sexual Offender Treatment Program was centered on the use of group therapy to give offenders insight into their societal and personal maladjustment. It was not crafted in response to any inquiry on the "needs" of sex offenders. No survey of sexual offender's stated motivations or analysis of criminal histories underpinned the program's treatment objective.[228] The method was chosen in accordance with a new understanding of nonpsychotic mental illness. The problem faced by most with a personality or mood disorder, in the eyes of the contemporary psychologist, was poor social adjustment. This, in turn, was almost always due to a fundamental problem with the way the patient situated themselves in the world. A sexual offender was obviously far worse in their social maladjustment than a depressed person. Placement in a group, a much longer stay in therapy, and strict regulation of their day was necessary to account for their lack of self-discipline. However, it was the

[228] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 1.

same socialization problem, not a discipline problem, that had caused the offenses. It was the former that therapy needed to target in the main. The cultivation of self-discipline in the sexual offender was a means of allowing for that socialization, rather than an end-in-itself.

The two doctors began writing a series of articles to tell the world of their new method. The two wrote four papers between them: one research report for an in-department bulletin, one critical evaluation of the Washington's sex psychopath law for the state law review, one which surveyed sex psychopath treatment across America, and a final paper that described the nascent program as it stood. The subjects of the papers were telling. They concerned themselves with the more concrete aspects of the program and, in the case of the survey, of programs elsewhere. They made little reference to existing criminology or psychiatric thought, instead describing their program philosophy as though it had no roots or connections with other movements or psychiatric principles. Mees and di Furia did make a serious effort to place themselves within the national *practice* of treatment, by conducting an innovative and effective survey of other mental hospitals. They did not have an interest in locating the program's understanding and approach to the sexual offender within social policy or psychiatric theory. Their critique of psychodynamic formulation engaged with the ideas solely as they functioned within the clinic. Their veracity as models of human behavior were not discussed. All of the authors cited in the *Prehistory* of the concept of the sexual psychopath, and all the terminology and theory they bandied about, were absent. This could not have been because of Mees and di Furia's ignorance of their publications. Their description of the maladapted, self-loathing sex offender was too similar to

Karpman's antisocial neurotic paraphiliac and too in line with the mainstream of psychiatric thought to have emerged without outside research.[229] Any outside influence was not cited. In line with this disinterest in theoretical engagement, Mees and di Furia made no comment on how their work related to the larger *practice* of corrections. The difference between the internal psychic troubles of the murderer and the rapist were not considered. With their initial slate of papers, Mees and di Furia set a precedent of nonengagement with wider theorization that would define the program's reports across its lifespan.

The first writing on the topic was a 1962 paper by Mees which could not be located. It was published in a research bulletin within the Division of Mental Health. The content is cited elsewhere as a simple description of the program's principles and activities.[230] Considering the size of the journal, the chances anyone outside the state saw it are almost zero.

The other three papers were published in much larger journals. The first of these was a paper penned for the Washington Law Review, examining Washington's sexual psychopath commitment law as it stood. Di Furia and Mees thought that the Sexual Psychopath law, while founded on a sound principle of rehabilitation, was outmoded. In an open letter to the Washington legislature, they articulated their concerns, and in the process revealed the course they wished the program would take. Their first two comments were straightforward: they wanted the term "Sexual Psychopath" replaced with the term "habitual sexual offender", and the end of the court's use of a psychiatrist

[229] Karpman, "The Sexual Psychopath", 88-89.
[230] di Furia and Mees, "Dangerous to Be at Large", 532.

as a "lie detector" who screened real "sex psychopathy" from feigned illness.[231] Their third comment sought to change the policy for discharge. In short it gave the hospital superintendent the ability to demand the offender be tried for their crimes when released from the hospital.[232] Their last complaint, and the most interesting, railed against the state's demand that the program operate strictly as an inpatient effort. The future of the program was, in the doctors' view, outpatient therapy. The triggers within society that had tempted the rapist to offend remained waiting for him when he left the hospital.[233] The program needed the license to allow offenders outside the hospital, so they could readjust to the pressures and temptations of the outside world.[234] Granting offenders increasing freedom gave an opportunity for physician guidance for the offender's reintegration.[235] The most drastic change suggested was the commitment of a majority of referred offenders to outpatient therapy straightaway.[236] The nature that the proposed outpatient program would take was not described. Regardless, Mees and di Furia's intent was clear. An outpatient program was the best possible means of curing an interpersonal socialization issue. Monitored engagement with society, not isolation, was necessary. To keep offenders confined would only delay their rehabilitation.

Their next article, "Legal and Psychiatric Problems in the Care and Treatment of Sexual Offenders", became one of the most prominent articles in the field. Mees and di Furia had searched for literature on sex offender rehabilitation when they began the

[231] di Furia and Mees, "Dangerous to Be at Large", 533.
[232] ibid, 536.
[233] ibid, 532.
[234] ibid, 532, 537.
[235] di Furia and Mees, "Dangerous to Be at Large", 532, 537.
[236] ibid, 534, 536.

program and found next to nothing. They wondered if this was because few programs existed or if these programs were simply not being documented.[237] To evaluate the state of the field, they created a survey and sent it to the administrator of every mental hospital of a certain unspecified size in all states that had passed sexual psychopath legislation. Of the close to 300 hospital administrators solicited, 122 responded with data.[238] Their responses showed a general disinterest in innovating treatment or noting what elements of standard practice were effective. The few commonalities were non-therapeutic security precautions, such a preference for locked wards and long commitment terms.[239] There was one hang-up: due to odd formatting, the question "How long do sexual psychopaths stay in the hospital?" got a number of incomplete and bizarre answers. In di Furia and Mees' opinion, the way that the hospital administrators filled out the survey suggested that the length of stay for a patient was an arbitrary period without a clear criterion for release.[240] Administrators effectively gave "sentences", releasing certain offenders before other ones because of a certain amount of time served. The remainder of the data is clear. Only 25, or ~20%, of hospitals received more than 15 court-committed patients. 44 hospitals who had been ordered by state authorities to receive sex offenders had received none, showing the lack of use of sex psychopath laws by a number of states.[241] 18% of hospitals had "no apparent treatment program...available for sex offenders", and 71% treated them alongside their other patients, without a distinct treatment program or protocol for their particular

[237] di Furia and Mees, "Legal and Psychiatric Problems", 980.
[238] ibid.
[239] ibid, 980, 984.
[240] di Furia and Mees, "Legal and Psychiatric Problems", 981, 984.
[241] ibid, 981.

problems.[242] Most of the statistics, di Furia, argued, showed that institutions were actively hostile to the possibilities of sex offender treatment.

What few hospitals had treatment approaches were little better. Their treatment philosophies, to di Furia's concern, were predicated on "dynamics and etiology" and "psychoanalytic and non-directive therapy". “Active therapeutic manipulations...are not used."[243] The hospitals were using effectively the same old-fashioned psychoanalysis used on all other patients. di Furia thought this was a regressive understanding of the sexual offender. The very act of offense was centered on deceit and manipulation. Attempting to unearth hidden practices by psychotherapy simply gave the offender another place to explain their activity away and bury their secrets. Talking about impulses on a psychodynamic level distanced the offender from them and from the problems that fed into their crimes. [244] The authors concluded with the reminder that these laws and their corresponding treatment programs existed to reduce recidivism and improve the mental health of sex offenders. "…[H]ospitals should take the initiative in developing effective treatment programs... otherwise, custodial rather than treatment orientation [may remerge] and we will lose the opportunity to fulfill our self-imposed obligation to society."[245]

These early reports made one particularly high-ranking ally: Governor Daniel Evans. In 1965, shortly after the publication of Mees and di Furia’s survey of other mental hospitals, he hailed the program as a highlight of Washington’s mental health

[242] ibid.
[243] ibid, 983-984.
[244] di Furia and Mees, “Legal and Psychiatric Problems”, 983-984.
[245] ibid, 985.

reform. Citing their study, he created an Advisory Committee to investigate how Washington could further the cause of sexual offender treatment.[246] MacDonald and di Furia kept Evans updated on the program's status throughout his term as governor, and he maintained interest and support through the end of his tenure.[247]

In the local press, the focus was naturally narrowed to the program itself. The new program's method and philosophy was summarized in *The News Tribune* in July 1963. This was the first mention of the program in the local popular press, and it was very positive. As the reporter described it, the program was a novel effort based on new theorizations that was already proving successful. He focused on the group's ability to pressure its members to conform to society's standards, and downplayed the self-leadership component.[248] Dr. William Conte, the supervisor of the Division of Mental Health, commented that Western State's program was "probably the only program of its kind nationally in a large general mental hospital".[249] At this time, the program remained small enough to avoid major public inquiry. Only twelve patients were enrolled for as program residents at the time the article was written.[250] The program's small size and "good behavior" dulled the public's interest. There was only more newspaper article written about the program before 1966. It, too, focused on describing the program's philosophy on what motivated the sexual offender.[251] The public had

[246] di Furia, "On the Treatment and Disposition of Sexual Offenders", 632.
[247] Giulio di Furia and George J. MacDonald to Daniel J. Evans, 1971, "RE: Treatment Program for the Sexual Offender:", Western State Hospital, Department of Social and Health Services, Division of Institutions.
[248] Joe Rigert, "Group Therapy Program at WSH Aids Patients", *The News Tribune*, Tacoma, WA (July 14th, 1963).
[249] Rigert, "Group Therapy Program".
[250] ibid.
[251] Hannula, "Roots of Sex Wrongs".

been major agitators for sexual psychopath legislation, but even when it resulted in a program, they remained disinterested. They would not turn their eyes to it until a 1965 murder called sex offender rehabilitation to their attention.

The program was inpatient in the interest of security, but residents were minimally confined. The ward was locked at night, but the individual rooms were not, and they were able to move about the hospital with little hindrance. This was about to change. Western State Hospital's public image, and image to the justice system, was improving. In 1962, the hospital was reaccredited by the Joint Commission. A three-year reaccreditation, "the highest form...that can be granted", followed in June of next year.[252] The hospital could once again take on resident medical students. Alongside this, the "milieu" philosophy proved a useful change. The growth of outpatient care reduced ward crowding, and increased attention to the patient's living conditions made the facility more livable for all.[253] While the hospital was on the upswing, however, the program's success was troubled. Dr. di Furia was promoted to the position of senior clinical director in 1962, busying his schedule.[254] Mees slowly phased out his involvement from 1963 onward as he entered a teaching a position at the University of Washington, finally leaving outright in 1965.[255] In July of 1963, Dr. Shovlain resigned as superintendent, and the Department of Institutions appointed di Furia as his successor that month. With his many new responsibilities, di Furia could no longer manage the

[252] A.P. Wire, "WSH Wins Accreditation by Joint Body", *The News-Tribune* (June 15th,1962).
[253] C. R. Fargher, William D. Voorhees, and L. S. Rankin, "A Coordinated Program for Rehabilitation of the Mentally Ill", *American Journal of Public Health* 52 no. 3 (1962): 418-27.
MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2.
[254] "Dr. di Furia New Hospital Assistant", *Suburban Times,* Lakewood, WA (November 14th, 1962).
[255] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2.

program on a day-to-day basis.[256] Dr. George MacDonald was hired on as Senior Clinical Director shortly thereafter.[257] With only Dr. Mees present in a reduced role, the sexual offender program had no proper supervision.

In the preface to their desired revision of the Sexual Psychopath statues, Mees and di Furia spoke to the national community and contended that research into effective treatment of the sexual psychopath was "long past due and immensely needed".[258] Their own effort, they argued, was going it alone, and improvement would be slow if no other states stepped up to the plate. Their lament, by and large, went unheeded. Only a handful of sex offender treatment programs opened for any length of time before 1970. The only other program west of the Rockies was the aforementioned California program at Atascadero State Hospital. In the 1950's, the program appeared successful. Between 1954 and 1957, just under two thirds of the 1,414 sexual psychopaths committed to the hospital were discharged as Safe to Be At Large.[259] The program remained reliant on prison-like surveillance and discipline. Toward the end of the 1950's, the more extreme interventions, such as lobotomy, were phased out as they lost favor in psychiatric care in general. As more attention came onto the program and its results, however, the program fell into disrepute among both professionals and the public. [260] 1960 saw a murder on the ward and a mass escape. The city's population petitioned Governor Brown to replace the medical administrator with a warden.[261] In response to the

[256] "Dr. Shovlain Quits Steilacoom Post", *Seattle Post-Intelligencer* (July 4th 1963), 3.
[257] Al Booze, "Western State Plans New Treatment Program", *The News Tribune,* Tacoma, WA (March 22nd, 1964).
[258] di Furia and Mees, "Dangerous to Be at Large", 531.
[259] Jenkins, *Moral Panic,* 89.
[260] Brecher, *Treatment Programs,* 40-41.
[261] AP Wire, "Hospital Chief's Removal Urged", *Los Angeles Times* (March 18th, 1960), B7.

outbursts, security was tightened further. One reporter compared it to San Quentin, with numerous headcounts every day and a long chain of procedures for going to meals, yard, and back to bunks.[262] Residents were not allowed to put posters on the walls or decorate their space in any other way. They had to keep all possessions in a box, ready to move at a moment's notice.[263] The effect was aggressive dehumanization. Moreover, the cost of such heavy security made it as expensive as a maximum-security prison.[264]

This security was toxic to treatment. Like Western State Hospital, milieu therapy became the primary philosophy of the hospital's practitioners at the end of the 1950's. A 1960 article claimed that "the treatment program for the committed cases is essentially that of the therapeutic community, with group therapy and patient government in the milieu…"[265] By 1966, the program had also incorporated interpersonal confrontation therapy. Their attempts to foster community in a hospital with extreme limitations on movement, independent action, and individualization failed. An outside team evaluating the program stated that resident morale was extremely low, primarily due to the heavy restrictions. Few offenders engaged with doctors any more than necessary.[266] Residents only received around three hours of group therapy and one "confrontation" session a week. [267] To the authors, "one to three hours per week is

[262] George Getze, "Atascadero Doubles as Prison and Hospital", *Los Angeles Times* (September 8th, 1963), L4.
[263] Michael Nasatir, D. Dezzani, and Mimi Silbert, "Atascadero: Ramifications of a Maximum Security Treatment Institution", *Issues in Criminology* 2 no. 1 (1966): 31-32.
[264] George E. Dix, "Differential Processing of Abnormal Sex Offenders: Utilization of California's Mentally Disordered Sex Offender Program", *The Journal of Criminal Law and Criminology* 67 no. 2 (1976): 234.
[265] Reginald S. Rood, "California's Program for the Sexual Psychopath", *The Cleveland Law Review,* Cleveland, OH (September 1960), 463.
[266] Getze, "Atascadero Doubles as Prison and Hospital", L4.
[267] Dix, "Differential Processing of Abnormal Sex Offenders", 36-39.

ludicrous in face of Dr. di Furia's…program at Western State Hospital where patients, carefully selected… receive five one and one-half hour sessions per week."[268] California's program was a cautionary tale at best, demonstrating that even major commitment of state funds and the cooperation of the justice system could lead to disaster if the therapeutic approach proved unsuccessful.

By 1964, di Furia and Mees' initiative for sex offender treatment had become a coherent program. Their achievement was not, however, the result of bold experimentation by two recent hires, guided by a spark of insight into the psychology of the sex offender. It was the result of a confluence of intellectual currents and political shifts at Western State Hospital. A broad intellectual movement toward environment and initiative-oriented therapy pushed institutions to emphasize patient leadership and group approaches. The program's understanding of sexual offense followed the same lines of the dawning "milieu" understanding of mental health. The offender's violations were considered the product of their failed relationship with society and reality. It was an illness of maladjustment, framed in the same fashion that most non-psychotic mental illnesses were framed in institutional psychiatry at this time. Program resident leadership took the "milieu" to its limit, by allowing the offender's therapy to rely wholly on their engagement with one another The doctors found that allowing the offender group to question itself resulted in high engagement, and they accordingly centered the new program around group interrogation. Following a national survey di Furia and Mees found their interest in the treatment of sex offenders a national rarity, and the two attempted to kickstart wider interest in the field by reporting his results in

[268]Michael Nasatir et. al., "Atascadero", 45.

academic journals. This initiative, however, was curtailed by the departure of both founders, and the "documentarian" style of these reports set an unfortunate precedent in the program of nonengagement with theoretical changes and sparse detail. While the initiative of di Furia and Mees was predicated more on a general tendency in psychiatry than a well-controlled experiment, it should not be discounted as more aimless sputtering. It was a coherent approach that reached sex offenders in a way no major program had before. As of 1964, thanks to the efforts of these two men, meaningful sex offender treatment on the West Coast had begun.

The MacDonald and Williams Era, 1965 - 1975

When Mees left his position at Western State Hospital in 1965, the Western State program had moved through its first phase of development. Its therapeutic goal and the central aspects of its method had been established, and they would remain much the same for rest of the program's lifespan. This early period, however, had the unfortunate quality of not only being an innovator, but of attracting very little attention from both political and academic authorities. The Division of Mental Health and the Western State Hospital administrations seemed to hardly notice it existed. Annual status reports from the Division of Mental Health and more detailed biennial surveys from the Department of Institutions were required by the state legislature following the hospital's 1957 scandal. The status reports from 1959 through 1964 and the 60-61 and 62-64 surveys do not mention sexual psychopaths or the emerging program in any capacity. Western State Hospital itself got a lot of attention, but the state's interest was in its new

outpatient pediatric unit and inpatient dementia unit.[269] Academic writing on the program from outside was nonexistent. The Atascadero program remained by far the most prominent in the literature, but as previously discussed, its serious issues and heavily correctional air made its lessons largely irrelevant to the Western State example. The program was not getting the constructive criticism it needed to improve.

Enough of the Washington courts retained their interest to keep the program populated. Unlike other states, the "sexual psychopath" commitment law was not voided by a lack of commitments. From July 1961 to June 1966, around 37% of those charged with a sexual offense in court were sent to the program. After observation screened out about 55% of the candidates, just below 20% of sexual offenders were kept for treatment.[270] This large percentage, however, came from a small pool" of the same lawmen repeatedly invoking the statue. A portion of judges and prosecutors in Pierce, King, and Clark counties sent the majority of the sexual offender cases to the hospital, and their commitments ensured the program's survival. Beyond this group, the program was rarely used.[271]

This shelter of disinterest proved useful. The program weathered what could have otherwise been a ruinous scandal. In early 1965, a group member attempted suicide. Dr. George MacDonald, Western State Hospital's senior clinical director, investigated. He discovered the program's "therapeutic community" had been corrupted by Senior Leader's abuse of their privileges.[272] The group's leaders had become

[269] "Biennial Report, 1963-1964", Washington Department of Institutions, Olympia, WA (1964), 9.
[270] Williams, *The Washington State Sexual Psychopath Law,* 2; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 12, 17.
[271] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 14.
[272] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 3; Brecher, *Treatment Programs,* 17.

responsible for the conduct of the group at large. What should have been a limiting factor became a point of leverage, as they spoke for the group to the staff. The Senior Leaders assumed nearly complete control. They chose the other group members' work assignments outright and gave the highest-paying jobs to cronies. They abused their grounds privileges to make an "off-ward pad for… illegal fun and games". They enforced silence by threatening to give negative marks to residents that confronted them or tried to go to the staff. Meanwhile, they told staff whatever the staff wanted to hear. Their falsified reports were accepted by the inattentive management without question, who promptly rubberstamped the leaders' disciplinary actions and job choices.[273] To avoid being booted, a resident would have to "play along". If they made trouble, they would be labeled a problem case in the Senior Leader's next report.[274] How the suicide attempt and the improprieties were connected was never disclosed.

[273] ibid.
[274] MacDonald et, al, *Treatment Of the Sex Offender: Ten Years*, 3.


THURSDAY MORNING.

Slaying Suspect Escorted to Cell
From left: Pros. George Kain, Capt. Jim Allen and Melvin Briggs.

Figure 2: Melvin Briggs, the killer of John Siverts and the impeteus for the centralization of Sex Offender care at Western State. From B. James Glynn, "Briggs Charged in Boy's Death", *The Spokesman-Review*, Spokane, WA (June 17th, 1965), Front Page.

Almost immediately after, the first public outcry against the commitment of sexual offenders to mental hospitals ordered the state to attention. On June 9th, the body of John Siverts, a 12-year-old boy, was found off Empire Highway south of Spokane.[275] Evidence quickly led police to Melvin Briggs, a cook in the city. He was previously committed as a sexual psychopath due to an offense against a different boy in

[275] "Clues Sought in Strangling Death of City Doctor's Son", *Spokesman-Review*, Spokane, WA (June 10th, 1965), front page.

Redmond, in 1959. He had been committed to Eastern State Hospital until 1963, when he was discharged as "safe to be at large" by the superintendent.[276] The hospital records stated that Briggs' behavior was exemplary, and there was no suggestion he should be monitored.[277][278] The community was outraged at the failure of Eastern State to protect the community from an offender who proved to be dangerous. This uproar was less strong among the general public in the Western part of the state, but it was still apparent.[279] The *Spokane Daily Chronicle* ran a multi-part investigative report on the treatment, or lack thereof, for sexual offenders at Eastern State.[280] Their findings showed that Eastern State used the same sort of high-security, low-effort "treatment" that Western State had previously employed. Offenders were released when it was convenient. The situation "made everybody sick", in the words of one state Senator.[281]

The situation did not result in Washington State's rejection of sexual offender rehabilitation, despite significant public and law enforcement hostility.[282] The state instead decided to eliminate the commitment of "sexual psychopaths" to Eastern State. In the legislative committee's view, Eastern State had shown it did not have an effective treatment approach for sexual offenders.[283] It did not know how to treat them and could not gauge their danger to the community. Western State's treatment approach, on the

[276] B. James Glynn, "Briggs Charged in Boy's Death", *The Spokesman-Review*, Spokane, WA (June 17th, 1965), Front Page; *The Sexual Offender: Safe to Be At Large?,* KWSC-TV.
[277] *The Sexual Offender: Safe to Be At Large?,* KWSC-TV.
[278] *01* Interview Transcript, 13.
[279]*The Sexual Offender: Safe to Be At Large?,* KWSC-TV.
[280] Don Rice, "Sexual Psychopath's Treatment 'Controversial'", *Spokane Daily Chronicle*, Spokane, WA (April 23rd, 1969), Front Page.
[281] *The Sexual Offender: Safe to Be At Large?,* KWSC-TV.
[282] ibid; Rice, "Sexual Psychopath's Treatment 'Controversial'", Front Page.
[283] MacDonald et, al, *Treatment Of the Sex Offender: Ten Years*, 5; *The Sexual Offender: Safe to Be At Large?,* KWSC-TV.

other hand, had an explicit treatment goal, a logical background for why that goal was pursued, and a programmatic methodology to achieve it.[284] The legislature decided, however, that the danger to the community of the "sexual psychopath" was too high for standard corrections. Any avenue to reduce their danger was worth the venture. Accordingly, the Western State program was designated by the Director of the Department of Institutions to be the sole program granted custody of committed sexual psychopaths. The program's formal title was hereafter the Treatment Program for Sexual Offenders, and this title was included on the title page of all the program's self-published reports.[285]

The Briggs affair became the primary focus of a 1966 television documentary titled "The Sexual Offender: Safe To Be At Large?". Produced by a crew primarily from Washington State University, the picture took an in-depth look at the Western State program and at the legislature's reasoning for supporting it. The latter angle was primarily sought by interviewing legislators about their thoughts on the Western State program and Washington's future in sexual offender treatment. The crew also interviewed mental health division director Dr. Conte, and a Seattle psychiatrist. The legislators were unanimous in arguing that a community program was necessary to treat sexual offenders. The Briggs affair, in their view, was not merely the failure of the hospital to properly treat the man. It was the end result of state institutions attempting to fulfill the public's impossible demand of reforming a "sexual psychopath" apart from

[284] di Furia, "On the Treatment and Disposition of Sexual Offenders", 632; *The Sexual Offender: Safe to Be At Large?*, KWSC-TV; "Biennial Report, 1965-1966", Department of Institutions, Olympia, WA (1966), 8.
[285] MacDonald and Williams, *The Washington State Sexual Psychopath Law*, 2.

the community. They accepted the program's arguments and stated their intention to create community programs that could meet the offender's needs for controlled reintegration. The shift of sexual offender rehabilitation to the hospital best equipped for the job was, therefore, only the first step in creating a complete program. The legislators admitted that this initiative would be heavily contingent on obtaining community support. They seemed fairly convinced, however, of the efforts' importance, and committed to its completion.[286] di Furia, as previously discussed, had agitated for the revisal of the Sexual Psychopath law to better accommodate outpatient efforts. These interviews suggested that his vision was approaching fulfillment.

This did not come to pass. Washington did not follow through on its interest with any programs, initiatives, or legislation. There is little evidence it even attempted to pass legislation to that effect. Much like the sex psychopath law itself, the state seemed content to let the issue die once public attention shifted. A separate outpatient treatment program for sexual offenders would not emerge for ten years, and it was not affiliated with Western State Hospital. MacDonald, as the program's new director, was left with the task to make the Western State program into a complete solution for sex offender treatment. This flew in the face of all standing psychiatric expertise, but with no further state support coming, there wasn't room to object. His mission was difficult. As of August 1965, MacDonald was in the position of reforming a program that had undergone major decay in its therapeutic efficacy. By that same time next year, he was responsible for the observation and treatment of all committed sexual psychopaths in Washington. By 1970, the resident population had skyrocketed into the triple digits, and

[286] *The Sexual Offender: Safe to Be At Large?*, KWSC-TV.

it was abundantly clear that no outpatient programs would be arriving to alleviate Western State's caseload. MacDonald was effectively tasked with creating an all-around performer in sex offender treatment within a hospital facing major staffing and budget cuts MacDonald responded by doubling down on the elements he believed had originally brought the program success. Through 1976, MacDonald, with the help of Robinson Williams, managed the program with the intent of keeping offender leadership the fundamental operating principle. He added numerous facets of treatment, including couple's therapy, work-release, and outpatient therapy to allow the treatment to permeate every aspect of the offender's life. In the process of enlarging the program, he significantly changed the program's internal focus to emphasize much more strongly the importance of the group itself in the offender's treatment. His changes made the program into a self-sustaining entity that could maintain the burden of a high number of commitments. The program's efforts in research and self-evaluation, however, were poor. The program remained invisible to outside observers.

MacDonald's investigation into the suicide attempt made it clear to him that the program would fail without dedicated management. It also piqued his interest in sex offender treatment. In August 1965, di Furia asked MacDonald to become the program's director, and he accepted.[287] Like di Furia, MacDonald had no prior background in sex offender rehabilitation. di Furia chose MacDonald because he thought MacDonald's "non-[mainstream]-psychiatric" philosophy was a good fit with the standing treatment model. MacDonald also had shown enthusiasm and initiative in

[287] *The Sexual Offender: Safe to Be At Large?*, KWSC-TV; MacDonald et, al, *Treatment Of the Sex Offender: Ten Years*, 3.

investigating the program's internal problems.[288] MacDonald joined the program just as the Briggs case broke, and he began his efforts to cure the program's ills under that incident's shadow.

His conclusion on the group's present state of the decay was that undue power had been invested in the group leaders. The principle of resident leadership was valid, but it had been implemented improperly.[289] His first changes from this conclusion were straightforward. The group leaders who had violated the staff's trust were removed from the program.[290] Group leaders could no longer the "center" of the proceedings. They maintained their standing as the session moderator, but their previous ability to control the group was strongly tempered. They were now chosen by election, not seniority, and could be removed by group vote.[291] A written transcript was prepared by a different group member, the "secretary", than the leader.[292] The group leaders and "runner", or secretary, were now required to have a daily "briefing" with the clinical director.[293] Leaders needed to give "sound therapeutic reasons" for the topics brought up in group, "show familiarity" with all group members, and explain the reasoning behind the confrontation or discipline of a particular member.[294] The hospital quit paying the offenders for their work. The various work positions, with their differing salaries, could no longer be a means of coercing or rewarding group members.[295] These

[288] *01* Interview Transcript, 5.
[289] Brecher, *Treatment Programs,* 17.
[290] MacDonald et, al, *Treatment Of the Sex Offender: Ten Years,* 3.
[291] Brecher, *Treatment Programs,* 20; Louise Wojtech, "This Is The First Time Anyone Bothered To Give Me Some Hope…", *The Daily Olympian,* Olympia, WA (October 21st, 1970).
[292] MacDonald et, al, *Treatment Of the Sex Offender: Ten Years,* 3-4; *01,* Interview Transcript, 12.
[293] MacDonald et, al, *Treatment Of the Sex Offender: Ten Years,* 3-4.
[294] ibid, 4.
[295] MacDonald et, al, *Treatment Of the Sex Offender: Ten Years,* 3.

practical changes in the way the group operated were successful in preventing "enterprising" group leaders from turning a therapeutic environment into their playground. While there were problems with discipline in the future, there was never misbehavior and abuse of privilege on this scale again.

MacDonald implemented stronger measures of surveillance and discipline over all members, to increase the group's accountability without hampering its initiative. The group had bought a tape recorder with the funds it had earned when their work was paid. Running it during the sessions now became a requirement, to provide an "objective" witness to the secretary's notes and to deter attempts at letting certain conversations go unrecorded.[296] Staff only consulted the tapes occasionally. They found that the transcripts were "more detailed" than the audio tape and almost always accurate.[297] These changes significantly increased the program's emphasis on the power of the group to police and monitor one another, with the leader now more of an agenda-setting equal than an administrator. In the realm of discipline, the program was given a more defined length. Offenders were previously released on the sole authority of the hospital staff. Therefore, their stay varied drastically, depending on the staff's opinion of their improvement, with some only staying a few months.[298] MacDonald was concerned that this encouraged offenders to try and convince everyone they were cured and seek release as quickly as possible, rather than engage with therapy. He also believed it opened the groups to undue moderation by the staff. The residents would appeal to the administration for their release, rather than attempt to prove to their

[296] ibid;
[297] *01*, Interview Transcript, 12.
[298] MacDonald et, al, *Treatment Of the Sex Offender: Ten Years*, 18.

fellows they were “ready”. He wanted tighter surveillance, but the group needed to remain the primary actor in the therapeutic process. Accordingly, the program began enforcing “mandatory minimums” of therapy. Once an offender had passed observation, they could not graduate the program until they had been there at least X months. The first minimum instituted was a year of inpatient therapy.[299]

MacDonald and di Furia emphasized combative, confrontive group sessions. Residents were expected to make their emotional displeasure with themselves or one another undeniably clear. *01* stated residents talked over each other, barraged one inmate with doubts of their loyalty to the program, accused each other of lying. At times, groups would become a screaming match.[300] The goal of such a “heavy” approach was to “demand” the offender understand they are accountable for what they do to others, and to problems anymore.[301] The documentary showed the interrogation of one patient, named Nolan. In the process of recounting what drove his offenses, he stated his desire to rape was predicated on "getting even" with the person in question. He then said this vindictiveness was an "inborn" trait. A chorus of voices yelled at him that he had just disrespected the group. After the outrage subsided, another group member explained he has effectively stated his own inability to control himself is representative of the group's action. Did he not think that the group could change, and was changing? Why did he smear the others with his own failure? His answer was defensive, did not mention the group, and stated that his experience was his own. His group members roared and doubted if he really considered himself a part of the group.

[299] *Annual Report, July 1st 1969 – June 30th, 1970*, Western State Hospital, Steilacoom, WA (1970), 2.
[300] Schwartz, “Overview”, 364; *01* Interview Transcript, 11-12.
[301] Wojtech, “The Unmasking of a Sexual Psychopath”, 2.

One of the leaders observed, “you constantly are talking on separate terms with the group. You set yourself aside…” As Nolan tried to defend his reticence, another resident asked, "Are you aware you have a real communication problem?" Nolan began to answer, "Yes, I'm aware, but...", only to be interrupted by the same man, shouting "Well, what else is new?" Throughout the sequence, the microphones are repeatedly overloaded by the volume of the shouts.[302]

[302] *The Sexual Offender: Safe to Be At Large?*, KWSC-TV.

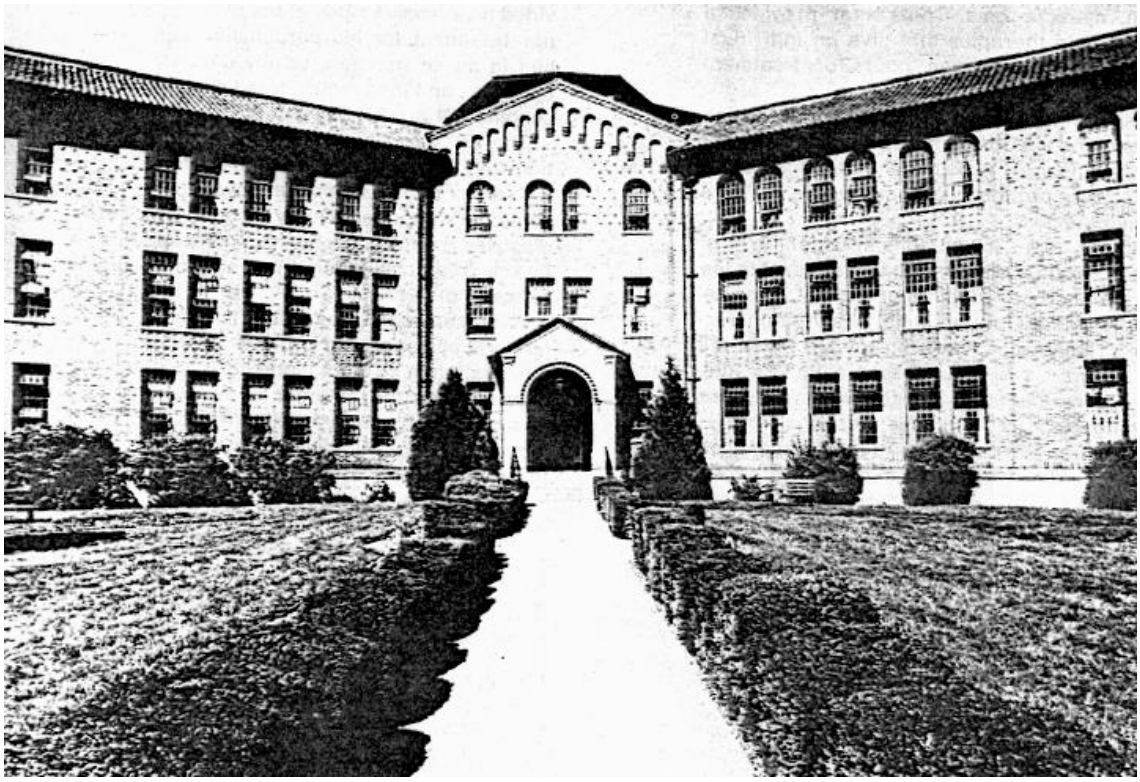

Figure 3: North Hall, where the Sexual Offender Treatment Program was based for the majority of its lifespan. From R.V. Denenberg, "Sex Offenders Treat Themselves", *Corrections Magazine* 1 no. 2 (November/December 1974), 55.

MacDonald sought friendlier relations between the program, the hospital, and the state. The resident's work around the hospital had helped to alleviate dislike, but the group remained alienated from the general patient population, and outside staff remained ill-informed about the offenders in their midst.[303] *01* began working at Western State Hospital on the Geriatric Admissions ward. She knew nothing of substance about the program until one of the janitors on her ward told her he was a resident and discussed the program with her.[304] MacDonald made it clear to the

[303] *01* Interview Transcript, 5; di Furia, "On the Treatment and Disposition of Sexual Offenders", 630-631; MacDonald, *Treatment Of the Sex Offender: Ten Years*, 4; *The Sexual Offender: Safe to Be At Large?*, KWSC-TV.
[304] *01* Interview Transcript, 1.

offenders that they were expected to be "open and responsible" members of the hospital community, as well as their own. They could not simply talk about their sense of duty in the group session – they had to live up to it. Heeding his call, residents joined patient government and volunteered to complete various tasks outside of their work assignments. By 1968, they were so well trusted that some even served in the hospital search posse, which combed the open land surrounding the hospital for escaped or confused psychotic patients.[305] They were unaccompanied, and could easily escape, but chose to cooperate. The therapeutic group was establishing itself as a participant in a wider hospital community.[306]

In the interest of improving the program, MacDonald began searching for ways to give the offenders educational opportunities that could help them on their return to society. He turned to recruiting volunteers from the public to treat offenders. Volunteers from the general public were sought throughout Western State Hospital in the 1960's and 70's. They primarily gave patients companionship and filled assorted service roles like Recreation Aide, "Fashion" Aide and Chapel Assistants Volunteer.[307] MacDonald's initial aim with volunteers gave them the more involved role of teacher. The first volunteer, Mr. Becker, was brought on in 1967. He taught assorted lessons in "social and interrelational skills" with lectures and exercises on specific days of the month. A short time later, a social worker, Ms. Mock, joined him.[308] MacDonald hoped that the two would be seen as "role models" as well as instructors by the offenders. This

[305] Rod Cardwell, "Down Into Western State Hospital's 'Grand Canyon'", *The News Tribune,* Tacoma, WA (January 16th, 1966), A18; MacDonald, *Treatment Of the Sex Offender: Ten Years*, 4.
[306] MacDonald, *Treatment Of the Sex Offender: Ten Years*, 4.
[307] "Guidelines for Volunteers", Western State Hospital, Steilacoom, WA (1972).
[308] MacDonald, *Treatment Of the Sex Offender: Ten Years*, 4-5.

pedestrian, "rote" state of affairs did not satisfy MacDonald, as the volunteers were doing the same *type* of task that the larger hospital's volunteers did. They provided a service, rather than gave the offender an opportunity to improve themselves. It was a few years before the program arrived at a solution.[309]

Dr. Robinson A. Williams was hired in February 1967 as Associate Director. He was chosen for his "broad background" in "clinical, correctional and administrative" experience. MacDonald viewed the program as lying outside of the "psychoanalytic approach" and sought a staff that could forge a new path alongside him.[310] With the arrival of Williams, MacDonald became more ambitious in changing the program. He wanted more than group accountability. He wanted to alter the program's model to make the group a more potent environment for change. The program's new elements, however, were not modifications devised wholly by MacDonald and Williams and imposed from above. The program considered group leadership an essential aspect of the program, to the extent that the program staff sought group input on the program's architecture and procedures.

The first instance of this occurred when MacDonald called a conference of leader-level residents, program staff, and some discharged graduates in May of 1967. The goal was to create some sort of outpatient follow-up after the offender completed inpatient therapy. The residents were very concerned a more gradual form of release was necessary to prevent the offender from being "shocked" into a relapse. Following their recommendations and staff consideration, a two-part scheme was drafted. At first,

[309] MacDonald et. al., *Treatment Of the Sex Offender,* 7.
[310] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, Introduction, 6.

offenders were allowed off the ward on weekdays to work an outside job, returning to the ward for evening therapy sessions and to sleep. This portion, called "work release", allowed the offender to begin taking on the demands of the outside world a day at a time.[311] An offender was only placed on work release if he had served admirably in a group leadership position, and if group and the program staff both agreed he was ready for it.[312]

Once the offender had spent at least three months on work-release and was thought to be adjusting to their new freedom well, they were placed on probationary release. They were required to attend weekly outpatient meetings at the hospital for at least a year and had to meet with a court-assigned probation officer. Generally, the offender was assigned eighteen months.[313] The outpatient portion of treatment was minimally involved beyond these meetings. of outpatient.[314] After they completed outpatient, they went on probation proper, continuing to meet with the officer per court orders. Its minimum length was also one year, but according to the later director Maureen Saylor, "almost everybody [got] five".[315] When the offender went on probation, it was the end of the hospital's official oversight of them. All graduates were told that they were members of their groups for the rest of their lives. They were free to return to the hospital and their group whenever they wished, to discuss their problems,

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[311] ibid, 7.
[312] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 7; Brecher, *Treatment Programs,* 21.
[313] *Annual Report, July 1st 1969 – June 30th, 1970,* 2; Denenberg, "Sex Offenders Treat Themselves", 60; Robinson A. Williams, *Community Adjustment of Treated Sexual Offenders*, Western State Hospital, Steilacoom, WA (1971), 1, Research Questionairre.
[314] Magaret Ainscough, "Hospital treats sexual offenders", *Corrections* 1 no. 4 (August 1976).
[315] Jan Gildenhar, "Sex offenders: WSH treatment aims at molester's responsibility and sense of himself", *The News Tribune,* Tacoma, WA (January 3rd, 1984), B-2.

to provide help to others, or even just to check in. A number did.[316] The new system promised continuing group oversight of offenders through their release. If, at any time, the residents sense that the offender was lapsing into old patterns of thought or behavior that preceded his return to offense, they could "pull" the offender back in and return him to their previous therapy arrangement.[317] The new outpatient program was greeted enthusiastically by the residents. The staff considered the innovation a good thing in and of itself, but also clear evidence that offenders could meaningfully contribute to the creation of the program architecture.[318] Therefore, these "conferences" between higher-level group members and program staff became the program's default method of brainstorming improvements and troubleshooting issues.

At the start of 1968, the program was beginning to grow rapidly, and the changes were piling up. The low cost of the program compared to prison and the attested lower recidivism rates attracted notice in the court system. Commitments had leaped in the two years before 1968. Between 1957 and 1966, the annual admittance rate had a median of 36 when exempting the outlier year 1962-1963. The number ultimately retained in the program was about 18 new patients in a given year.[319] The strain made itself known quickly. The 1966 new arrivals of were initially moved into the preexisting group, resulting in a group that brushed near forty men.[320] The 27 men in treatment found themselves wholly preoccupied with evaluating the new arrivals and

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[316] *01* Interview Transcript, 18.
[317] *Guided Self-Help: A New Approach… July 1973-June 1974,* 5; Cary Quan Gelernter, "Failures cast cloud on sex-offender program", *Seattle Times* (March 7th 1983), C2.
[318] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 7; *Annual Report, July 1st 1969 – June 30th, 1970,* 2.
[319] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 11, 17.
[320] ibid, 5.

could not give each other adequate attention in group.[321] Unable to maintain a therapeutic environment, the men created a regime of control over the new arrivals and each other. Group discipline became “authoritarian” and arbitrary, rather than treatment-oriented. The decay in quality was not because of a lack of supervision. The closer oversight procedures established in the wake of the 1964 suicide allowed MacDonald to notice the trend quickly. He was not, however, able to direct the therapy to meaningful ends by administrative intervention. Guiding the sessions did not solve problems with disenfranchisement, and unspecified “irresponsible behavior” continued to rise.[322]

MacDonald, after consideration, fingered the expanding group size as the primary problem. No matter what was done by the clinician, he thought, if a group had close to forty people, the residents could not engage with each other. He split the program into two "virtually identical” therapy groups of ~20 residents.[323] MacDonald thought around 20 residents had been “maximal for efficient operation". It allowed for every resident to have time to speak in a session and get to know their fellows well, without becoming overly attached to each other and unwilling to confront behavior. The two groups elected their own group leadership. They acted independently of one

[321] MacDonald et. al., *Treatment of the Sex Offender: Ten Years*, 5.
[322] ibid.
[323] ibid.

another. The leaders convened to talk about tactics and to gauge the program's aggregate progress.[324]

Splitting the group had instant results. Residents became engaged with each other and with the group sessions again. "Irresponsible behavior" declined dramatically. In this initial "split" to two groups, the groups remained physically close together and were in frequent contact. These two groups were led by different leaders who followed different agendas, but the two could easily keep tabs on the other. [325] By October 1968, the expanding patient population led the program to split off another new group, which was housed outside of the "headquarters" in North Hall.[326] The distance marked a new challenge. It cut early-stage offenders, who had limited grounds privileges, off from the other groups' residents. The offenders still "dined together", but there were so many of them that they could not possibly get to know everyone at meals alone. Group leaders found they had difficulty keeping abreast of the developments in the other groups, and difficulty maintaining intergroup procedures. The program had another all-group conference. The staff and residents arrived at twice-monthly town hall style meetings as the solution. The new meetings were effective. The staff trumpeted their success in the 1970 Annual Report, underlining that residents had been essential in developing these changes.[327]

MacDonald was initially unfazed by the program's growing population and limited financial support. He believed that an increasing number of smaller groups

[324] Wojtech, "This Is The First Time Anyone Bothered To Give Me Some Hope…"
[325] Wojtech, "This Is The First Time Anyone Bothered To Give Me Some Hope…".
[326] ibid; *Annual Report, July 1st 1969 – June 30th, 1970,* 2.
[327] *Annual Report, July 1st 1969 – June 30th, 1970,* 2.

would not demand a great increase in administrative oversight. Proportional staff increases were not necessary. Because the therapy was primarily resident-driven, as long as there remained adequate staff for oversight within each group, the groups could effectively manage themselves. A larger administration might prevent the occasional escape, but it would not give the offender higher-quality treatment. The program could not be managed into effective therap. The treatment was in the hands of the participant offenders. The groups had to be given sufficient resources and privileges to encourage cooperation, be kept small, and be allowed to run themselves.[328]

"[We] have confidence that the program can meet the new problems...of increasing size, increasing complexity of services, and of increasing critical appraisal...[as] its substance is people: patients, staff and volunteers who believe in the untapped self-help capabilities of the offenders themselves..."
George MacDonald et. al., *Treatment Of the Sex Offender,* 9

As MacDonald's administration continued, his perceived success brought the program further attention and further commitments. MacDonald sensed the growing interest and projected ~80-90 admissions for observation to the program from the summer of 1968 to the summer of 1969. The reality was only slightly below his expectations. 67 offenders were admitted in 1968 and 76 more in 1969. The program became more selective to compensate, cutting the acceptance rate to ~42%, but this did little to stop the overflow.[329] From 1967 to 1969, the group was seeing three times the number of new arrivals than before.[330] The situation developed in the next three years,

[328] Howard B Kellogg Jr. and the Committee for Review of the Sexual Offender Program at Western State Hospital, *Report to the Secretary from the Committee for Review of the Sexual Offender Program at Western State Hospital,* Olympia, WA (August 15th, 1979), 3; MacDonald and Williams, *The Washington State Sexual Psychopath Law,* 3.
[329] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 14; Williams, *Characteristics and Management,* Figure 2.
[330] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 5.

as commitments rose near-exponentially.[331]Accordingly, the program split off a new group at least once a year for five consecutive years.[332] This was not the result of a "prosecution boom" of sex offenders. There was only an 8% increase in the number of commitments to both adult corrections and the Sexual Psychopath program at the time.[333] Instead, there was a dramatic increase in percentage of those sent to the offender rehabilitation program, rather than Corrections. From July 1961 to June 1970, this percentage skyrocketed from 37 to 68%.[334] The suspicious policeman in *Safe To Be At Large?* was being overruled by hopeful prosecutors and justices.

The groups were originally named based on their positons within the hall and on the Western State campus – East Group, West Group, North Group, and so on – but as the groups proliferated, the program switched to more poetic names. As of mid-1976, the groups were North, East, South, West, Friendship, Star, Rainier, Brotherhood, Echo, Aquarius, Sunrise and Evergreen.[335]

The program's population rose as Western State Hospital's population fell. Governor Daniel Evans was a strong supporter of the Western State program but was a strong advocate for deinstitutionalization of the mentally ill. Under his tenure, funding for mental institutions declined accordingly.[336] In 1966, Western State had an average daily population, or ADP, of 1770 patients. About 25 of those at any given time were

[331] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 5.
[332] ibid; *Guided Self-Help: A New Approach… July 1973-June 1974,* Telephone Directory, 10.
[333] Williams, *Characteristics and Management,* 2.
[334] ibid.
[335] MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976,* Cover, Back Page Flowchart.
[336] Mary J. McGoffin, *Under the Red Roof: One Hundred Years at Northern State Hospital,* Private Press, Sedro Woolley, WA (2014), 95-96.

sexual psychopath commitments.[337] In 1971, the hospital's average daily population had dropped to 1,124 patients, including an average of 125 sex offender commitments at any given time.[338] Western State's budget fell alongside its population numbers. The 1973-1975 Biennial Budget projections for Washington list the budgeted figures for the state's mental institutions generally, but do not break down the budget and expenditures of each hospital. The "general trend", however, is clear: the budget for mental institutions in Washington dipped from ~16,082,000 to ~14,528,000 from 1970 to 1972, with a further proposed decline to ~12,167,000 by 1974.[339] Simultaneously, Northern State Hospital in Sedro-Wooley was closed in 1973, with its remaining patients "discharged" either to Western State, to community care, or, most often, to the Greyhound station.[340] The program was, in a twist of fate, no longer attempting to discharge offenders to free up ward space for "civilian" patients. Instead, it was claiming more and more disused space from a hospital system that was being cut to the bone.

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[337] "Biennial Report, 1965-1966", Department of Institutions, Olympia, WA (1966), 9; di Furia, "On the Treatment and Disposition of Sexual Offenders", 631; MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 5.

[338] *Guided Self-Help: A New Approach… July 1973-June 1974*, Statistical Report, 10; "Program Policies (Revised June 1976)", p. 6, attachment to a Memorandum, George Macdonald to Giulio Di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry", Western State Hospital – Treatment – Box 93, Washington State Archives, Accession No. 95A213.

[339] Office of the Governor, *State of Washington Budget, 1973-1975 Biennum*, Olympia, WA (Janurary 1973), 282.

[340]McGoffin, *Under the Red Roof*, 86-87;.Office of the Governor, *State of Washington Budget, 1973-1975 Biennium*, 5, 7.

Figure 4: Stills from the 1966 Documentary "The Sexual Offender: Safe To Be At Large?"

The stills show, from left to right, show: Dr. George MacDonald, one of the program's founders; a group session, showing the group leaders by the tape recorder; a wider view of the group, with the tape recorder on full display; the end of a conjugal visit, with the father handing his child back to his wife; the same conjugal visit in progress, with North Hall in the background; and two offenders sitting on the lawn during recreation.

MacDonald and Williams were refining the group's understanding of itself at the same time they were changing its procedures so dramatically. With the arrival of MacDonald, the "group" as an entity both in and out of therapy took on much more weight in the program. Mees and di Furia had created "the group", but the group living situation's contribution to therapy had not been fully realized. They observed the group's constant exposure to itself had positively affected the ability of offenders to gauge the attitude and commitment of their fellows. The group was not merely more familiar with the offender's problems, but better able to read his emotions and tell when he was hiding something. [341] As one report put it, "A man who can readily con even a skilled psychiatrist finds it hard to con 15 fellow-offenders with whom he has been living in close quarters for 168 hours a week, week after week."[342] On a more reflexive level, the group understood that the news media would present the residents as a homogenous group. If one member slipped, the entire program would be under public criticism. The group's public vulnerability was, accordingly, "leverage" against an offender that pushed him to mind his behavior.[343] All of Mees and di Furia's observations were predicated on how a group member acted toward other members and the "public audience", rather than how the group might accomplish the program's mission of reforming the individual.[344] Further, the group thus formulated only offered risks for it participants. The threat of confrontation and shame within the session and

[341] di Furia and Mees, "Legal and Psychiatric Problems", 984; di Furia, "On the Treatment and Disposition of Sexual Offenders, 630; Wojtech, "The Unmasking of a Sexual Psychopath", 1-2.
[342] Brecher, *Treatment Programs,* 16.
[343] di Furia, "On the Treatment and Disposition of Sexual Offenders, 630-631; *The Sex Offender: Safe to Be At Large?* KWSC-TV.
[344] Rigert, "Group Therapy Program at WSH Aids Patients".

the threat of a wrathful public sending him to prison was seen as pressure to stay in line, rather than incentive to change.

MacDonald observed that the group was more than a pressure cooker. "Group membership" was also "group belonging", and the offender's newfound inclusion fundamentally changed his understanding of himself. As previously stated, the offender was thought to be emotionally distant, resulting in social isolation. When he entered the group, he was forced to become emotionally open under threat of expulsion. In the short term, he would "play along", if nothing else, confessing his sins and completing tasks to appease the others and maintain his membership.[345] When his efforts met with approbation and acceptance, MacDonald thought, the offender would discover his fears of socialization were exaggerated. He would see how the other offenders were helped by his criticism and his attention.[346] It wasn't easy for the offender to put himself in the open, and he would lower his internal defenses slowly, fearful of facing the reality of his crimes.[347] He was not alone, however, and as he came to accept how he had hurt his victims, he saw how others in his group avoided reality, and pushed them to come to the same realization. He revealed a side of himself that he had never seen before, a side of him that helped others, rather than hurt them.[348] He achieved a lasting emotional satisfaction that was previously absent. His cooperation would turn into active

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[345] Brecher, *Treatment Programs,* 14-15; Hendricks, *Some Effective Change Inducing Mechanisms,* 5.
[346] Brecher, *Treatment Programs,* 15; Denenberg, "Sex Offenders Treat Themselves", 60-61; Mottram, "The story of a child molester".
[347] David C. Hall, *Group Psychotherapy Marathons in the Treatment of Habitual Sexual Offenders,* Western State Hospital, Steilacoom, WA (1971), 1-2; Jerry Lillihei, "Group Therapy – Does It Work?", *The Westernaire*, Steilacoom, WA (October 1974), 2; MacDonald and Williams, *The Washington State Sexual Psychopath Law,* 3.
[348] Denenberg, "Sex Offenders Treat Themselves", 60; Hendricks, *Some Effective Change Inducing Mechanisms,* 7-9; Lillihei, "Group Therapy – Does It Work?", 2; MacDonald et. al., *Treatment Of the Sex Offender: Ten Years,* 4, 22.

investment of himself in the group as he pursued this new feeling. A new, positive self-image was built up by habit.[349] During a confrontation, the group asked the offender how he felt about his place in the group. By asking, the group ensured that the offender knew the way he felt was important, even if it very forcefully disagreed with him. His presence was something the group ostensibly thought was worth keeping. At the end of treatment, the offender had found happiness and peace in living in the open. They would stop hurting others not only to avoid the consequences, but because they found greater happiness in a new, positive lifestyle and a new, positive self.[350] For MacDonald, the group was more than a mirror that the offender could not escape. The group was a mirror where he could see himself smile for the first time.

The change in the program's theoretical understanding was accompanied by further development of the group structure. The most obvious aspect of this move was the creation of "steps". Previously, the group was a self-managed but open-ended environment. While the internal issues of the offenders were believed to be much the same, the path to overcoming them was intentionally left minimally described. "Where" a resident stood on the path to success was determined by the other group members according to whatever criteria, explicit or unstated, they chose.[351] MacDonald, working with the groups, began laying out a series of necessary "realizations", behaviors and tasks to move from "offender" to "ex-offender". The groups then drafted their own set of "steps" that each member had to fulfill.[352] The "steps" approach soon solidified into a

[349] Hendricks and di Furia, "Lifeboat", 2; Hendricks, *Some Effective Change Inducing Mechanisms,* 9-10.
[350] Hendricks, *Some Effective Change Inducing Mechanisms,* 6, 10.
[351] *The Sex Offender: Safe to Be At Large?* KWSC-TV; Denenberg, "Sex Offenders Treat Themselves", 59-60.
[352] Ainscough, "Hospital treats sexual offenders".

program module in of itself. The steps were a hierarchy of privileges and responsibilities. Offenders who were admitted to the program past the observation period were placed on Step One. Every two weeks, the offender could ask to be promoted to the next step.[353] To reach the next step, the offender had to have shown themselves to be accomplished in the capacity that the step in question "tested", and to have been a model resident.[354] Promotions from "member" to "junior leader" to "leader" were limited to those who had reached a certain level. Step Seven was accordingly the most important, as reaching it made the offender eligible to become a group's co-leader.[355] Each step had certain tasks and character requirements. For example, an offender had to write and present a comprehensive report on the nature of their sexual offense(s) for Step Five. The report's focus was what had led the offender to commit his specific crimes, what choices or signs were apparent before he violated someone, and how he could avoid lapsing into a cycle of offense going forward.[356] What a resident was expected to learn and do as part of the group was thereby standardized within the group, creating benchmarks of progress. Different groups had different progressions, but the vast majority of the goals were the same across the program.[357] Every offender would know the road ahead of them, what they needed to achieve, and what they needed to help others achieve.

This expectation of honesty was joined by an expectation of vigilance. It was assumed that since everyone in the program had committed sexual offenses, they had to

[353] Henderson, "A Pothole".
[354] "Guidelines for Volunteers", Western State Hospital, Steilacoom, WA (1972).
[355] Denenberg, "Sex Offenders Treat Themselves", 60.
[356] Hendricks and di Furia, "Lifeboat", 17;
[357] Ainscough, "Hospital treats sexual offenders".

have serious socialization problems. The members had to closely watch one another for signs of these patterns or for signs they were hanging on to their deviant sexuality. If a group member believed another was lapsing into old behavioral patterns, or was behaving inappropriately in any way, he was obligated to confront the other offender on their actions. The group's goal with these "confrontations" was less to determine *if* someone had violated group protocol, but to determine *why* they had done so. A resident who had been slacking on the job might have been hiding something, fearful of the group's response. He could also have viewed himself as "smart" and "above" the others for refusing to participate in the work, as he knew the group would do his share to keep the program's good image.[358] Once an issue or a transgression was brought before the group, all members had a chance to speak on the matter before the group decided a course of action.[359]

The refinement of the group disciplinary procedure also showed the increasing prominence of the group as a collective entity. Each individual group drafted their own ground rules for behavior. Certain rules were common throughout all groups on the program, but in addition, each group set their own "code" which governed their group sessions and the general conduct of that group's members. These codes gave expectations of participation and self-discipline, as well as proscribed certain actions beyond the program wide rules. Generally, a transgression resulted in a curtailment of a privilege. The code, however, only specified what not to do. Each punishment was awarded uniquely. The primary goal was to relate the offender's wrongdoing to the

[358] Denenberg, "Sex Offenders Treat Themselves", 60, 62; Hendricks, *Some Effective Change Inducing Mechanisms*, 7, 11.
[359] Denenberg, "Sex Offenders Treat Themselves", 61-62; Henderson, "A Pothole".

particular problems of character and socialization that his transgression had shown.[360]Groups also imposed additional restrictions on individual members, based on their individual habits and the needs of their treatment. For example, a used car salesman had used his gift of gab to talk around his problems. He was prohibited from speaking outside of group, to prevent him from using charm to avoid scrutiny.[361] To complement this point, almost everything the offender did was qualified as a privilege, subject to removal at the group's discretion.[362] The group was an agent of targeted, shifting control, rather than an enforcement agency carrying out defined punishments for defined rules. Every member was to participate in the enforcement of proper behavior, forcing them to consider the meaning and purpose of the rules, as well as the letter of them.

The admissions process was reconfigured to make the group a central figure. The offender was put into a group on a tentative basis during his ninety-day observation evaluation.[363] This was now his group, for however long he stayed in the program. The new offender observed the group's sessions for the first few days, learning about their fellow residents and the everyday pattern. They received their group's manual. It outlined the gist of the treatment philosophy, the group's procedures, and a few practical details about life on their ward. Each group had slightly different "steps" and procedures, and each wrote their own manual for new arrivals.[364]

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[360] Brecher, *Treatment Programs,* 17.
[361] Denenberg, "Sex Offenders Treat Themselves", 62.
[362] Denenberg, "Sex Offenders Treat Themselves", 15; Wojtech, "The Unmasking of a Sexual Psychopath", 2.
[363] Brecher, *Treatment Programs,* 15; Hendricks, *Some Effective Change Inducing Mechanisms,*
[364] Brecher, *Treatment Programs,* 13-14.

After a few days immersing themselves in the environment, the inductee had to write an autobiography that covered the important events of their life, their offenses, and their feelings throughout. The group reviewed it for its honesty, totality, and insight. For the first point, they could request access to police reports and court records. *01* suggested this was rarely done, but the option was available.[365] The staff and group expected the new resident would protest his innocence or downplay the severity his actions. They allowed it at first.[366] If the group found the autobiography insufficiently revealing, they would tell the inductee to rewrite it.[367] Most offenders had to rewrite their autobiography at least once.[368] While he wrote his autobiography, he was assigned his first job, which was always on the group's ward. Once his autobiography was accepted, he became a full participating "speaking member" in the group. The other full-time committed residents monitored his state and progress over the rest of the ninety days.[369] When the end of his observation approached, the group had a special session where it determined whether or not an offender would be accepted. The senior staff had the final word on admittance, but they generally followed the group's choice: in 1974, they followed the group's decision 85% of the time. If the staff and group disagreed, the leaders and staff would meet to discuss what had divided them and what each party could better bear in mind in the future.[370] If the offender was accepted, he

[365] *01* Interview Transcript,
[366] Brecher, *Treatment Programs,*
[367] Hendricks, *Some Effective Change Inducing Mechanisms,* ; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 2; *The Sex Offender: Safe to Be At Large?* KWSC-TV; Denenberg, "Sex Offenders Treat Themselves", 60.
[368] Bill Ripple, "No 'Ruzickas' in WSH now", *The News Tribune* (d.uk.); Denenberg, "Sex Offenders Treat Themselves", 60.
[369] Brecher, *Treatment Program,* 15; Wojtech, "This Is The First Time Anyone Bothered To Give Me Some Hope…";
[370] Brecher, *Treatment Program,* 15; Denenberg, "Sex Offenders Treat Themselves", 59.

was officially “on the ladder” at Step One and went from an “observation man” to a “resident” proper. He had officially begun his treatment.

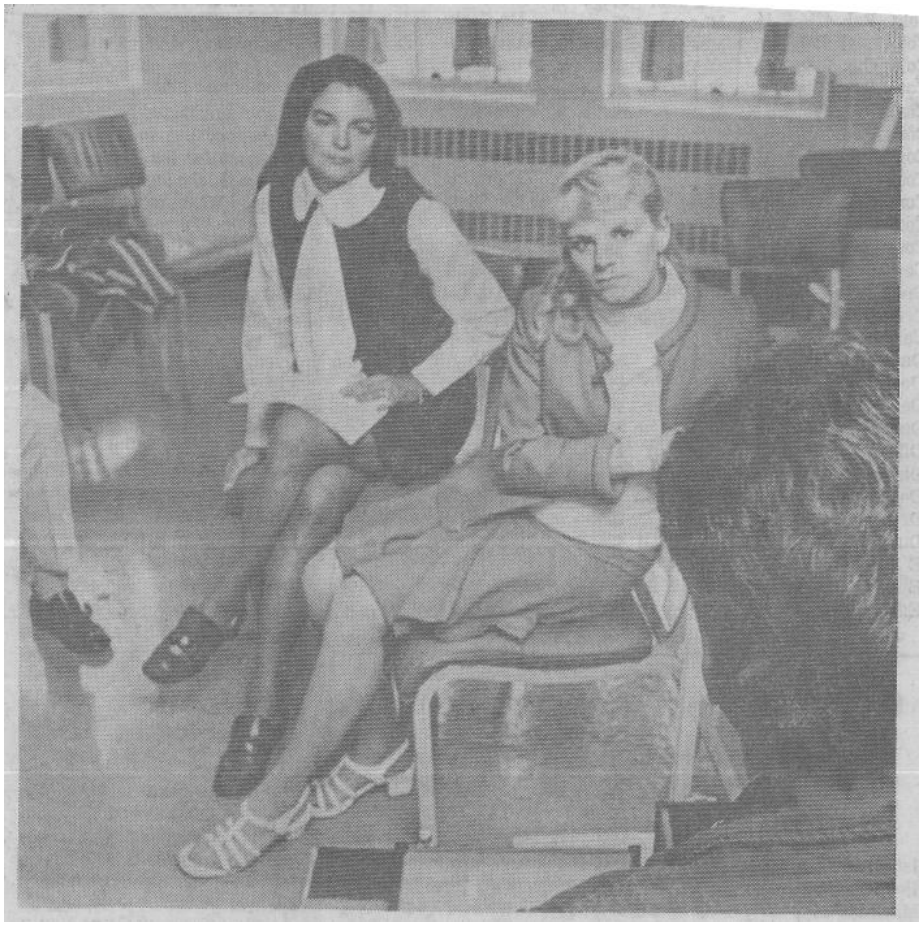

Figure 5: Two women volunteers listen to an offender talk during a group session. From Louise Wojtech, "Volunteers play role in rehabilitation", *The Daily Olympian*, Olympia, WA (October 22nd, 1970).

As MacDonald and Williams dramatically reinvented the concept of the therapeutic group, they sought to expand the program’s methods to capitalize on other potential avenues to rebuild the offender’s character. In their new efforts, they maintained their focus on improving the offender’s ability to socialize and relate with others. The volunteer program was their first target for overhaul. They had sought to make the program less "insular" and more reflective of the problems and temptations

residents would face on release. Lectures on etiquette were not equivalent to practicing keeping good conduct in the face of daily aggravations or more acute emotional disruptions. They also interrupted the group's internal analytical process with outside pedagogy. In the program's view, offenders had to be confronted with "true" socialization, with real people who might harbor great anger against them for their actions or profound indifference to their problems. Granting the offenders more involvement with the outside world before work release, however, wasn't feasible without a major change in the program's structure to a partially outpatient modality, which the State had previously refused for a number of reasons.

The program's solution was to bring what it thought offenders found the most challenging – socialization – inside, to the offenders. The program began assigning volunteers to group sessions. The program used volunteer pairs – one man and one woman in each, whenever possible. The pair would no longer give lectures or engage in discussions of topics. Instead, they simply sat in and weighed in on the group's discussion when they thought it appropriate. [371] The program found that many men were extremely poor at handling the presence of a woman in any capacity, and that their presence during group almost paralyzed some of them. One offender couldn't speak to the woman volunteer assigned to the group, and instead tried to tug at her hair to get her attention.[372] In 1968, the volunteer initiative earned the program another vocal supporter. Jerry Holzinger, a popular Seattle talk show host, joined as a volunteer, and found the work so rewarding that he joined the program staff, staying with the program

[371] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 4; "Volunteer Corner". *Fort Retorter* 5 no 1, Western State Hospital, Steilacoom, WA (January 1978), 1.
[372] Brecher, *Treatment Programs,* 20.

until the end of the 1970's. His presence significantly raised the program's profile, and the number of volunteers jumped from four in July 1969 to ten in June 1970.[373]

As MacDonald became more confident in the new model, he began introducing group psychodrama, a traditional therapeutic tool.[374] The group psychodrama had a number of operating elements. To help the reader get a sense of their character, an example session has been included as Appendix B. Generally, the sessions were intentionally artificial situations in which the volunteers would roleplay all sorts of figures - strangers, potential romantic interests, a woman coworker. Sometimes, some of the men would take on a role as well, but most often the men were to play themselves. The resident would then have to accomplish some sort of basic socialization goal, such as asking a woman out on a date or telling them about their criminal past. Sometimes, the conversations were primarily exercises in empathy, such as when the woman roleplayed as the mother of a victim.[375] The volunteers recruited were largely women.[376] The program believed the vast majority of sexual offenses, regardless of the victim's age, were rooted in an inability to have a healthy, emotionally open relationship with an adult woman.[377] For that reason, women volunteers were essential. While staff preferred a man and a women working as a "couple", to provide a

[373] "Volunteer Corner", *Fort Retorter* 5 no. 1, 1; MacDonald et. al, *Treatment of the Sex Offender,* 5.
[374] Lewis Yabionsky and James M. Ennsis, "Psychodrama Theory and Practice", 1-2, in *Handbook for Volunteers,* Western State Hospital, Steilacoom, WA (1972?); Wojtech, "Volunteers play role".
[375] Laurel Butler, "The Role of the Female Citizen Volunteer in the Treatment of Sexual Offenders at Western State Hospital, Fort Steilacoom, Washington", in *Handbook for Volunteers,* Western State Hospital, Steilacoom, WA (1972?), 4.
[376] Butler, "The Role", 2; Jones, "Women help", F1.
[377] Majorie Jones, "Women help in sexual-offender program", *The Seattle Times* (July 7th, 1976), F-1; Wojtech, "Volunteers play role".

male model of healthy interaction, they were unable to find as many men who were agreeable volunteers.[378]

There were a number of rules to keep the sessions as safe as possible. Touching the volunteers, except for extremely limited contact initiated by the volunteer, was forbidden.[379] The volunteers themselves were screened for any emotional issues. They were given a handbook to read which detailed what would happen in a session and what to expect, then asked to sit in on some sessions as an observer. In later years, they were also given some training in offender rehabilitation to prepare them.[380] These sessions were eventually given set for all groups at Tuesday, from 2 to 4 P.M. The time was chosen to allow the group's therapy supervisor to sit in on the meetings. The result of these precautions meant that there were very few incidents, and none resulted in a serious assault.[381] The primary issue was, instead, romantic relationships between the residents and the women volunteers.[382] The program explicitly preferred married women because they [thought] they [were] less likely to become romantically involved [with the offenders]..."[383] The problem was serious enough that it demanded frequent warnings and constant attention from the program staff to prevent it. The Volunteer Handbook listed five "expectations" for volunteers. Three of them were:

- Do not favor or get involved with any one man,
- Do not meet with anyone outside of standard sessions "without... the approval of the [group's] therapy supervisor", and

[378] Butler, "The Role", 1.
[379] Jones, "Women help", F1;
[380] Butler, "The Role". 6-7; Jones, "Women help", F1.
[381] Jones, "Women help", F1.
[382] Butler, "The Role", 3.
[383] ibid, 5.

- Do not pursue any kind of private involvement with a resident before, during, or after the resident's stay in the program.[384]

In the most grievous breach of these rules, one volunteer "helped a resident escape and took off to California".[385] These affairs, however, were rare. The program was generally effective at screening out "unsuitable" candidates. Despite the large possibility for a public outcry, there was never a public scandal of any kind about the use of volunteers, giving the program a valuable source of support when talking to figures from the DSHS and the Legislature. Because of its powerful effect on the group members and its excellent safety record, MacDonald considered the volunteer program the most effective supplement to group therapy the program devised.[386]

Around the same time, MacDonald and Williams sought to dramatically overhaul the way the program worked with married offenders and offenders in long-term relationships generally. Married offenders were a very large portion of the program's population. The percentage of married offenders hovered around 50% through 1968 and humped at around 60% for the first years of the 1970's.[387] On admission, the offender's family, if they had one, was now a particularly intense source of stress. The offender's marriage was threatened if not immediately ended by the reveal of his wrongdoing. Further, his wife was under severe emotional strain, coming to terms with their husband's wrongdoing, bearing community shame, and often being forced to make major changes to financially survive.[388] Many of the married offenders

[384] "Guidelines for Volunteers", Western State Hospital, Steilacoom, WA (1972).
[385] Jones, "Women help".
[386] ibid.
[387] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 6; MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, 3; MacDonald and Williams, *Annual Report: July 1973 – June 1974*, 12.
[388] Brecher, *Treatment Programs*, 19; MacDonald et. al., *Treatment of the Sex Offender: Ten Years*, 6;

expressed fears of losing their wife and children while he was confined, and sought to change his ways specifically so they could return to them.[389] MacDonald and the other program staff believed their problems at home needed to be addressed for effective treatment. Guilt, shame, and unresolved preexisting disputes made the family a great deal of stress for the offender. If he was not given a means to see his loved ones and work through their problems, the stress might drive him to re-offense.[390] Along these lines, staff believed that the family was the offender's best available post-release support. Familiarizing the offender's wife with his internal problems would give the offender someone who could support him upon release.[391] For obvious reasons, the program was less explicit in the popular press about its second reason for trying to improve these relationships: the offender's wife was an appropriate, of-age sexual partner for child sexual abusers. Encouraging the offender's attraction to his wife would curtail his desire for unacceptable sexual acts and targets.[392]

MacDonald began a host of efforts to support these couples, some of which went well beyond "therapy" in the traditional sense. The most important of these was the aforementioned couple's therapy program. Women who decided to stay with their husbands were "strongly" encouraged to participate. di Furia had started a once-a-month session for married couples at the end of his initial administration of the program. Under MacDonald's administration, the effort was ramped up drastically to

[389] AP Wire, "The average sex offender…", A-5.
[390] MacDonald and Williams, *Annual Report: July 1973 – June 1974,* 5;
[391] MacDonald and Williams, *Annual Report: July 1973 – June 1974,* 5; Hitchen, "Denial", 154.
[392] Denenberg, "Sex Offenders Treat Themselves", 62, 64; Curt Milton, "Western State", *Suburban Times,* Tacoma, WA (October 19th, 1979), A1.

weekly three-hour sessions.[393] The population rolls for the program suggest fairly high participation. 17 wives were on the rolls in June 1970, two years after the program's debut. That number jumped to 30 by 1973 and 49 by 1976.[394] The couples' sessions were conducted within groups, meaning that only the wives of offenders within a particular group met. Therefore, the sessions themselves were quite small. A 1972 outside report observed one group's couples' meetings over a few months and reported only "three to five" couples participating at any given time.[395]

MacDonald's efforts had a strong basis in the sex offender's treatment, but MacDonald also strongly believed in the importance of family. He thought he needed to make sure "the offender… remain[ed] as active as possible in his role of father", as children needed a father figure and that a man's crimes should not strip his children from him.[396] With all of these improvements, the staff created a comprehensive "program-within-a-program" for offenders with wives, fiancés, or other committed long-term relationships. MacDonald's enthusiasm extended to assisting in forging these bonds, under the right conditions:

> "Perhaps the ultimate in the program's emphasis on strengthening martial and family ties has been the celebration of two weddings at the hospital, complete with beautiful receptions on the ward…" [397]

An unintended but positive result of this aspect of the program was that the families of offenders were major public advocates for the program. In newspaper and

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[393] di Furia, "On the Treatment and Disposition of Sexual Offenders, 630; *Guided Self-Help: A New Approach… July 1973-June 1974,* 17.
[394] *Annual Report, July 1st 1969 – June 30th, 1970,* 4; *Guided Self-Help: A New Approach… July 1973-June 1974,* 10; MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976,* 7.
[395] Hitchen, "Denial", 154.
[396] ibid.
[397] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 6.

scholarly articles, they testified to the intensity of the therapy and to the positive change it had on their husband's behavior.[398]

The program's bold changes and minimal paper trail were facilitated by a lax attitude toward medical experimentation that prevailed in the profession. Regulations on experimentation with human subjects were minimal through the end of the 1950's. For psychiatrists and psychologists, the situation was even more lax, and almost no oversight personnel or procedures existed. In two famous examples, Kinsey openly deceived subjects to obtain their confidence, and Milgram made the subject believe an unseen other party was receiving near-fatal electric shocks. The question of "Quis custodiet ipsos custodes" began to percolate through the 1960's, but it was as a point of discussion, rather than a point of policy. Major, binding changes to Human Subjects research was not instituted until the mid-1970's.[399] Western State Hospital, therefore, had few to answer to when it began the "self-guided" sessions.

The staff's claims that the program was the only one of its kind in the country made it, by definition, experimental. The staff understood this, and they warned their colleagues that results may vary. di Furia's 1966 *Northwest Medicine* article and MacDonald's 1968 report both stated explicitly that the treatment's impact should be thought uncertain.[400] They did not, however, either take the steps necessary to evaluate

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[398] John Gillie, "Lies, say women, of WSH charges", *The News Tribune,* Tacoma, WA (June 30th, 1977); Mottram, "The story of a child molester".

[399] H. K. Beecher, "Ethics and Clinical Research", *The New England Journal of Medicine,* in *Bulletin of the World Health Organization* 79, no. 4 (2001): 367-72. Jonathan D. Moreno, "Goodbye to All That: The End of Moderate Protectionism in Human Subjects Research", *The Hastings Center Report* 31 no. 3 (2001), 11-15; Bradford H. Gray, Robert A. Cooke and Arnold S. Tannenbaum, "Research Involving Human Subjects", *Science* 201 no. 4361 (1978), 1094-1095.

[400] di Furia, "On the Treatment and Disposition of Sexual Offenders", 631; MacDonald et. al., *Treatment Of the Sex Offender: Ten Years,* 8.

the treatment's results or give much thought to how the offender might be impacted behaviorally or mentally in the long-term by the self-guided group sessions. As will be discussed in greater detail later, the program made few serious inquiries into treatment efficacy of the group approach. The end of the self-published reports marked the end of this information's appearance elsewhere. The few surveys taken focused on the offender's change in the Minnesota Multiphasic Personality Inventory across their time in the program and re-offense on release.[401] The use of this metric alone is questionable as clinical data. Staff took positive comments and appraisals from former group members at face value and reiterated them to the popular press as a sign of success.[402] The program never attempted to find out if any problems besides sexual crime emerged after an offender's graduation. The "experiment" effectively never ended. The program was not confronted for these gaps by any scientific or academic community. Only Washington's efforts to evaluate the program and actively sought the opinion of Dr. Kellogg, Dr. McGovern and other psychiatrists from 1979 on.

The program was not communicative with the larger academic community, but the academic literature of the time does hold a tentative insight into the program's philosophy. The program literature seemed extremely confident that sex offender treatment was a sure bet, and that there was no question some sort of therapeutic intervention would reap dramatic benefits for the program. This may be because the majority view in psychiatry held that sexual offenders were low-recidivism criminals.

[401] Nichols, "Effect of treatment of the habitual sexual offender as measured by the Minnesota Multiphasic Personality Inventory", 4-5; Williams, *Community Adjustment,* 1-2.
[402] Wojtech, "The Unmasking of a Sexual Psychopath", 2; Wojtech "This Is The First Time Anyone Bothered To Give Me Some Hope…";

Kenneth G. Gray and Johann W. Mohr wrote in *Sexual Behavior and the Law* that "The low rate of recidivism for sexual offenses in general has long been recognized.... "[403] Atascadero Hospital listed a rate of 14% recidivism for male homosexual pedophiles and 7% for male heterosexual pedophiles.[404] The belief in a "one-time" offender was shared by members of the criminal justice policymaking community. Sol Rubin, a counsel for the National Council on Crime and Delinquency, states that "of all types of criminals, sex offenders have one of the lowest repeater rates [sic]...."[405] These arguments were not accepted wholesale. Gebhard's 1965 study of sexual offenders complained that the existing recidivism studies only surveyed imprisoned offenders, which skewed against offenders who didn't get caught a second time. He therefore made no claims on recidivism compared to other criminals and demanded further study in the area.[406] These doubts, however, were the minority in the field. The program staff similarly believed that sex offenders were an especially treatable sort of criminal. If a man was captured before his habits became too entrenched and redirected from the negative environment of prison, they thought his chances for meaningful change were good.[407]

The believed certainty of help, however, did not preclude the possibility of harm. Questions about informed consent were more prescient at the Western State program than in most other circumstances. The overwhelming majority of program

[403] Kenneth G. Gray and Johann W. Mohr, "Follow-Up of Male Sexual Offenders", in *Sexual Behavior,* ed. Slovenko, 745.
[404] ibid, 749.
[405] *Psychiatry and Criminal Law*, 90-91.
[406] Gebhard, *Sex Offenders,* 709-711.
[407] *The Sex Offender: Safe to Be At Large?* KWSC-TV; MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 8.

initiates sought to join the program to avoid jail. Many also wanted to stop their behavior, but avoiding jail was the primary concern for most offenders upon their entry.[408] MacDonald, in the 1968 report, noted that the majority of those committed to the program were declared sexual psychopaths with criminal charges pending a trial. Those who had not been charged frequently had struck a deal with the state prosecutor in advance of an indictment.[409] Therefore, those who left the program would rarely return home without a court battle, if not a certain jail sentence. The staff argued that the offender was not placed under undue stress in choosing the program or prison. The "fork" of a hospital stay or jail time was the reality of the offender's continued wrongdoing.[410] If they wished to return to court, they were encouraged to say so. The staff wanted no one kept in the program without their consent. Further, the demands on treatment involvement with offenders meant they (supposedly) largely controlled what was happening in therapy. They were not "guinea pigs", but "co-participants" in an investigation of the possibilities of group therapy. Leadership granted them influence in what they did while in therapy well beyond what most test subjects receive.[411] The program staff were far more concerned with offenders who sought an "easier" term than jail and the offenders that the courts refused to withdraw from the program.[412] They were much less concerned about the possibility that the program did psychological damage, and never investigated the long-term effects of their approach. No participant

[408] Brecher, *Treatment Program,* 14-15.
[409] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years,* 11.
[410] Brecher, *Treatment Program,* 16; Hendricks, *Some Effective Change Inducing Mechanisms,* 7; Williams, *Characteristics and Management,* 4.
[411] *Guided Self-Help: A New Approach… July 1973-June 1974,* 8.
[412] Wayne Kilbourne, "Editorial Comment on Program" (November 24th, 1970).

brought a case against the program for being less effective than "advertised" or for causing long-term emotional harm.

The lack of supervision was coupled a lack of academic analysis in general. In April of 1971, the program was awarded a Significant Achievement Award by William Ogle, on behalf of the APA. His reasoning was simple: "You people happen to have put together the elements of correction, education, and medicine… It is cheap. It is good. It works."[413] Tellingly, his knowledge of the program had come from a personal visit. When that award was granted, only three nationally available articles had been written about the program. All had been written by program staff, and two were part of di Furia and Mees' first batch of articles on the program and were well out of date.[414] The fourth and last article for five more years arrived in 1972.[415] No full-length outside analysis of this program was made before Brecher's 1978 report. One mention of the program, from an article criticizing Atascadero, has been quoted earlier in the paper. This was one of a handful of "national" mentions found before the turn of the decade.[416]

The reason for the coverage deficit was multifaceted. The first and most important factor was the staff's focus on maintaining the support of local law

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[413] *Guided Self-Help: A New Approach To Treatment of Sexual Offenders, Annual Report July 1973-June 1974*, Western State Hospital, Fort Steilacoom, WA (1974): 9.
[414] These works are Giulio di Furia, "On the Treatment and Disposition of Sexual Offenders", *Northwest Medicine* 65 no. 8 (1966), 629-32; Giulio di Furia and Hayden L. Mees, "Legal and Psychiatric Problems in the Care and Treatment of Sexual Offenders (a National Survey)", *American Journal of Psychiatry* 120 no. 10 (1964), 980-85; and George MacDonald and Giulio di Furia, "A Guided Self-Help Approach to the Treatment of the Habitual Sex Offender", *Hospital & Community Psychiatry* 22 no. 10 (1971), 310-3.
[415] Emily Hitchen, "Denial: an identified theme in the martial relationship of sex offenders", *Perspectives in Psychiatric Care* 10 no. 4 (1972), 152-159.
[416] Michael Nasatir et. al., "Atascadero", 45. The other two found were William Borders, "TV: 'The Sexual Offender: Safe to Be at Large?', *The New York Times* (July 22nd, 1966), 45, a review of the documentary, and Emily Hitchen, "Denial: an identified theme in the martial relationship of sex offenders", *Perspectives in Psychiatric Care* 10 no. 4 (1972), 152-159, which discussed the program's couples-therapy sessions.

enforcement.[417] Academic approval was irrelevant if the program lost the trust of the criminal justice system that supported it. Therefore, from the beginning, the program prized local support over national psychiatric approbation. In 1965, Dr. Mees gave presentations on the program not to academic groups, but to the Pierce County Bar Association.[418] "Close working relationships" with judges, prosecutors and probation officers were cultivated by sending frequent status updates on individual offenders and "regular" statistical updates and status reports.[419] The staff toured counties with slide projection presentations to "advertise" the program to courts that gave it little attention. The program even invited "a few probation officers and… superior court judges" to visit and "live" in a group for a few days to experience the program firsthand.[420] Maintaining contact with dozens of people about hundreds of cases took up time that could have been used to research, write and publish reports for an academic audience. Interested parties who couldn't visit the hospital were limited to mailed "program descriptions" of a few pages, and copies of their assorted self-written and published reports.[421]

The second reason was the scattershot state of sex offender literature at the time. As previously stated, only a handful of independent researchers visited the Western State program before 1979. This was the norm for sex offender treatment programs at the time. Western State was undiscussed because the field in general made few clinical enquiries. The first journal dedicated to child abuse, *Child Abuse and Neglect*, did not

[417] *Guided Self-Help: A New Approach… July 1973-June 1974*,
[418] Hannula, "Roots of Sex Wrongs".
[419] MacDonald and Williams, *The Washington State Sexual Psychopath Law*, 2-3.
[420] MacDonald and Williams, *The Washington State Sexual Psychopath Law*, 2-3.
[421] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 7.

begin until 1975, and criminal sexual behavior was not given its own journals until the end of the decade. Accordingly, no "formal mechanism" for programs and researchers in the field to communicated with one another existed "until the 1980's". In an article in *Commonwealth* magazine, Dr. Barbara Schwartz, a renowned expert in sex offender treatment, described her introduction to the field:

> "[In 1972], as a mental health clinician in Albuquerque, NM, [Dr. Schwartz] was asked to compile a study of how other states treated sex offenders. She laughs when recalling her resulting report… "The literature was one half page," she says. She could find only one program in the country even touching on the subject." - Commonwealth, "A Question of Commitment".

This lack of knowledge was partially a problem of communication. Research and discussion of the sexual offender continued in the 1960's and 1970's, even after the profession had backtracked on the "sexual psychopath". The efforts were small, but their results were considered significant enough for publication. Numerous articles appear on the treatment of sexual offenders in both general journals, such as *International Psychiatry Clinics,* and in specialized organs, such as the previously-mentioned *International Journal of Offender Therapy and Comparative Criminology* and *Federal Probation*.[422] Gebhard's mammoth 1965 work *Sex Offenders: An Analysis of Types* combined the results of a mammoth survey of convicted felons with assorted psychological explanations for the development of the impulse to molest or rape.[423] It did not describe any treatment methodologies besides individual therapy. A handful of

[422] Abel, Levis, and Clancy, "Aversion Therapy Applied to Taped Sequences of Deviant Behavior in Exhibitionism and Other Sexual Deviations: A Preliminary Report", *Journal of Behavior Therapy and Experimental Psychiatry* 1 no. 1 (1970), 59-66; Frisbie, "Treated Sex Offenders"; Resnik, H L, and M E Wolfgang. "New Directions in the Treatment of Sex Deviance." *International Psychiatry Clinics* 8, no. 4 (1971): 211-26.
[423] Paul H Gebhard et. al., *Sex Offenders: An Analysis of Types*, Harper & Row, New York (1965).

academic studies considered recidivism. These reports gave a small degree of attention to existing rehabilitation programs. [424]

Even this research, however, received little attention. It was also almost entirely theoretical, or, as in Gebhard's case, statistical exploration of sex offender psychology. To give another example, the *International Journal of Offender Therapy…* had a symposium on the treatment of "sexual offenders" in its second issue of 1972.[425] The definition of "sex offender" was used broadly to mean anyone in violation of laws on sexual behaviors, including prostitutes and (outside the U.S.) pornographers. Over the 77 pages, no practical approaches are described at all. Some of the observations are about patients the practitioner encountered in a rehabilitation program, but the program itself is not discussed.[426] The offender's treatment environment, in an ironic reversal of the milieu understanding, was not discussed.

Only the rare piece, such as H.L. Resnik and M.E. Wolfgang's *New Directions in the Treatment of Sexual Deviance,* broke this pattern and analyzed the practice or results of sexual offender treatment.[427] These more "practical-minded" surveys were rare. Reports that described a program's day-to-day operations, such as the 1966 report on Atascadero, were rarer still.[428] What works did detail offender treatment appear to

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[424] Louise Viets Frisbie, "Treated Sex Offenders Who Reverted to Sexually Deviant Behavior", *Federal Probation* 29 no. 2 (June 1965); Murray L. Cohen and Harry L. Kozol, "Evaluation for Parole at a Sexual Offender Treatment Center", *Federal Probation* 30 no. 3 (Sept. 1966).
[425] Various Authors, *International Journal of Offender Therapy and Comparative Criminology* 16 no. 2 (1972): 99-176.
[426] S.W. Engel, "From the Heidelberg Criminological Institute: A Case Report", *International Journal of Offender Therapy and Comparative Criminology* 16 no. 2 (1972): 138-139; Melitta Schmideberg, "A New Treatment Model: The Successful Rehabilitation of an Israeli Prostitute", *International Journal of Offender Therapy and Comparative Criminology* 16 no. 2 (1972): 143-146.
[427] H. L. Resnik and M. E. Wolfgang, "New Directions in the Treatment of Sex Deviance", *International Psychiatry Clinics* 8, no. 4 (1971): 211-26.
[428] Nasatir et. al., "Atascadero", 31-32.

have been state-funded, state-published research, such as Louise Frisbie's 1969 analysis of California's sex offender treatment initiatives.[429] These works received little academic notice and were difficult to locate. What programs existed had great difficulty ferreting out information about who was attempting treatment, let alone what these other programs were doing. Edward Brecher's 1978 survey noted that program administrators were "without exception astonished" to hear that twenty programs existed at the time. Most had believed there were only a handful.[430]

The dearth of literature did not mean the program was wholly unknown. A Wisconsin "sexual psychopath" treatment program inside Waupun State Prison used the Western State SOTP as a successful example while asking the state legislature for a non-prison inpatient facility of their own.[431] In 1974, another program, the Behavioral, Emotional, and Attitudinal Development program, was begun at Minnesota Security Hospital, taking its approach verbatim from Western State, with explicit credit.[432] In general, however, the program received little attention in the academic literature. Through the mid-seventies, legal critique of the sexual psychopath commitment statues and psychoanalysis of the "generalized" offender dominated what little literature there was on the psychology and treatment of the sexual offender. Western State, despite its local prominence, a nationally-syndicated television documentary and a lauded, distinct approach, remained under the professional radar.

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[429] Louise V. Frisbie, *Another Look at Sex Offenders in California,* Bureau of Research and Statistics Monograph 12, Department of Mental Hygiene, Sacramento, CA (1969).
[430] Brecher, *Treatment Programs,* vii; Schwartz, "Overview", 363.
[431] Brecher, *Treatment Programs,* 78.
[432] ibid, 45-46.

As there was no academic effort to investigate the program, the program's documentation was limited to what it wrote itself. A flurry of self-published reports were written by the program staff in the first half of the 1970's. The first of these was MacDonald and Williams' 1968 summary of the program's history and current position. It was written to "pull the past together", give a coherent description of the program's therapeutic target, and describe in brief the program's development.[433] This was followed by biannual reports on the program in general, and a half-dozen reports written on particular aspects of the program, irregularly published. The biannual reports were intended for figures in the justice system and the government. They focused on costs, program population, and other demographic information rather than treatment philosophy or specific clinical practice. The other articles were primarily intended for clinicians and focused on treatment philosophy, methodology, and attempts to gauge the program's results. Due to the lack of outside documentation, much of the available information on the program at this time was only documented in these self-published papers.

The staff's reports had serious problems. Like the documents from the Mees and di Furia era, the self-published reports of the MacDonald era described and discussed only the principles immediately applicable to their program. Only one document, Hendrick's *Some Effective Change Inducing Mechanisms in Operation in The Specialized Treatment Program For The Sex Offender* (1973), was an exception. The reports did not attempt to compare the program to others, did not attempt to square it with criminology generally. Much of the reports were simple description, with little

[433] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* Introduction.

analysis or explanation. Only one, Nichol's "Effect of treatment of the habitual sexual offender as measured by the Minnesota Multiphasic Personality Inventory", conducted anything like an experiment, with a control population, a research goal and clear, explicit data.[434] The majority conducted some quantitative analysis of the population statistics, but it was overwhelmingly focused on resident population demographics. The number of offenders in the program is important information, but it is not a substitute for This statistical analysis left a lot to be desired. For example, MacDonald and Williams' 1968 retrospective states that according to "hospital records", the program's recidivism rate was only 8.9%. They give no other information whatever – how long they followed an offender after release, what qualified as "recidivism", the sample size, or any other essential information.[435] Even simple practical investigation was rare. The mechanics of running an inpatient program for treating sexual offenders were left to the reader's imagination. No report surveyed or studied the actual state of the group membership's accountability to each other and the group, the group member's ability to interact with women, or other program objectives in any fashion outside of Dr. Nichol's personality testing. The program, in aggregate, did not try to determine if the program's efforts resulted in the changes it sought in the offender.

A closer look at one report helps illustrate these problems. David C. Hall, a therapy supervisor, wrote a report on the experimental use of group psychotherapy marathons among one group of the program in 1970.[436] The marathons were described

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434 Nichols, "Effect of treatment of the habitual sexual offender as measured by the Minnesota Multiphasic Personality Inventory".
435 MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 8.
436 Hall, *Group Psychotherapy,* 1.

as "tri-monthly...20 to 30 hour limited encounter sessions devoted to the voluntary revelation and exploration of serious emotional conflicts…"[437] The goal of these sessions was to concentrate on the building of trust and intimacy between the group members, via group confessions. The offender was more emotionally vulnerable in these long meetings. Exhaustion, tension, and to no small extent boredom pushed him to volunteer more about himself and his feelings to his fellows.[438] The length of the session meant that all the offenders would have the time to bare their souls to those assembled. These confessions were hoped to be inroads for other offenders to learn about one another, and perhaps about themselves. By this reflection, Hall postulated the group would form deeper emotional connections. Hall believed that a closer emotional bond would result in more effective group therapy. If the offender cared for the others in his group, he would take their recommendations and censures in later, regular sessions to heart. He'd similarly invest more of himself into the rehabilitation of others, to help them with their problems. The impact of the group sessions would, theoretically, be greatly improved.[439] He conducted a number of group marathon sessions to test his hypothesis.

Hall's account was extremely lacking by any standard. The whole report was only three pages, one of which was devoted to an introduction that recapitulated the principles of the program writ large. No description of a marathon session was given. The actual success of his approach was not measured in any quantitative or qualitative way. The four perceived benefits of the technique, presented in a list, are only supported

[437] ibid, 1.
[438] Hall, *Group Psychotherapy,* 2.
[439] ibid.

by assertion and arguments to the program's theoretical underpinnings.[440] The report stated the intent of the technique for a paragraph, then flatly commented that it accomplished those things, without saying how, or why he thought the technique had shown its success. The logistics of holding such a long therapy session were not described, despite the numerous obvious problems it poses. The obvious problem of exhaustion is touted as a means to wear down the offender's defenses. What to do when the interrogator is falling asleep as well is not addressed, and techniques for the therapy supervisor to use in such a mammoth In an offhand remark, Hall noted the marathons were particularly useful in teaching the offenders "approaches and techniques" for therapy that they can apply to their group sessions. He mentioned this as though it needed no introduction. Mention of offender "training" could only be found in one other document, and it did not describe it in any detail, either.[441]

The report concluded with Hall's considerations about the possible problems with the marathon approach. Critique was rare in the program's reports, and Hall's cautionary analysis was a welcome note of concern. Hall's thrust is that the offender's vicious confrontation of one another did not guarantee that the group faced the reality of a victim's pain, or realized they could change.[442] A group member was, by a certain phase in their treatment, used to detailing their offenses to each other. Their confessions, Hall argues, could be more commiseration than revelation. The repeated

[440] One of these four asserted benefits was less than convincing. Hall asserted that an "unsatisfactory encounter" in the marathon session could be "pursued further in regular sessions." A negative encounter from a regular session can also be revisited in a later session. There is no need for a twenty-hour session to attempt to parse a conversation that started on the wrong foot.
[441] Program Policies (Revised June 1976)", p. 2, attachment to a Memorandum, George Macdonald to Giulio Di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry".
[442] Hall, *Group Psychotherapy,* 3.

unearthing of their crimes may have been propagating a sense of shared guilt and fundamental wrong in the offender, reaffirming him that he was a “bad boy” who would always be damaged, always be distant from others. Fifteen hours of parading his faults and finding them reflected in others may only have underlined his identification of themselves with his wrongs. Further, if they did find greater intimacy with their fellows in a shared experience of pain, they may have simply absorbed the pleasure from it, rather than any lessons. "...A group emotional orgasm [Hall’s own words] can be little more than an extension of the self-defaming behavior involved in his deviant pursuit of sexual gratification".[443] When some of the group is not involved in this moment, which Hall attested happened in every session, then they feel alienated, frustrated, and confused – the same stressful feelings that had fueled their offenses. Even in a group theoretically dedicated to their treatment, certain offenders still felt “left out”.

Hall acknowledged these faults and recommended that "limits [be] set to curtail” how much offenders could relish the pleasure of their alienation. He did not describe what those limits might be, even in a general sense.[444] Hall underestimated the problems he raised with this criticism; they struck at the heart of the program’s treatment philosophy. The possibility that the group therapy approach facilitated confession, not change, applies logically to the use of a group therapy approach regardless of the session length. A later outside report stated that marathon sessions were used to “focus on” a particular member.[445] That is not mentioned here, but regardless, the principles underpinning these sessions and the program at larger were the same. Therefore, the

[443] Hall, *Group Psychotherapy*, 3.
[444] Hall, *Group Psychotherapy*, 2.
[445] Denenberg, “Sex Offenders Treat Themselves”, 62.

possibility that the program engendered talk, not action, permeates the broader course of therapy that the program pursued. The program was potentially teaching offenders only how to corral their emotions to a "safe" place of discharge, of confession, which lightened their emotional burden but made little impact on their perpetuation of violent crimes. It was not rehabilitation, only therapy. Hall saw this objection coming but made no effort here to address it. He seemed to assume that the program was not obligated to assure Washington of its efficacy and that his concerns could be resolved later.

These reports, in short, were largely glancing blows on the actual efforts the program was undertaking on a day-to-day basis. In this case, marathon sessions as an actual therapeutic practice remained largely a mystery to the reader, and much of what it described about the program raised more questions than answers. The staff were aware that their reports had serious deficits. To a certain extent, this was because program staff wrote them in their "spare time". Before the significant hiring spree in 1971, the amount of spare time the administration had was extremely small.[446] The presence of only two research personnel hindered the program from undertaking more involved, precise projects. This does not excuse, however, the paucity of information the final reports contained. The staff defended themselves on the grounds that the program was a treatment center, rather than a research facility:

> "The Center has a definite philosophy about research and program evaluation activities. First, the Center believes that its primary reason for existence is the better protection of society through effective treatment of offenders, and therefore research activities should be consistently

[446] H.R. Nichols, "Effect of treatment of the habitual sexual offender as measured by the Minnesota Multiphasic Personality Inventory", WA Dept. of Health and Social Services, Steilacoom, WA (1971): Preface.

> directed toward practical improvements in the treatment process rather than the pursuit of academic or scientific recognition…"[447]

Their argument would hold water if they had proven their preexisting method of treatment successful. The lack of even earnest inquiry into offender recidivism, however, make the argument ring hollow. Practical improvements of a treatment method which is ineffective is a zero-sum effort. While the reports were better than no analysis at all, their numerous blind spots and lack of follow-up study put them below the standards of scientific inquiry. The program was narrated, not analyzed.

William's 1971 *Community Adjustment of Treated Sex Offenders* delivered the first formal survey of recidivism made by the program, a survey plagued by many of the same problems as the reports in general. Williams followed twenty-four offenders designated "safe to be at large" and conditionally released as program graduates between January 1st, 1968 and June 30th, 1970. Seventy-five percent of those released had been charged with assorted offenses against minor females. Only two offenders apiece who had raped adult women or molested minor males were counted, while the remaining two were exhibitionists. This data on what patients were likely to see release is no Williams underlined that the re-offenses had been primarily with exhibitionist offenders, for exhibition offenders. There had been no rearrests for violent assault and child molestation. He concluded that "society's prime concern" were being effectively managed by the program.[448] The very small sample size of this report and its lack of long-term follow-up were not noted. Williams appeared to believe the primary concern

[447] *Guided Self-Help: A New Approach… July 1973-June 1974*, 7-8.
[448] Williams, *Community Adjustment*, 2-3.

would be whether or not the survey was successfully caught all re-offenses, which he assures the reader it did: "…Program staff are fairly confident that the data is valid, because of the very close surveillance of the men by the program and probation officer during their first year of conditional release."[449] In time, the questions that the program staff left unanswered would return to haunt them.

In some of these reports, there is a figure listing the number of offenders that biennium who were sent back to court with recommendations for community release, without treatment or incarceration. This category seems beyond the hospital's authority to demarcate, but in keeping with their general reticence, only one of the reports explained why this option existed. The hospital was *not* recommending anyone be released without a jail term or treatment of some kind. The "Community Release" classification was instead the program's classification for the non-correctional commitment of offenders to other programs. The other programs were not sex offender treatment – there was almost no sex offender treatment elsewhere in the state, public or private. It was also not the immediate graduation of the offender to the outpatient portion of the hospital's program. Rather, it sought to offer a non-jail option for sex offenders with mental health or substance abuse problems that were not amenable to treatment by the program's method. Offenders referred to the program for observation were evaluated in three areas:

-Were they a sexual psychopath?
-Were they amenable to treatment?
- Were they safe to be at large?[450]

[449] Williams, *Community Adjustment,* 2.
[450] Williams, *Characteristics and Management,* 20-21.

T.P.S.O

WEEKLY SCHEDULE

MON	10:30-12:00	Clinical Staff Conference**
	1:30-2:30	Daily Conference*
	3:00-5:00	AFTERNOON MEETING
	5:00-7:00	Recreation
	7:00-9:00	EVENING MEETING
TUES	9:00-10:00	Job Placement Meeting
	10:00-12:00	Program Policy Meeting
	1:00-2:00	Daily Conference, with Volunteers*
	2:00-4:00	AFTERNOON MEETING, WITH VOLUNTEER WORKERS
	4:00-5:00	Afternoon Meeting Rehash*
	7:00-8:30	Dance
	6:30-10:00	MARRIED COUPLES GROUP THERAPY MEETING
WED	10:30-12:00	Clinical Staff Conference**
	1:30-2:30	Daily Conference*
	3:00-5:00	AFTERNOON MEETING
	7:00-9:00	EVENING MEETING
THUR	9:00-11:00	Senior Staff Meeting**
	1:30-2:30	Daily Conference*
	3:00-5:00	AFTERNOON MEETING
	5:00-7:00	Recreation
	7:30-10:30	OUTPATIENT GROUP THERAPY MEETING
FRI	1:30-2:30	Daily Conference*
	3:00-5:00	AFTERNOON MEETING
	7:00-9:00	EVENING MEETING
SAT	8:00-12:00 AM	Recreation (2 hours per Group)
	7:00-9:00	Movie
SUN	9:00-11:00	Optional Recreation
	7:00-9:00	EVENING MEETING

*Attended by group leaders and/or staff and selected general and trial members.

** Attended by staff only.

NOTES

MEALS 6:30-8:15, 11:00-1:00, 4:30-6:15

JOB ASSIGNMENTS Weekdays 7:30-11:30
12:30-2:00

DAILY CONFERENCE Group leaders and 1 general or trial member with clinical staff Supervisor of group.

GROUP THERAPY MEETINGS These meetings are the pivotal point of treatment for all patients in whatever phase of treatment. They are conducted by the patients themselves with close daily guidance and assistance of staff. (They amount to a minimum of twenty-five hours per week per patient.) Likewise work and recreation is conducted with the same self-help approach with staff guidance.

AFTERNOON, EVENING MEETINGS The core meeting of program. Attended by all general members, group leaders, and trial members who have completed Data Sheets and Autobiographies.

CLINICAL STAFF CONFERENCE Program Director and all clinical staff.

JOB PLACEMENT MEETING Group leaders, staff advisor and Industrial Therapy.

SPECIAL MEETINGS OF GROUP Can be called at any time by any member to handle any problem needing immediate attention.

(Rev. 11/74)

Figure 6: a weekly schedule of the program. From *Guided Self-Help: A New Approach To Treatment of Sexual Offenders, Annual Report July 1973-June 1974,* Western State Hospital, Steilacoom, WA (1974), "T.P.S.O Schedule", 21.

The first two questions were folded into one four-class system. If the hospital found the offender was a sexual psychopath amenable to treatment, then they were eligible for the program. If they fell into the other three categories, they were disqualified from the program. It was the designation used to "screen" those considered ill-suited for the program out of it. The third qualification, however, was different. The hospital superintendent could state to the court that, in their opinion, the offender was or was not safe to be at large. If the latter, the offender would be directed either back to court or into the program, depending on the finding of the previous two questions. If the

former, the hospital suggested the court to acquit the offender of their charges and release them into the community either with or without supervision. This was not just a theoretical possibility. Of 140 offenders evaluated from January 1968 to June 1970, 109 were classified as "not safe" and necessitating some sort of intervention, 18 were classified as "safe with community supervision and treatment", and three were classified as "safe to be at large" outright.[451] This phenomenon received little comment in the program's material. It was a point of such little concern that, as of 1971, "the Center [had] no… system of feedback to learn whether the committing courts followed [their] recommendations [of release] …"[452] To the Center's credit, these were suggestions, not decrees, and the court had the choice to overrule their decision if they believed the Center mistaken. "Informal feedback indicate[d]" that, overall, the program's suggestions were followed for at least the majority of the 21 offenders in question.[453] The majority of these offenders, according to one source, were senile elderly, chronic alcoholics, or offenders with a developmental disability. The "confrontational" approach of the program was irrelevant, as these offenders were not fully aware of their actions and could not engage with others or control themselves. They needed a different form of treatment. What "treatment programs" or "supervision" existed to assist these offenders was not described. One source vaguely states they were "appropriate community treatment facilities". Most likely, these offenders were sent to facilities explicitly designed for their particular problem, be it alcoholism, dementia or something else, that had the security to handle escape-risk clients. Whatever it was,

[451] Williams, *Characteristics and Management*, 21.
[452] ibid.
[453] ibid.

program authorities thought it sufficient and used it with double-digit percentages of offenders through the end of the decade.[454]

There was one notable therapeutic method tested in the program that MacDonald did not explore. In 1965, Dr. Mees conducted an experiment in "aversion treatment" on an offender. "Unpleasant stimulation" was used over 13 weeks in 1965 to change a patient's "sado-masochistic masturbatory fantasies…to normal heterosexual ones". The full report cited in the paper was never published. No later report mentions this experiment in aversive conditioning.[455] Mees was ahead of his time. This unpublished report is one of the earliest mentions of aversive conditioning with a sex offender in the clinical literature, and perhaps the first within a codified treatment program. Papers describing experiments in conditioning human beings with aversion therapy appeared sporadically from the 1940's on, but they were generalized to all sorts of behaviors. In the 1960's, behavioral psychologists became very interested in reconditioning homosexual men, seeking to make them heterosexual. A number of studies, some quite comprehensive, were undertaken. Pedophiles or rapists, however, did not get the same attention by other conditioning practitioners until the early 1970's, and those efforts took until the end of the decade to reach wide acceptance.[456]

Despite the promising result initially shown, MacDonald chose not to pursue aversive conditioning. The program's failure to capitalize on Mees' innovation was

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[454] Denenberg, "Sex Offenders Treat Themselves", 60; MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, "Statistical Report", 9; Williams, *Characteristics and Management*, 24.
[455] di Furia, "On the Treatment and Disposition of Sexual Offenders", 631.
[456] David A. Crawford, "Treatment Approaches with Pedophiles", in *Adult Sexual Interest in Children*, eds. Mark Cook and Kevin Howells, Academic Press, London (1981), 192-193; Charles E. Colson, "Olfactory Aversion Therapy for Homosexual Behavior", *Journal of Behavior Therapy and Experimental Psychiatry* 3 no. 3 (1972), 185-87; Nathaniel McConaghy, "Aversive and Positive Conditioning Treatments of Homosexuality", *Behavior Research and Therapy* 13 no. 4 (1975), 309-19.

uncharacteristic, considering his success and the generally experimental environment of the program. It was the result of the program's change in treatment goals during MacDonald's ascendance. Mees' experiment took place at the end of di Furia's tenure. At that time, the "deviant desire" of the offender was thought a product of his negative mindset. Their desire was a very literal outgrowth of their internal maladjustment. It had no staying power of its own. Making offenders understand how their violations hurt others would make the offenses unappealing, and the offender's need to resort to violation would fade as they adopted a healthier self-understanding.[457] As the "group" approach cohered under MacDonald, desire and mindset were increasingly divorced from one another. Di Furia's understanding was still correct: the desire to violate others grew from a negative self-image and a mindset of rejection. However, as it became entrenched in habit, it took on a life of its own. It was not satisfying, but it was, for that moment, pleasurable. The staff considered desire something that was beyond the capacity of the group to eliminate: "the program has learned that most offenders will continue to have deviant desires [through and after] treatment".[458] Desire was more diffuse and non-negotiable than the practical evidence of behavior that it left. Building a will within the offender to stop their negative actions was considered a more achievable goal. Attempting to dull particular deviant stimuli would start a task – eliminating deviant desire – that could not be finished. Following the Mees experiment, MacDonald made a complete commitment to the patient self-help group as the sole mode of therapy. Attempts to uproot the offender's deviant desire directly were set aside for the decade,

[457] di Furia, "On the Treatment and Disposition of Sexual Offenders", 631.
[458] MacDonald, *Treatment Of the Sex Offender: Ten Years*, 7; Williams, *Characteristics and Management*, 26.

and the strategy of conditioning did not come back on the program's radar until 1981. Ironically, it was this delay in beginning aversive conditioning that made the program a target of later criticism.[459]

MacDonald thought the program was revolutionary. In his view, "[our] so-called 'behavior modification' treatment approach [was] in absolute contrast to the [standard] psychoanalytic approach" that dominated the analyst's understanding of the offender.[460] Writing the reports, the staff laid a lot of emphasis on the originality of Western State's treatment modality.[461] di Furia had already claimed their program was unique, and he and MacDonald would continue to claim their program was the only one of its sort in the country through the mid-seventies.[462] These claims became increasingly inaccurate over the 1960's. Atascadero attached themselves to the "therapeutic milieu" understanding as quickly as Western State did, and from the available history on similar programs in New Jersey and Pennsylvania, it seems that group therapy for offenders was in fact very common.[463] This is not to say the program was not a major pioneer in the field. The program's choice to have offenders lead the sessions was truly novel, and few programs had such frequent sessions coupled with an intensive outpatient program. By 1968, Dr. Geraldine Boozer had solidified a program in Florida which explicitly

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[459] Kellogg et. al, *Report to the Secretary,* 7; Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 26-28.
[460] MacDonald et. al., *Treatment Of the Sex Offender:* Introduction.
[461] MacDonald et. al., *Treatment Of the Sex Offender,* 7; Wojtech, "The Unmasking of a Sexual Psychopath", 1.
[462] Paul Henderson, "Sex offenders – Doctor defends unique group therapy program", *The Seattle Times,* April 20th, 1974.
[463] Brecher, *Treatment Programs for Sex Offenders,* 49-50; Cole, "From The Sexual Psychopath Statute to "Megan's Law"", 297-299; Joseph J. Peters et. al., "Group Psychotherapy of the Sex Offender", *Federal Probation* 32 (September 1968), 41.

copied Western State's modality, down to the principle of resident leadership.[464] In general, however, these claims of originality speak more to the staff's ignorance through the 1970's of programs elsewhere than of the actual state of sex offender treatment.[465]

The program slowly moved from regional attention to scattered national interest. As previously stated, discussion of this program was nearly nonexistent in the professional literature. Other clinicians, however, were interested in learning about its approach, and wrote the program directly. One letter came from Dr. Rogers, the director of Health and Rehabilitative services in Florida, in August 1972. MacDonald responded with a collection of reports and an invitation to tour, tagged with his succinct summary of the program: "…it works, it is as cheap or cheaper than prison, and it is duplicable."[466] Dr. Rogers was invited to send a member "or two" of his staff to tour and to write again if he had any further questions.[467] A woman in British Columbia wrote to Williams, and he sent her a collection of documents and invited her to a full day tour of the facility.[468] This resulted in a visit from "representatives of the Canadian Government". At times, the visit was a mutual exchange: a treatment program in Minnesota sent a consultant for a seminar on sex offender treatment.[469] The discussion of the program was, through this period, limited to this kind of change.

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[464] ibid, 23-24.
[465] Brecher, *Treatment Programs,* vii.
[466] George J. MacDonald to W.D. Rogers, September 14th, 1972. Western State Hospital, Division of Mental Health, Department of Social and Health Services.
[467] ibid.
[468] Robinson A. Williams to Marie Weeks, July 11th, 1972. Western State Hospital, Division of Mental Health, Department of Social and Health Services.
[469] *Guided Self-Help: A New Approach… July 1973-June 1974,* 7.

The program's explosion in population rapidly taxed staffing levels. As early as 1968, staffing was "critical[ly short]". For the care itself, the problem was easily fixed by the addition of "only one or two [more] trained clinical staff".[470] However, the "secondary" efforts of "program development, evaluation, research and interpretation" required at least two new dedicated professionals in MacDonald's view.[471] He suggested that this be undertaken by patient graduates - "one...to work with the outpatients, parole staff and community agencies....[and] two others...to work as research aides..."[472] However, there was no follow through on their request until 1971, when the state finally allotted it a substantial budget increase to hire more staff. MacDonald and Williams wrote to the Department of Social and Health with a considered proposal. The program did not want a proportional increase in staff numbers. While some support staff were necessary, the numbers could be drastically less than a "normal" psych ward. MacDonald and William's proposal, in fact, asked for three fewer ward attendants and the reduction in hours of one nurse from their previous allotment.[473] The offenders were expected to take care of themselves, their living space, and monitor one another. They did not need staff to do it for them, and to have staff do it for them would derail attempts to make the offenders more personally responsible. Therefore, MacDonald and Williams instead sought to proliferate the number of staff therapists, giving each group a dedicated staff leader. MacDonald and Williams,

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[470] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 8-9.
[471] ibid.
[472] MacDonald et. al., *Treatment Of the Sex Offender: Ten Years*, 8-9.
[473] George J. MacDonald to Robert Walsh, memorandum, February 26th 1971, "Personnel Needs, Treatment Program for the Sexual Offender", Steilacoom, WA, Washington State Archives, Department of Social and Health Services - Division of Adult Corrections 1970-1981 Collection, Subgroup Subject Files, Box 48, Accession No. 03A205.

however, considered the qualification and duties of the state position classifications previously used too divergent from the actual job to continue their use.[474] "Psychologists" and "Psychiatrists" were trained to deal with the disturbed, not the maladjusted, and "Psychiatric Social Workers" were overqualified to work at the level the position demanded.

To fill the needs of the program, the two wrote their own, new classifications for "Therapy Supervisors".[475] The duties of their new classification differed in principle and in practice from most therapy positions. To reiterate, in the Western State program, the initiative for treatment was laid with the individual. The Therapy Supervisors did not create detailed psychological profiles of each offender and did not conduct individual therapy. They did not even attend the majority of group sessions. The other residents, gathered in group, were the offender's "therapists" and inquisitors, and he was, in turn, theirs. The new therapy supervisors had to be good organizers who could, alongside their resident group leader, guide their specific group's reformation. They had to be intimately familiar with the members of their group and assist in their progress as best they could. The four tiers of the position were divided "according to the degree of responsibility" the therapist undertook. For example, a Therapy Supervisor II needed a B.A. degree with a behavioral or social science major, and a year of experience as a Therapy Supervisor I or experience within a similar group program. A Therapy Supervisor IV needed a M.A. in the "clinical field" and three years of clinical experience.[476] With these classifications, MacDonald and Williams sought to intensify

[474] MacDonald to Walsh, "Personnel Needs", 7-8.
[475] ibid, 1-2.
[476] ibid, 3, Calendar.

the group dynamic by adding additional oversight, as well as keep costs at the low levels the program had maintained for a decade.[477] The program staff and Superintendent di Furia wrote to an ascending line of Division of Mental Health officials over three months, asking that their new classifications be accepted. It took directly appealing to Dr. William Conte, the then-Deputy Secretary of the DSHS and a long-time supporter of the program, to gain approval.[478]

MacDonald had a secondary aim with introducing these new classifications. He wanted to hire program graduates to work with the program full-time. His reasoning was the same that endorsed a "self-help" group in the first place: "it takes one to know one".[479] MacDonald strongly believed that the input and presence of the other residents was essential to the program's success. They were personally familiar with a maladaptive cycle of sexual abuse. More importantly, they were personally familiar with the difficulties of living with their guilt and living a lie. They could look into the daily life of another and find, in certain behaviors and attitudes, the same doubt and uncertainty that had driven them to violate other people.[480] He took this point to its logical conclusion: the right offender could lead rehabilitation as well as any trained professional. di Furia and Mees had believed in this as well, but it was not until MacDonald that the program began hiring graduates.[481]

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[477] MacDonald to Walsh, "Personnel Needs", 1, 4; Williams to Conte, "Personnel Situation", 2; *Guided Self-Help: A New Approach To Treatment of Sexual Offenders, Annual Report July 1973-June 1974,* 4.
[478] Giulio di Furia to Robert J. Shearer, memorandum, March 17th 1971, "Personnel Needs, Treatment Program for the Sexual Offender", Steilacoom, WA, DSHS Subgroup Division of Adult Corrections Accession No 03A205 Box 48; Robinson A. Williams to William R. Conte, memorandum, June 8th, 1971, "Personnel Situation, Treatment Program for the Sexual Offender", Steilacoom, WA, DSHS Subgroup Division of Adult Corrections Accession No 03A205 Box 48;
[479] *01* Interview Transcript, 19; Denenberg, "Sex Offenders Treat Themselves", 54.
[480] Williams, *Characteristics and Management,* 20.
[481] di Furia, "On the Treatment and Disposition of Sexual Offenders, 630.

Before the revision of classifications, there were few positions which the standard offender was qualified for. The only position a graduated offender was qualified for, provided they had sufficient schooling, was Hospital Attendant or Clinical Aide, and there were at least two offenders hired as such before the new classification scheme was implemented.[482] For most, the program instead allowed them to volunteer. Their labor was limited to clerical duties such as typing reports and tabulating figures. Some of those who did these jobs were listed as contributors on the reports.[483] With the new classifications of Therapy Supervisors, MacDonald made the goal of having graduates lead residents in therapy a reality. It took a little while, however, for this goal to be fulfilled. The program first employed them as full-time research assistants and statisticians, positions that amounted to extensions of their previous clerical work on reports, as such labor was rightfully thought "desperately needed".[484] When this need was satisfied, he recruited program graduates to serve as therapy supervisors. Any program graduate with a high school diploma was eligible to become a Therapy Supervisor Aide. Those who did well in the position were encouraged to return to college. From there, they were only limited in their advancement by their ability to progress in higher education.

Of the graduate-employees, the most prominent was Larry R. Hendricks. He went through the program shortly after Williams arrived as associate director. Upon his graduation, he started working in the program as a Clinical Aide, and completed a

[482] MacDonald to Walsh, "Personnel Needs", 3.
[483] MacDonald et. al., *Treatment of the Sex Offender: Ten Years*… was co-authored by "Douglas S".
[484] *01* Interview Transcript, 20-21.

Bachelor of Arts degree at a local college "by way of in-service training".[485] As he gained experience, he moved further up the ladder, and by 1973, he was a Therapy Supervisor II in charge of his own group.[486] By 1977, he reached Therapy Supervisor III and was appointed the director of the *Lifeboat* drug offender program. His contributions to the program went beyond major professional positions. He was also the sole program graduate to independently write a published paper on the program. His 1973 work, "Some Effective Change-Inducing Mechanisms in Operation in the Specialized Treatment Program for the Sex Offender", was one of the program's series of self-published reports. Unlike the others, it was a standalone, serious work that attempted to place the program's methodology within contemporary academic literature of sociology and criminology. Hendricks related the then-popular formulation of "out-group" psychology to the understanding of sexual offense employed by the Western State program.[487] The paper broke from the program's general non-interaction with the more "abstract" conceptualizations that dominated academic discourse. Further, it was one of the best reports the program produced. For MacDonald, there couldn't have been a better example of the program's promise than Larry Hendricks.

The program's focus on group leadership was maintained even with the ramping population. In 1973, the program saw a record number of escape attempts. MacDonald established a committee to deliberate on what measures to implement. As before, resident leaders and group representatives were included alongside program staff.

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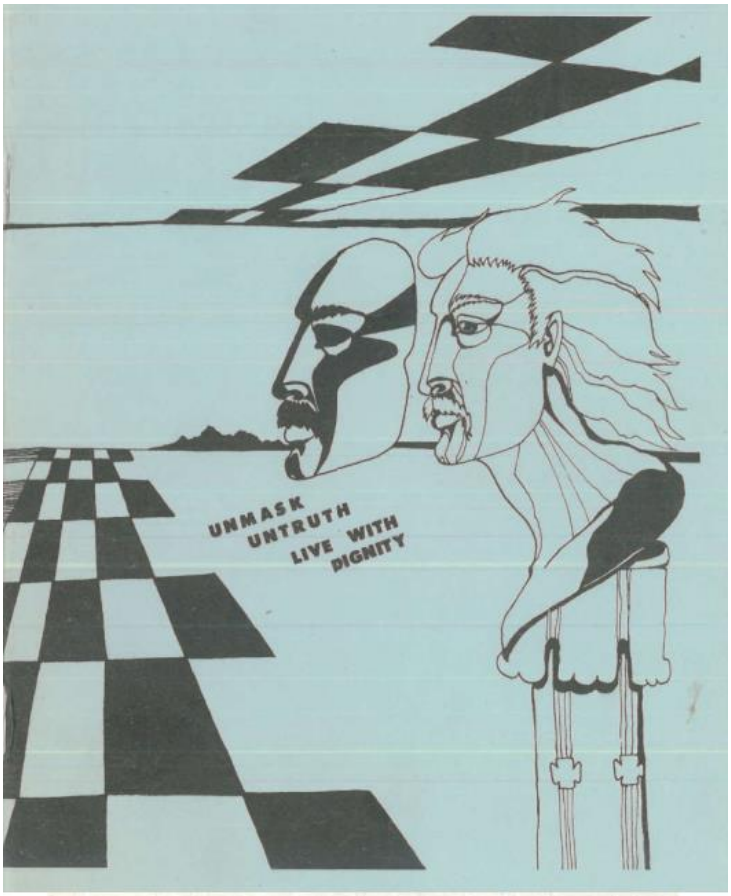
[485] "Annual Report, July 1st 1969 – June 30th, 1970", Western State Hospital, Steilacoom, WA (1970), 2.
[486] *Guided Self-Help: A New Approach To Treatment of Sexual Offenders, Annual Report July 1973-June 1974*, Western State Hospital, Fort Steilacoom, WA (1974), Staff Directory.
[487] Hendricks, *Some Effective Change Inducing Mechanisms.*

Collectively, they decided not only to change some protocols but to make a significant change in the operation of the program. The group ultimately created the "buddy" system.[488] The system was simple: offenders were to be accompanied by another resident at almost all times, including any trips off the ward. The policy was far-ranging. Work release on other wards was done with a buddy. The offender's group leader or another "buddy" was present for a resident's meetings with their group's therapy supervisor.[489] The buddy system was not foolproof: on several occasions, two or more residents would conspire to escape together, biding their time until they were dispatched as "buddies".[490] In general, however, the buddy system was extremely effective. It dramatically improved security, cutting the escape rate by 80% in three years and gave the individual offenders more perspective on the treatment of their fellows.[491] The degree of group oversight within the program was so intense that some commentators accused the group of fostering a 1984-like "groupthink" in the offenders. The staff argued that this level of intervention was necessary to make the offender change his ways, and that no lesser intensity would suffice.[492]

[488] MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, Statistical Report, 3.
[489] ibid; Gildenhar, "Rehabilitation issue".
[490] Denenberg, "Sex Offenders Treat Themselves", 61.
[491] Program Policies (Revised June 1976)", p. 5, attachment to a Memorandum, George Macdonald to Giulio Di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry".
[492] Brecher, *Treatment Programs,* 16.



Please accept our home as your home. We hope your stay in our community will prove a growing and positive experience.

P.S. As Janis Joplin once said, "GET OFF YOUR BUTT AND FEEL THINGS".

Figure 7: The cover and concluding note of a handbook for new residents of the Mentally Ill Offender program. The cover text - *Unmask Untruth, Live With Dignity* - was a program motto. From *Mentally Ill Offender Unit Observation / Evaluation Unit Handbook,* Western State Hospital, Steilacoom, WA (d.uk.).

Confidence in the program's approach was strong, and MacDonald soon got his wish of applying the program's method to other groups of offenders. The first of the program's offspring was born in Spring of 1973. It was a modified form of the program intended for the seriously mentally ill. Dr. Donald Allison was enlisted as the head psychiatrist, while MacDonald remained its director, making him the clinical director of

the legal offender programs at the hospital generally.[493] The Mentally Ill Offender Program, as it was called, had the same guiding principles as the SOTP. The practical application was modified, however, due to their mental health problems. "Confrontation" within "mini-socie[ties]" of ten residents, overseen by a therapy supervisor, remained the core of the group's therapy.[494] Residents progressed through a levels system as their behavior and understanding, in the group and therapy supervisor's judgement, improved.[495] According to *01,* these groups had significantly less autonomy.[496] The ability of the group to "make its own rules" and moderate the progress of its members was limited by the abilities of its highest-functioning members, who were automatically designated leaders by the therapy supervisors.[497] This difference in level, however, was not a shift in character. The primary internal target of alienation and inferiority and the therapeutic means of reaching that target remained the same as the sexual offender program. The justice system had confidence in the program. It started with just over twenty residents, but in a year had grown through transfers and commitments to sixty, and its population would land near a hundred by the end of the decade.[498]

MacDonald also sought to make good on his aim to bring the best-qualified offenders out of corrections and into the program. This short-lived initiative by the program, which allowed qualifying inmates serving jail sentences to be admitted for

[493] Robert Mottram, "Criminally Insane get treatment at Western State", *The News Tribune,* Tacoma, WA (November 11th, 1973); *01* Intervew Transcript, 14.
[494] Mottram, "Criminally Insane…" (November 11th, 1973).
[495] Charles Morris to Milton Burdman, memorandum, April 19th, 1974, "Facilities and Program for Mentally Ill and Sexual Offenses – Progress Report", 2.
[496] *01* Intervew Transcript, 14.
[497] ibid.
[498] Morris to Burdman, "Facilities and Program…", 8.

observation, ended up having serious consequences. MacDonald had complained since the first major reports that the most qualified offenders with the greatest chance of reformation and success were being diverted from the program. In the early years of the program, however, he chose not to conduct outreach, and claimed that an increase in the resident population couldn't be supported with the program's standing funding.[499] As the program continued to grow, he seemed to lose this reserve, and began to advocate for the enrollment of specially selected prison inmates in the program. The 1974 Annual Report begins its section on security with a bold challenge to sentencing procedure: "The fact that courts are still sending about 15% of convicted sexual offenders directly to prison without benefit of the 90-day observation indicates that some prosecutors and judges choose not to utilize the obvious advantages of the sexual psychopath statue in certain cases." The staff knew a number of those sent straight to prison were grossly unsuited for treatment, but protested that "some potentially good treatment candidates" were being lost behind bars, where they would harden into sure recidivists.[500] MacDonald's needling eventually got him his wish, and a batch of offenders were sent to the program in 1973.

MacDonald's push to allow convicts into observation, however, ran into a major procedural barrier. As previously discussed, after 1967, the superintendent could not remove an offender they deemed unsuitable for treatment from the program without a court's permission.[501] In addition, all offenders who had been convicted had to go

[499] MacDonald et. al., *Treatment of the Sex Offender: Ten Years*, 14-15.
[500] *Guided Self-Help: A New Approach To Treatment of Sexual Offenders, Annual Report July 1973-June 1974*, Western State Hospital, Steilacoom, WA (1974): 3.
[501] Bob Donohoe, "No help for WSH officials this year", *Suburban Times*, Lakewood, WA (May 15th, 1985).

before their committing court for the final approval of their parole or work-release placement. As their sentences were suspended, this was a rarely a problem. For these new offenders who transferred to the program from prison, they had to go before their parole board without this suspended sentence, leading to major discrepancies between their prison release date and what the hospital would prefer.

In one instance, a "Mr. Wilson" was being held in Washington State Penitentiary on a 7 1/2 year minimum term for a rape conviction.[502] He was admitted to Western State in March 1973 for observation as a sexual psychopath, and the staff found him an ideal candidate.[503] He entered the program, performed well, and was certified "safe to be at large" and ready for work release by the Senior Staff Committee in July 1974.[504] His parole board, however, denied the hospital's request to place him on work release, as it was before he was due to have his next meeting with the parole board.[505] Writing back, Mr. Williams asked what reason had compelled them to reject the decision.[506] The board's Chairman responded three months later with an extremely vague letter that reaffirmed their decision was final and implied that Mr. Wilson was "not a fit subject for release". The Chairman noted that Mr. Wilson was still six years from his earliest date of parole under his original sentence. An abridgement of that time was implied to be unacceptable. He concluded by asking that in the future, a parole

[502] Larry Hendricks and George MacDonald to Tom Rolfs, memorandum, June 5th, 1973, "RE: [Mr. Wilson], Classification No. 128092", Public Institutions – Institutions – Western State Hospital – Box 26, Washington State Archives, Accession No. 02A565.
[503] Hendricks and MacDonald to Rolfs, "RE: [Mr. Wilson] …", Accession No. 02A565.
[504] Larry Hendricks and George MacDonald to Bruce Johnson, memorandum, July 16th, 1974, "RE: [Mr. Wilson], No. 128092", Public Institutions – Institutions – Western State Hospital – Box 26, Washington State Archives, Accession No. 02A565.
[505] Robinson A. Williams to Bruce Johnson, memorandum, August 14th, 1974, "RE: [Mr. Wilson], No. TR 128092".
[506] Williams to Johnson, "RE: [Mr. Wilson] …", Accession No. 02A565.

meeting for transfers such as Mr. Wilson be rescheduled upon his entry into the program, to time with their expected graduation.[507]

The troubles with procedure, however, rapidly faded into memory, as the single worst event in the program's history ended the initiative immediately. In January 1974, a resident named James Ruzicka escaped. While on the lam in Seattle he committed two rape-murders, then committed a rape in Portland before being captured. The escape and its aftermath were the program's first of three public relations disasters in the 1970's, and it left the greatest public impact of the three. James Ruzicka was first admitted to the program for observation in March of 1973. He was one of the transfers from Corrections. He had been found guilty of the attempted rape and assault of an adult.[508] During his time in the program, he maintained sufficient perceived progress to reach level four, which gave him escort privileges for offenders working on other wards.[509] He walked away at 9 A.M. on January 31st, 1974, while escorting others to their work assignments.[510] At this point in the program, according to *01,* there was "no policy to notify Mental Health, DSHS or the public [about an escape], because there was still a sense… nine out of ten times, [they'd come] back."[511] When the staff realized he was missing, they began a search of the grounds and notified Superintendent di Furia. Di Furia, according to previous example, did not tell the police until hours after Ruzicka's escape. Ruzicka went to Seattle, where he killed two teenage girls in Seattle in

[507] Bruce Johnson to Robinson A. Williams, memorandum, November 8th, 1974, "RE: [Mr. Wilson], # 128092", Public Institutions – Institutions – Western State Hospital – Box 26, Washington State Archives, Accession No. 02A565.
[508] *01* Interview Transcript, 16; Robert H. Mottram, "New WSH probe sought", *The News Tribune,* Tacoma, WA (March 28th, 1974).
[509] *01* Interview Transcript, 15.
[510] Henderson, "Sexual Offenders", *The Seattle Times.*
[511] *01* Interview Transcript, 15.

February, then fled to Portland, where he sexually assaulted another girl before his capture.[512]

Shortly after Ruzicka's recapture, another terrifying crime spree compounded the program's problems. In March, the first news stories broke detailing a puzzling series of kidnappings in the Seattle area. The disappearances all had the same suspect, who drove a Volkswagen and targeted college-age women with a ruse about a broken arm. Lacking a solid lead, Seattle police sought to collect relevant files from the SOTP program to see if any former program members "fit the bill", and to interview current program members for further information. A 1973 law temporarily denied law enforcement access to either source, infuriating the police and creating further bad press for the program.[513] Western State quickly reached an agreement with law enforcement about the files, but the damage was done.[514] The kidnappings, later revealed to be killings, remained unsolved for years. Suspicions lingered that the SOTP had "harbored" the killer, meaning that the killer was one of the program residents committing his crimes while on work release, or that he had been caught and placed in the program on a different charge and was biding his time, letting the trail run cold. Almost a decade later, the spree was found to be the work of Ted Bundy. He was never affiliated with the program in any capacity. The news arrived too late, however, to clear the air.[515]

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[512] Bill Ripple, "No 'Ruzickas' in WSH now", *The News Tribune*, Tacoma, WA (d.uk.).
[513] Paul Henderson and Ross Anderson, "Files of sex criminals closed to police", *The Seattle Times* (August 4th, 1974).
[514] Ross Anderson, "Police will get psychopath data in missing-woman case", *Seattle Times* (August 16th, 1974).
[515] Denenberg, "Sex Offenders Treat Themselves", 61; *01* Interview Transcript, 23.

The last decade of attempted positive public relations by the program were instantly torched.[516] The public seized on the perceived laxity of the program's security and demanded the state investigate the hospital. A legislative hearing was held in February, followed by an investigation by the House Social and Health Services Committee into the program in April. It found that from July 1973 to February 28th, 1974, there were seven escapes from the program, including Ruzicka.[517] While only Ruzicka's escape had such horrific results, the quantity alarmed outsiders. The Committee Chairman, Representative A.A. Adams, demanded that "…something has to happen. There has to be better security on these people."[518] A *Seattle Times* article pointed asked, "Should a potentially dangerous sex offender be placed in an institution that has little or no prisonlike security?"[519]

The program began a dual-pronged response to the bad PR of the Ruzicka escape. The program had obviously known the potential security issues. In newspapers, they first apologized for putting the public at risk. A *Seattle Times* reporter asked di Furia "what went wrong", and he demurred "What can I say?...We are reviewing every step of his program here...".[520] Then, the program sought to create own positive PR.[521] A flurry articles appeared shortly after the Ruzicka case in the *News Tribune* that sought to present the "good side" of the program to the public. One emphasized the program was not "soft" on offenders, another stated that more dangerous, escape-prone offenders

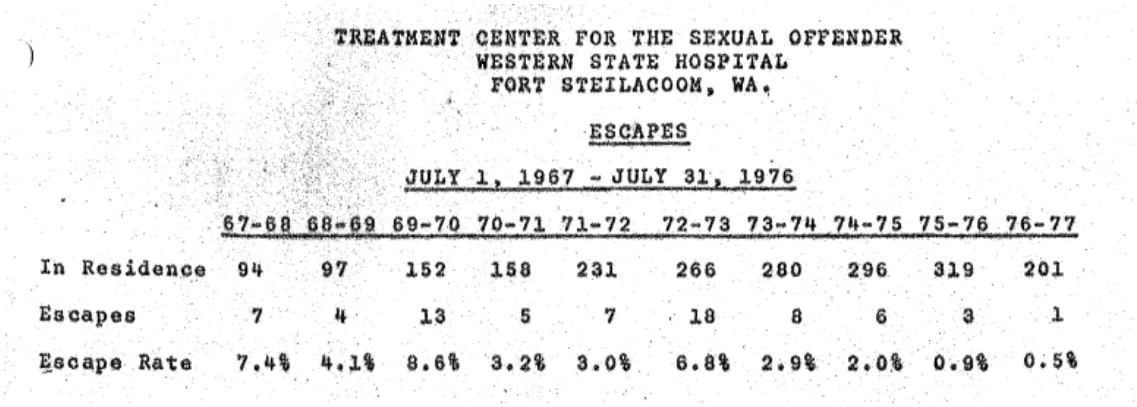
[516] Denenberg, "Sex Offenders Treat Themselves", 61; *Guided Self-Help: A New Approach To Treatment of Sexual Offenders – Annual Report, July 1973-June 1974,* 8.
[517] Denenberg, "Sex Offenders Treat Themselves", 62.
[518] Mottram, "New WSH probe sought".
[519] Henderson, "Sexual Offenders", *The Seattle Times.*
[520] Henderson, "Sexual Offenders", *The Seattle Times.*
[521] *Guided Self-Help: A New Approach To Treatment of Sexual Offenders – Annual Report, July 1973-June 1974,* 8.

would be monitored more closely from now on, and another gave a first-person narration of a sex offender's rehabilitation.[522] *01,* in our interview, said that the legal offender programs appointed a former therapist as a "kind of a PR man". Another source suggested this person may have been Sid Acuff. Whoever, exactly, he was, he was tasked with engaging local media, asking them to come to the program and describe it to the public as it functioned day-to-day. That way, as opposed to the occasional horror story of an escape, locals would be familiar with the program as it operated on an everyday basis.[523] Governor Daniel Evans helped their efforts by chiming in with support to various local media outlets. "If you want to get to…no failures, the answer is permanent high security. But that in itself would be a failure. There would be no hope [of rehabilitation]".[524]

This spin campaign, which played up the possibility of rehabilitation to the public, was the program's primary response. Staff made few changes following the Ruzicka escape of their own accord. The issue was, to them, exaggerated. The program staff noted that the escape rate had dropped since the introduction of the buddy system in 1973. Escape was a rarity that demanded reevaluation of the residents and their therapeutic process, but no great changes to the therapeutic method or to the program's protocol.[525] The public's outcry was generally dismissed as ignorant and reactionary. An internal memo on escapes gave their timeline of their response to the Ruzicka

[522] Henderson, "A pothole in psychopath's long road"; Mottram, "The story of a child molester"; Ripple, "No 'Ruzickas' in WSH now".
[523] *01,* Interview Transcript, 23; Gillie, "3 flee WSH drug program".
[524] Denenberg, "Sex Offenders Treat Themselves", 61.
[525] "Program Policies (Revised June 1976)", 3, attachment to George Macdonald to Giulio Di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry".

fiasco. The first line is: "1-1974 to 5-1974: The public expressed concern about escapes."[526] Williams spoke of "dramatic" but rare escapes as an inevitable aspect of running a meaningful, successful program.[527] To change the program drastically in response to a rare event would curtail the ability of the offenders to treat one another with little gain. The program's choice to hold the line was in general supported by the rest of Western State Hospital. di Furia remained a firm believer in the program and its methods, and advocated for the outfit whenever possible.[528] The April 1974 *Fort Retorter*, a Western State Hospital staff newspaper, ran a piece supporting the program's staff in the wake of Ruzicka escape, rhetorically calling for a "kinder" media portrayal.[529]



TREATMENT CENTER FOR THE SEXUAL OFFENDER
WESTERN STATE HOSPITAL
FORT STEILACOOM, WA.

ESCAPES

JULY 1, 1967 - JULY 31, 1976

	67-68	68-69	69-70	70-71	71-72	72-73	73-74	74-75	75-76	76-77
In Residence	94	97	152	158	231	266	280	296	319	201
Escapes	7	4	13	5	7	18	8	6	3	1
Escape Rate	7.4%	4.1%	8.6%	3.2%	3.0%	6.8%	2.9%	2.0%	0.9%	0.5%

Figure 8: A table of the escape rate over a decade of the program. This "typed", heavy photostat look is typical of the internal documents surrounding this program. Also notice the ballooning population. From "Program Policies (Revised June 1976)", p. 3, attachment to a Memorandum, George Macdonald to Giulio Di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry", Western State Hospital – Treatment – Box 93, Washington State Archives, Accession No. 95A213.

[526] "Program Policies (Revised June 1976)", p. 3, attachment to George Macdonald to Giulio Di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry".
[527] Denenberg, "Sex Offenders Treat Themselves", 62.
[528] Henderson, "Sexual Offenders", *The Seattle Times.*
[529] *Fort Retorter* 1, Issue I, Western State Hospital, Steilacoom, WA (April 12th, 1974): 2.

The program staff did believe that some sort of response was necessary to an escape, less from a security angle than a therapeutic one. Ruzicka had managed to conceal his intent from his fellow residents, even his group, who supposedly was familiar with his pattern of offenses and his individual problems. The group clearly needed to reevaluate how it conducted itself, and evaluate how their "honest and open" discussion had deteriorated.[530] They decided on a procedure they called "grounding".[531] Grounding was the program's equivalent to a correctional facility's lockdown. All residents were confined to their ward, work release was suspended, visitor privileges were limited, and an escorting aide was required for any non-leader offender to leave the ward.[532] The schedule was strongly tightened. Breakfast was brought to the group. After they ate, they entered group sessions with occasional breaks for the rest of the day.[533] While the group worked through the issues in their method, they postponed their regular self-analysis and halted step progress.[534] The therapy supervisor would be presented for these sessions, evaluating their findings. The group would eventually create a coherent presentation that stated why they believed the therapeutic environment had decayed and what changes in approach and procedure they would take to fix them. If their supervisor and the senior staff agreed with their conclusions, they would be allowed off grounding. If not, it continued.[535] No previous escape had been met by such restrictive measures. In characteristic fashion, these groundings had a clear procedure

[530] *Guided Self-Help: A New Approach… July 1973-June 1974*, 3.
[531] *01*, Interview Transcript, 16.
[532] John Gillie, "3 ousted from sex program", *The News Tribune*, Tacoma, WA (April 23rd, 1976); Larry R. Hendricks and Giulio di Furia, "Lifeboat: A therapeutic community for the incarcerated drug offender of Western State Hospital", Western State Hospital, Steilacoom, WA (1977), 21, 23.
[533] *01*, Interview Transcript, 17.
[534] *01*, Interview Transcript, 17.
[535] ibid.

and character, but were wholly informal. There was no written policy on how and when to conduct them at any point in the program's history.[536] The procedure attempted, and largely succeeded, to make a restriction imposed from above a challenge that the group would have to collectively meet. It was not simply discipline, but an avenue for the group to conduct even more introspective analysis. The staff were satisfied by the results of "grounding" in the Ruzicka case, and for the rest of the program's life, "grounding" would become the default response to a serious breach of conduct or an escape by a group.[537]

The public's concern about security was strong enough that the DSHS was ordered by the legislature to investigate the program. The department conducted an internal review. The review itself could not be located, but a summary was found in a memo between Morris and Burdman, two DSHS officials. The DSHS gave the program their enthusiastic approval. Its innovation and apparent success in "reaching" offenders on an emotional level was applauded. There was little actual analysis of the treatment modality in the summary – more of a general approbation of the program's efforts. The review's findings on program security, which were presented separately, were also very positive. The use of residents as door monitors was thought a success. It cut down on staff requirements while bolstering the therapeutic goal of self-reliance. The buddy system was thought a natural extension of this principle and similarly praised. Since the measures "[had] not been abused", the DSHS saw no reason to order a change.[538] The

[536] Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 42.
[537] "Program Policies (Revised June 1976)", 3, attachment to George Macdonald to Giulio Di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry".
[538] Morris to Burdman, "Facilities and Program…", 5.

DSHS mainly sought small-scale "tightening" of previously existing measures and better communication between the program and law enforcement in the event of an escape.[539] The program's walking patrols and car surveillance were found lacking in practice, and the hospital was told to make this a continuous, rather than sporadic, security measure. They ordered the program to hire a new guard force. The group ultimately hired was unarmed and intended as a means of detection rather than enforcement. Headcounts were increased, first to three a day, then to one every four hours, including overnight.[540] The staff were instructed to no longer report an escapee as " 'discharged' … to those involved in apprehension", and to make no delay in contacting law enforcement when an offender was found missing.[541] The program was, effectively, asked to follow through on preexisting measures. The primary overseeing agency that was best positioned to demand changes from the program waved it on as it stood.

A few more concrete security reinforcements were floated by the Legislature, such as an eight-foot chain link fence surrounding the grounds. They never came to pass.[542] Program staff insisted that those barriers would negatively impact the program's morale and, correspondingly, the efficacy of its treatment.[543] They also pointed out that the rest of the hospital was still a hospital, and that a high fence would negatively impact the rest of the patient's treatment. When $200,000 was apportioned for the

[539] Morris to Burdman, "Facilities and Program…", 6-7.
[540] Denenberg, "Sex Offenders Treat Themselves", 61; Morris to Burdman, "Facilities and Program…", 5-6; "Program Policies (Revised June 1976)", 2, attachment to George Macdonald to Giulio Di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry".
[541] Morris to Burdman, "Facilities and Program…", 5-6.
[542] Bill Ripple, "No 'Ruzickas' in WSH now", *The News Tribune,* Tacoma, WA (d.uk.).
[543] ibid; Henderson, "Sexual offenders", *The Seattle Times*; Denenberg, "Sex Offenders Treat Themselves", 61.

construction of a perimeter fence in the 1975-1976 legislative session, the "top management" of the DSHS intentionally let the money rot.[544] The most significant Post-Ruzicka change relating to the program was undertaken by an agency wholly unrelated to the program. The Deputy Director of Community Services ended transfer of correctional inmates to the program in October 1974, ending the program's initiative in treating correctional transfers for good.[545] The program's self-concocted grounding system was, from then on, the official default response to an escape attempt or a serious breach of program policy for the next decade. The Washington State government, pressured by the public, did not yield. The program carried on.

George MacDonald had first taken the lead when the program was in crisis. Working with Robinson Williams, he had dramatically changed the program's focus and expanded its treatment methodology. The changes impacted the program to the extent that he was often labeled by the DSHS "the architect" of the program proper.[546] His changes were massive improvements. He struck a balance between the self-managed therapy group and its directing staff in evaluating the group's results without compromising its principles. The reports suggested staff had a great deal of confidence in the program as it stood and sought to keep the program as close to what it had been both with its security and its treatment policies. While MacDonald made these changes, he remained committed to di Furia's original model: creating a space where the offender was held accountable by others for their actions. His tenure, however, was

[544] Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 62.
[545] Ted M. Wilson to Leo Schmiege, Memorandum, November 15th, 1974, "RE: I.D.T. Transfers Sexual Offenders".
[546] ibid, 13.

largely successful “on credit”. The program’s cavalier attitude, unchallenged by the state and unimpeded by public concern, would prevail for the next half-decade with mixed results.

Interlude: A Day in the Life of an Imaginary Resident, 1976

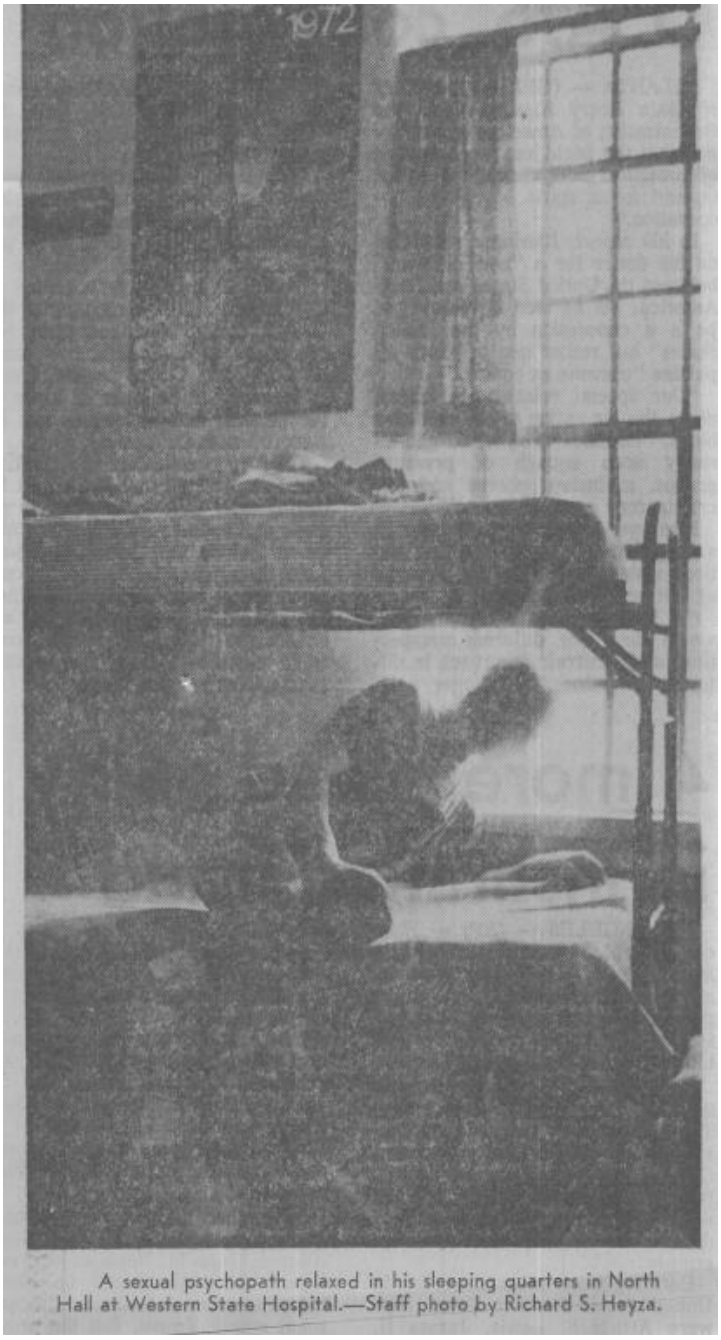


Figure 9: A program resident reclining on his bunk. From Paul Henderson, "Sex offenders – Doctor defends unique group therapy program", *The Seattle Times* (April 20th, 1974).

At 6 A.M. on a Thursday in 1976, a convicted child molester, "Adam", was awoken. He had dreamed a schoolteacher humiliated him in public for molesting a student of his. He made a mental note to bring it up in the afternoon group session. The group member assigned the task of morning rounds moved on to the next dorm.[547] The offender was just accepted to the program by his group, East Group, two weeks ago. He slept in its main dormitory, a sunroom. A group's sleeping arrangements differed, depending on the ward, but there were always spartan. Each offender had only a bed and a footlocker.[548] For most groups, which were on North Hall, the offenders stayed in bunk beds in large repurposed sunrooms. Some groups from the late seventies on stayed on wards in Central Hall, with two-men rooms down the corridor.[549] Some groups, like Star Group, had to make do with iron cots due to a lack of furniture.[550] Wards were generally large enough to hold more than Offenders who progressed to work release were given, space permitting, a private room in the "short hall". These rooms were extremely small. They had a bed, a chest of drawers and a nightstand. There was little room for much else.[551] None of the wards were designed to house offenders and were constructed and outfitted like institutional psychiatric wards of the era. Some wards had barred windows, but the program staff preferred to put the Mentally Ill Offender groups on these wards instead. The upside of the sunroom design was that he floor-to-ceiling windows were helpful in waking people up in the early mornings.

[547] Brecher, *Treatment Programs,* 15.
[548] *01* Interview Transcript, 9; *02* and *03* Interview Transcript, 3.
[549] ibid, 3.
[550] Brecher, *Treatment Programs,* 15.
[551] ibid.

Our offender, "Adam", choose his clothes for the day from his trunk before getting ready to shower. There was no uniform and a minimally prescriptive dress code, so he is free to wear what he wishes. In most regards, program residents were treated the same as other residents of the hospital. There were no "badges" or any other kind of distinction for staff or residents, and they were hard to tell apart on sight alone.[552] There was little privacy in the dormitory. Offenders could hang a sheet over their beds, but they were otherwise wholly open to observation by their dormmates, which was the intention.[553] Adam hurried to the large group showers to be ready for the 6:30 AM breakfast.

The offender's day was highly scheduled. Residents had different wake-up times depending on their "step" in the program and their job at the hospital, but most were expected to wake at 6:00 AM.[554] Breakfast was served at 6:30 AM. Adam went to the main cafeteria for breakfast with the rest of his group, escorted by his group leader. There was no staff escorting offenders around campus unless there was a need to move an "observation man" or a group was grounded.[555] He returned to the ward at 7:00 AM, giving him enough time to tidy their living space and complete any small chores before he goes on the clock at his work assignment.

On most weekdays, patients started their job at 7:30, broke for lunch at 11:30, and returned to work until 2:30 PM. This meant they worked thirty hours most weeks.

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[552] *01* Interview Transcript, 9; *02* and *03* Interview Transcript, 4.
[553] *01* Interview Transcript, 9.
[554] *Guided Self-Help: A New Approach To Treatment of Sexual Offenders – Annual Report, July 1973-June 1974,* 17; Denenberg, "Sex Offenders Treat Themselves", 61; Brecher, *Treatment Programs,* 15.
[555] Denenberg, "Sex Offenders Treat Themselves", 61.

He was, like most offenders, on the janitorial staff.[556] He had been confined to his ward for his duties while under observation. Now that he was a full member of the group, he went with his work partners to the male geriatrics ward, which was a welcome change.[557] While on the other wards, he got to know the patients and staff there. For Adam's group leader, their work assignment shift stopped at 1:30 so they could attend a one-hour "Daily Conference" with the Clinical Staff Supervisor. On their return from their work shift, the offenders had a little while to get prepared for their 3:00 PM Afternoon Group Therapy Meeting. Afternoon group sessions were focused on more "discussion" topics and procedural, intake work, such as hearing an "observation man" read their autobiography, but included layout and confrontations as well.[558] Once this was over, Adams received a small portion of free time, which allowed him to do whatever he needed or wished to before 5:00 dinner.[559]

After dinner, their activity depended on the day. On Monday, Wednesday, Friday and Sunday, there was an Evening Group Therapy Session for all patients, while on Tuesday and Thursday there were special sessions for married couples and outpatients, respectively.[560] Evening sessions started at 7:00 PM, granting an hour block of time after dinner on Tuesdays. On Mondays and Thursdays, there was instead mandatory recreation. Evening sessions were the time for "requests". These requests

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[556] MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, 3.
[557] "Program Policies (Revised June 1976)", 2-3, attachment to George Macdonald to Giulio Di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry"; Brecher, *Treatment Programs,* 19; Denenberg, "Sex Offenders Treat Themselves", 62.
[558] *Guided Self-Help: A New Approach To Treatment of Sexual Offenders – Annual Report, July 1973-June 1974*, Weekly Schedule; *01* Interview Transcript, 9; Denenberg, "Sex Offenders Treat Themselves", 59.
[559] "T.P.S.O. Weekly Schedule", Western State Hospital, Steilacoom, WA (1972).
[560] *Guided Self-Help: A New Approach To Treatment of Sexual Offenders – Annual Report, July 1973-June 1974*, 17.

were, quite literally, any request an offender wanted to make to the group. This included reinstating a privilege they had lost, taking away a privilege from an offender they thought was abusing it, seeking a change in work assignment, having a meeting with the Therapy Supervisor, and request for maintenance or materials, among many other things.[561] On the schedule, the Evening Group Session was two hours long. In actuality these sessions lasted until all the items on the agenda and on the offenders' minds were cleared, which often took the sessions an hour or more overtime.[562] On days without scheduled evening sessions, most residents met with their dormmates in voluntary "sit-in" sessions, discussing their problems amongst themselves from their bunks.[563]

As Adam went to sleep, he looked forward to the weekend. Weekends were more relaxed. He, and all other non-leaders, had no work assignment and few assigned activities. There were televisions on the wards and various recreation possibilities, including – thanks to the facilities' age – shuffleboard lanes. There was also a kitchen which residents could use to bake treats and small meals, if they wished. The groups were invited to join the rest of the hospital in watching a Saturday night movie. Westerns were a favorite.[564]

> "I really believe they felt a responsibility…[to] confront behavior if they saw [it]… If somebody was doing something they weren't supposed to be doing, then they'd have a special group. You could hear that ring out over the ward: "East Group, Special Group." And, they'd all come in, they'd have a meeting, and talk about what went on. And they genuinely, genuinely had a sense that they were responsible for each other and for each other's success."
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> - *01,* Interview Transcript, 6

[561] *01* Interview Transcript, 9; Denenberg, "Sex Offenders Treat Themselves", 61-62.
[562] Denenberg, "Sex Offenders Treat Themselves", 62; *01,* Interview Transcript, 8.
[563] Denenberg, "Sex Offenders Treat Themselves", 61.
[564] AP Wire, "The average sex offender may be the guy next door", A-5; Denenberg, "Sex Offenders Treat Themselves", 57; "T.P.S.O. Weekly Schedule", Western State Hospital, Steilacoom, WA (1972).

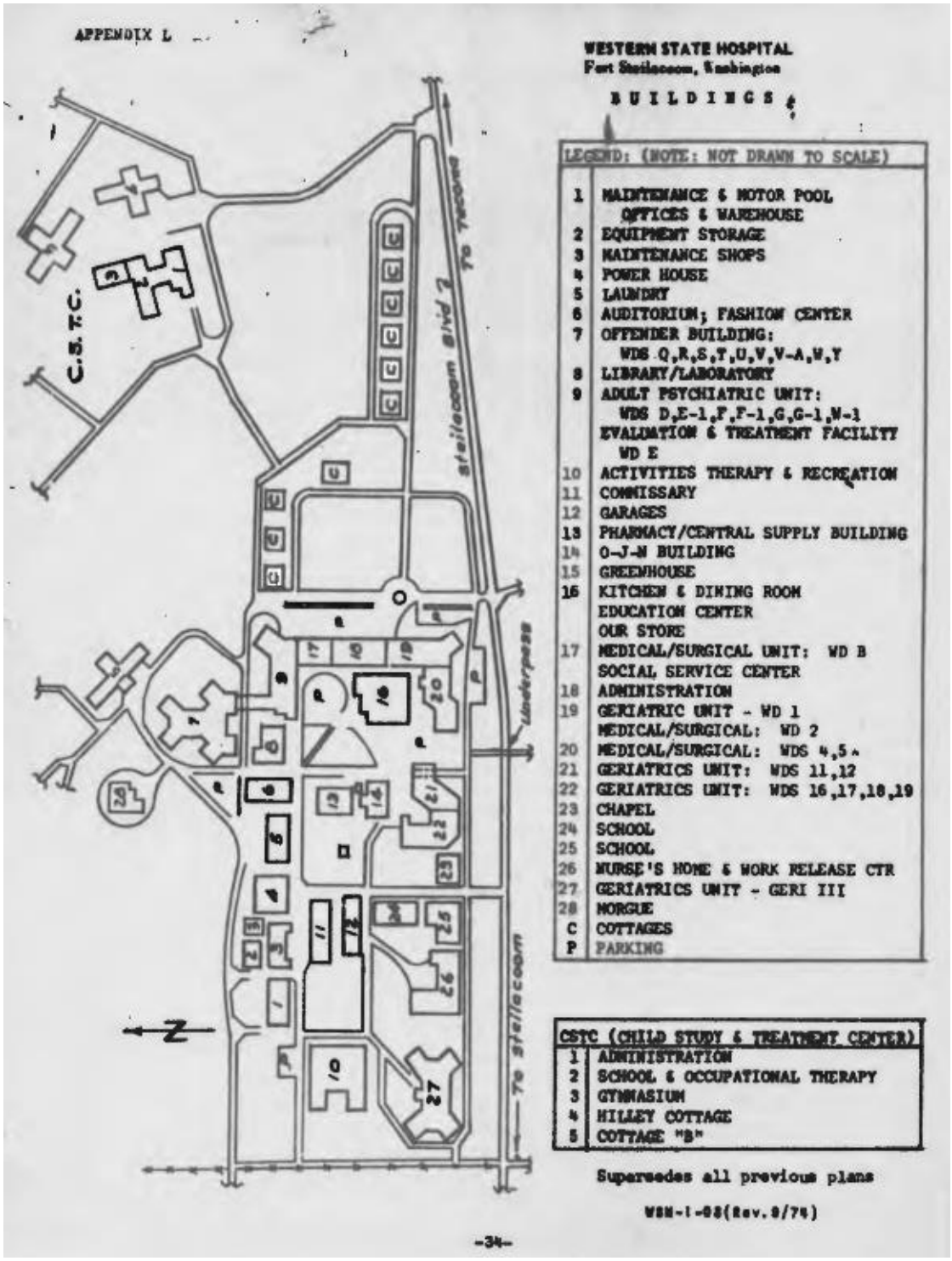

Figure 10: A map of the grounds of Western State as of 1977. In *Lifeboat: A therapeutic community for the incarcerated drug offender*, Western State Hospital, Steilacoom, WA (January 1st, 1977), 7.

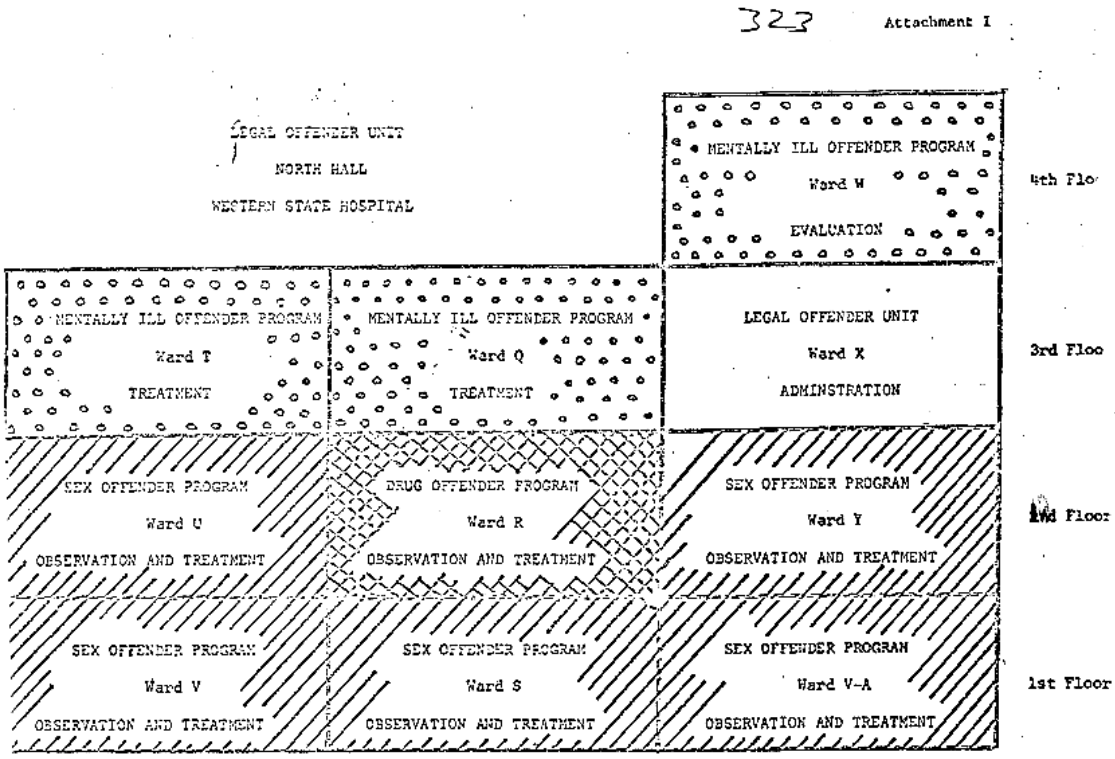

Figure 11: Ward Map of North Hall, the main Legal Offender unit. There were generally two groups on each ward for the Sex Offender program, and one for the Mentally Ill Offender program. From Charles Morris to Milton Burdman, memorandum, April 19th, 1974, "Facilities and Program for Mentally Ill and Sexual Offenses – Progress Report", Attachment I.

Holding the Line: Lateral Program Expansion, 1975-1979

"Control is inevitable. One can control oneself or society will…Look to the time when you can, through your own efforts, live decently, humanely and fully free."

- Larry R. Hendricks, in *Lifeboat: A therapeutic community for the incarcerated drug offender*, Western State Hospital, Steilacoom, WA (January 1st, 1977), 7.

In 1975, Assistant Director Robinson Williams departed for private practice.[565] William's old position of "Assistant Director" was henceforth known as "Acting Director". The program's choice for the position was H.R. Nichols, a therapy supervisor who had been with the program for at least seven years.[566] Williams' departure marked the end of the sex offender program's most successful era. The program had grown drastically to a daily population well over five times its previous resident load. The staff, led by MacDonald and Williams, managed to maintain the program's unique approach as it scaled up to match. Further, the program's services massively expanded, realizing di Furia's original vision of an "internal community" more closely than his original program design had. The program, like most of its kind, went unrecognized nationally, but received significant attention from justice and law enforcement officials in Washington. Confidence in their approach was high enough to bring them through the disastrous Ruzicka affair with little corresponding changes from any agency.

The program's apparent success hid its growing instability. The Ruzicka affair was the beginning of greater state government oversight of the program. In that

[565] MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, 2.
[566] MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, 2; AP Wire, "The average…", A-5.

instance, it was transient and forgiving. As a few high-profile escapes and internal scandals accumulated, their attention became more frequent and more critical. Public opinion fell drastically. The program was little more than tolerated by the public for the rest of the decade. Worsening matters, the program's cost continued to rise over the second half of the 1970s. The DSHS and the Legislature began demanding changes to program policy, rather than allowing it to "go its own way". The program staff, looking inward, found them faced with clear problems with the treatment modality. Strong demographic skews and dissatisfaction among some of the couples pointed to unintended negative consequences of the self-guided group. More worryingly, an early recidivism survey and the horrific crimes of Larry Hendricks warned the program staff that the program might be, in fact, unsuccessful in changing behavior, even in offenders who seriously invested themselves in change. The program, for better or worse, was not challenged by the state on these problems until the end of the decade. From 1975 to 1979, the program took on water, as its numerous internal issues became more and more apparent and interfered more and more with conducting therapy.

At the time of William's departure, some worrisome trends were showing themselves in the program's population. The Sexual Psychopath unit was now receiving a majority of all convicted sex offenders in observation. The justice system still showed significant prejudices in who underwent the commitment process. The first gap erupted between rural and urban offenders. Simply put, judges in the urban King, Thurston and Pierce counties were far more likely to sentence an offender to the program than judges in rural counties.[567] This divide was complicated by a socio-economic divide between

[567] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 14.

Eastern and Western Washington. Eastern Washington was, and is, far more rural than Western Washington, with only a handful of major cities and a dramatically lower population density. Accordingly, the sexual psychopath statue saw less use on principle in Eastern Washington. The 1968 report stated that, for the first ten years of the program, "courts in very small counties [did] not [use the statute... whether] east or west of the mountains". This is supported by comparable proportional rates of commitment between three urban counties in the east - Yakima, Walla Walla, and Spokane - with three urban counties in the west - Grey Harbor, Pierce and Thurston.[568] In 1970, the vast majority of commitments in Eastern Washington came from Spokane and Yakima counties. These two counties are named after their respective cities, which are the two largest in the region.[569] The text noted that courts in Eastern Washington were "interested", with the implication that their use was tentative. The sporadic commitments the report describes agrees, showing rural courts meting out a handful of observation recommendations in a given year.[570] The 1976 report does not discuss county of commitment in the text, but its statistics show the same story: a steady use of the service by Yakima and Spokane counties, the rise of the service in a few rural counties and its fall in some others, adding up to the disproportionate representation of urban offenders within the program. The text tacitly acknowledges this, stating that commitments "predominately [come] from the Western half of the state, [and] either

[568] MacDonald et. al., *Treatment of the Sex Offender: Ten Years*, 14.
[569] Williams, *Characteristics and Management*, 3.
[570] ibid.

King or Pierce counties."[571] Eastern and Western Washington were more separated than might be originally supposed regarding the use of this program.

A more pronounced and more difficult to combat divide was the low nonwhite, non-heterosexual population in the program. Legally, the judge and the prosecuting attorney could commit anyone they believed disordered and amenable to the treatment offered by the program. Their decision was supposed to be based on the court-appointed psychiatrist's testimony and their own impressions of the offender's commitment to change. The unspoken barrier was that both the judge and prosecutor had to believe the offender "deserved" enrollment in treatment, rather than prison. The legal system strongly favored older white men of means over younger, poorer and minority men.[572] According to the acting director, their bias toward white offenders could not be accounted for by the seriousness or violence of the offense committed. While charges of younger offenders were generally steeper charges of the same type of crime the older offenders faced, Williams claimed this was not because they committed different crimes. Williams attributed this to "less than adequate legal counsel" for younger offenders and a corresponding inability to get the charge reduced, rather than the actual commission of more serious crimes. Racial minorities were excluded at an even higher rate, having less than one-third the chance of entering the program than a Caucasian offender.[573] The bias was a source of frustration for the program, as it precluded a number of good treatment candidates:

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[571] George J. MacDonald and H.R. Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976,* Western State Hospital, Steilacoom, WA (1976), 2, 6.
[572] Williams, *Characteristics and Management,* 2-3.
[573] ibid.

"Adult Corrections receives a very large number of young and first offenders, including many of minority races, who have the best potential...and the Specialized Program [at Western State] receives... older men, chronic recidivists, and men of low intelligence, all of whom have very poor potential for treatment."[574]

The problem did not entirely lay with the court. Dr. Williams observed that the program's internal gatekeeping system of "acceptance after observation" was significantly biased toward certain majority groups. As previously stated, the majority of admissions were settled by the treatment group's vote. People of color were, in fact, accepted at a higher rate than Caucasians. This may have been the result of a small sample size, however, because only ten people of color made it to the observation period.[575] The program was instead biased toward rejecting offenders who committed crimes against men or boys. The rate of acceptance for offenders against women was 46%; for offenders against men, it was 24%.[576] The 1973-74 and 1975-1976 reports only tallied the percentage of the resident population that had offended against males, not the percentage who were accepted beyond observation. The percentage of the population who had offended against men kept steady at around ~20%, suggesting that this trend held.[577] Younger offenders – those between 18 and 20 – were also significantly less likely to be kept for treatment at this time, although the difference was less pronounced.[578] Dr. Williams also noticed that this inequality of participation appeared to have an impact on an offender's success. No people of color graduated the

[574] Williams, *Characteristics and Management,* 2-3.
[575] ibid, 25.
[576] ibid.
[577] *Guided Self-Help: A New Approach… July 1973-June 1974*, 6; MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, 10.
[578] Williams, *Characteristics and Management*, 25.

program during the period surveyed. Offenders against women who were kept for treatment had a 43% chance of graduating the program. Offenders against men had a 28% chance. Offenders below the age of 24 had a <10% chance.[579] In William's view, this was likely due to lingering biases of the group members against homosexually-oriented men and against more "hotheaded" adolescents that resulted in a "anti-therapeutic", prejudiced group dynamic.[580] As long as their prejudices remained unchallenged, their biases would persist, and in an environment which hypersensitized men to group attitudes, they would be intensified.. One man who had molested young boys attested that, on his arrival in the group, "there was extreme mistrust… and a fear [he'd make] sexual advances…"[581] In his 1977 trial, a defendant, Wilmoth, was sentenced to observation at Western State Hospital. When he returned to court, he stated he preferred prison to the program:

> "After I get out, I can't live with my wife for another 18 months... The homosexuals, I can't get along with them at all, and I don't feel that [the program staff] help people all that much. I asked some of the older members if they thought- they had been there for 2 years and I asked them if they thought the program had helped them and they says [sic] no, they didn't, and they had been to prison before and that didn't help them either."[582]

Williams had concluded his 1971 report by calling for "study in great detail" of "treatment procedures" to improve the balance of the group demographics.[583] These efforts, however, didn't arrive. By 1975, younger offenders were closer to parity

[579] Williams, *Characteristics and Management,* 25-26.
[580] ibid, 26-27.
[581] Mottram, "The story of a child molester".
[582] State V. Wilmoth, 22 Wn. App. 419, 589 P.2d 1270 (1979).
[583] Williams, *Characteristics and Management,* 26-27.

figures, but this was primarily because of a major increase in the court commitment of rapists, who were on average younger than pedophiles and non-assaultive offenders.[584] The bias against nonwhite and homosexual offenders persisted. Later surveys of offender characteristics kept mute on the problem, and stopped providing resident demographics, making it harder to determine if the populations began to "level out". No attempt to solve the problem in any fashion was acknowledged in the literature.

Under the tenure of MacDonald and Williams, the demographic problems were at least discussed. The program's greater issues, however, were not. First, the program could not continue treating people at the rock-bottom cost it once claimed it maintained. Before 1971, only MacDonald and Williams, accompanied by a complement of ward attendants, were the "treatment staff". The cost of treatment was therefore exceedingly low, even when operational costs were factored in.[585] The 1971 report on the adjustment of released sex offenders to the community states that the daily cost per offender is "$5.97, less than one-half the cost of $13.46 for adult correctional institutional care in the State of Washington…."[586] This operation was not sustainable. MacDonald and Williams hollered for additional staff for three years.[587] Once they got it, however, the costs of the program increased much more per capita than they had accounted for. For the first few years, they claimed that costs remained low. This claim appears to be based on faulty math. When the Therapy Supervisors were added to each group in 1971,

[584] *Guided Self-Help: A New Approach… July 1973-June 1974*, 6; MacDonald et. al., *Treatment of the Sex Offender: Ten Years*, 15; MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976,* 10; Williams, *Characteristics and Management,* 23.
[585] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* Introduction.
[586] Community Care 3.
[587] Williams, *The Washington State Sexual Psychopath Law*, 3.

MacDonald and Williams stated that salaries for all staff amounted to ~$147,750. Operating costs were estimated at ~$26,725. This left a total of around $173,500 in annual expenditures for the program, with a cost per resident per day of $6.25.[588] Their estimate of "operating cost", when compared to later figures, seems to have been wildly inaccurate. The 1974 annual report stated that operational costs besides salaries were $478,301, with the total cost of the program annually running around ~$800,000. The program now estimated a cost of $14.81 per resident per day. The mammoth jump in operating expenses was not mentioned. [589] Later budgets universally put operating costs at a figure the same order of magnitude as the cost of salaries. The early economy of the program, then, was the result of less than precise accounting and unsustainable staffing, rather than a legitimately cheaper approach.

While the cost savings were not as good as advertised, the program was still economically competitive with the prison system. As of 1974, the average cost per prisoner per day in Washington's prisons was ~$20.79. The 1974 annual report, a number of memos, and academic journal articles played up the finding.[590] Corrections was not pleased:

> "The attached December 10 memo from Western State Hospital concerns me. On other occasions, the staff at WSH have made comparisons of their program with Adult Corrections… They have not been carefully thought out and could be harmful if used inappropriately by readers."[591]

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[588] MacDonald to Walsh, "Personnel Needs", 7.

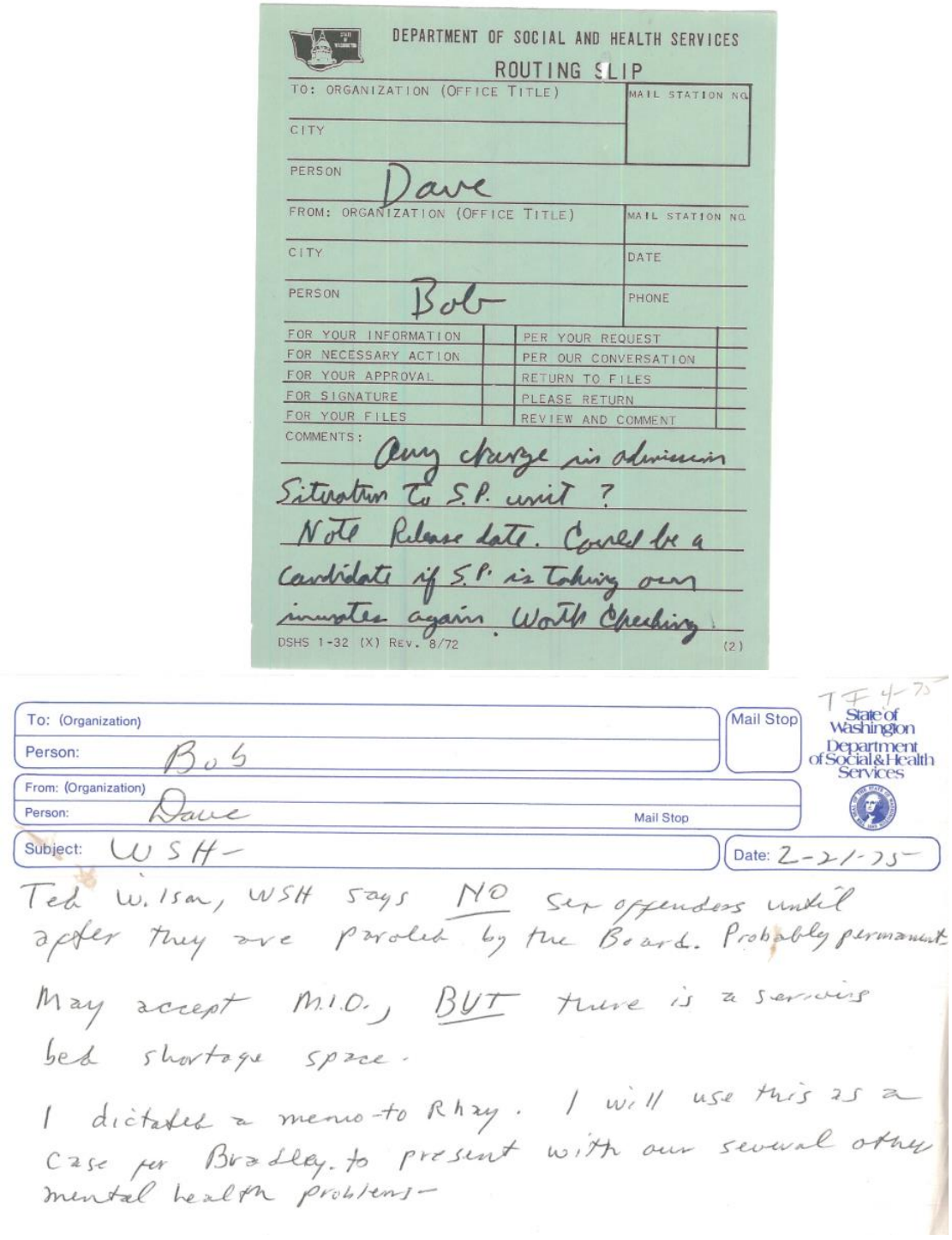
[589] *Guided Self-Help: A New Approach To Treatment of Sexual Offenders – Annual Report, July 1973-June 1974,* 4.

[590] *Guided Self-Help: A New Approach To Treatment of Sexual Offenders – Annual Report, July 1973-June 1974*, 4; Williams, *The Washington State Sexual Psychopath Law*, 2; Denenberg, "Sex Offenders Treat Themselves", 58.

[591] Milton Burdman to Barry Van Lare and Hal Bradley, memorandum, December 23rd, 1974, untitled.

Correction's cautions proved wise. In 1976, the program costs were reported to have escalated to "20.00 per day per patient", putting the program at near-parity with the prison system.[592] Proportional costs continued to grow, to an unspecified degree, for the rest of the decade.

[592] MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, 3.



DEPARTMENT OF SOCIAL AND HEALTH SERVICES

ROUTING SLIP

TO: ORGANIZATION (OFFICE TITLE) | MAIL STATION NO.

CITY

PERSON Dave

FROM: ORGANIZATION (OFFICE TITLE) | MAIL STATION NO.

CITY | DATE

PERSON Bob | PHONE

FOR YOUR INFORMATION		PER YOUR REQUEST	
FOR NECESSARY ACTION		PER OUR CONVERSATION	
FOR YOUR APPROVAL		RETURN TO FILES	
FOR SIGNATURE		PLEASE RETURN	
FOR YOUR FILES		REVIEW AND COMMENT	

COMMENTS:

Any change in admission Situation to S.P. unit ?

Note Release date. Could be a candidate if S.P. is taking over inmates again. Worth Checking

DSHS 1-32 (X) Rev. 8/72 (2)

To: (Organization) | Mail Stop

Person: Bob

From: (Organization)

Person: Dave | Mail Stop

Subject: WSH | Date: 2-21-75

TF 4-75

State of Washington Department of Social & Health Services

Ted Wilson, WSH says NO sex offenders until after they are paroled by the Board. Probably permanent.

May accept M.I.O., BUT there is a severe bed shortage space.

I dictated a memo to Rhay. I will use this as a case per Bradley to present with our several other mental health problems—

Figure 12: Two memos between "Bob" and "Dave", two unknown DSHS employees, discussing the bed shortage at the Mentally Ill Offender Treatment Program and the closure of correctional transfers. From The Department of Social and Health Services 1965-1979 Archives, Subgroup Division of Adult Corrections, Box 48, Accession No 03A205.

The program's cost problems were joined by even more serious concerns about program efficacy. A mysterious document sits in the Washington Archives, alongside other documents about the program. This anonymous sheet was the most comprehensive recidivism survey of the program made before the 1985 audit.[593] The audit covered all residents who had gone on work release and/or graduated the program from December 1967 to November 1974, a total of 216 men. A date, "August 19th, 1976", is stamped at the top. Two names of unknown relation to the program are handwritten at the top, one of which with a phone number and address included below. Their relationship with the program could not be determined, and the address has since been redeveloped into a car audio business. The survey and its findings are not mentioned or cited in any other report. Two clues strongly suggest it was written by program staff: the survey used the methodology suggested in the 1974 *Annual Report,* and the word "us" is used to describe offenders reporting offenses to their group.[594] There is no "title page" or direct attribution.[595]

The results of the survey were dramatic and discouraging: recidivism of program graduates was dramatically higher than previously thought. The chart broke down the data in three interesting ways: first, the person's offense at the time of commitment, second, the point in treatment they reoffended, and third, whether police discovered their crimes or whether the offender confessed them to program staff.[596] The survey only followed recidivism for sexual crimes, and only tallied the lapse of the

[593] "Treatment Program for the Sexual Offenders – Reoffense Study" (d. uk), 1.
[594] *Guided Self-Help: A New Approach… July 1973-June 1974*, 8.
[595] "Treatment Program for the Sexual Offenders – Reoffense Study" (d.uk.), 1.
[596] ibid.

offender, rather than the number of their offenses once they "relapsed". The results were discouraging. The most successful treatment category were incest offenders with a recidivism rate of just under 10%. The least successful treatment category was the "miscellaneous" non-assaultive offenders (voyeurs and exhibitionists), with a 30.3% recidivism rate. Concerningly, around 40% of all recidivists were undetected before their confession. It suggested that police arrests would underrate total recidivism considerably, and that the group was very good at inculcating responsibility in the offender, to the extent that they forfeited their freedom to comply with it. The bombshell figure was a general recidivism rate of around 20.3% for released offenders. This was much higher than the previous figures of 8.9%, reported in the 1968 history, and the low ~1/8 proportion suggested by Robinson's 1968-1970 survey. [597] With few other programs publishing recidivism data, and few other programs lasting as long as Western State's had, this report was of significance not only in evaluating Western State, but as an evaluation of sex offender treatment more generally. Yet the survey disappeared from view. It was not cited in the 1976 annual report, in the Kellogg report, in the Brecher survey, or by any other document, including the otherwise quite-comprehensive Krell audit. This survey was assuredly seen by program staff at the time. For whatever reason, it was not seen by anyone else.

The program tried to avoid letting this strain show publicly. The 1976 report painted a rosy picture of operations at the Center and underlined the recent increase in program security.[598] The media representative the program had hired was doing good

[597] ibid.
[598] MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, 4.

work. Positive stories on the program ran regularly through the turn of the decade. The stories sought to humanize the sex offender in the eyes of the public and make his treatment seem possible. One in August of 1974 told the story of "Ernie", an offender who had emerged from the program after two years of advancement and found a happy marriage with the mother of a young son.[599] Another, in November 1976, emphasized the frequent recidivism of "untreated" offenders such as "Frank", then stated those who have gone through the Western State program have an "eight in ten" chance of "not [being] convicted of a sexual offense again".[600] Others focused on the role of volunteers. With an eye to recruitment, these stories featured testimonials from satisfied volunteers. As those volunteers described it, they found the time they spent in the program valuable for their purpose. Their efforts had resulted in another person's change for the better.[601] In fiscal year 1976, the program had 29 volunteers.[602]

Some of the changes the program underwent at this time were neither "good" nor "bad" in of themselves. The program's numbers maintained their upward trajectory, but its demographics changed significantly. In 1972, the average daily resident population circled around 125.[603] The number of offenders committed for observation continued to rise through 1976, as a greater and greater percentage of offenders were referred to the program. While staff became more selective, they did not set an explicit population ceiling. The resident population ballooned to a daily average of ~180 in

[599] Mottram, "The story of a child molester".
[600] AP Wire, "The average sex offender…", A-5.
[601] Jones, "Women help", F1;
[602] Brecher, *Treatment Programs for Sex Offenders,* 20.
[603] "Program Policies (Revised June 1976)", 6, attachment to George Macdonald to Giulio di Furia, August 7th, 1976, "Legislative Budget Committee Inquiry"; MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 8.

1976, and it threatened to increase further. The type of offenders that the program was receiving, however, was changing. Through 1969, the program had been populated overwhelmingly by offenders who targeted children.[604] In 1970, the percentage of program admissions who targeted adults hovered was 7%. By 1975, this percentage had more than doubled, landing at 27%.[605] This was, according to the program, the result of two factors. The women's rights movement brought the seriousness and prevalence of rape to public and law enforcement attention, resulting in a much greater number of rapists being charged and brought to trial. At the same time, judges and prosecutors were growing more confident in the program's ability to handle sex offenders, and were increasingly open to committing violent offenders to treatment.[606] This new proportion would hold until the early 1980's.[607]

A significant shift in group therapy took place near the middle of the decade: the "de-escalation" of the therapeutic environment. The group's "confrontations" were directed to be less intense. Group sessions remained founded on "confrontation" as a principle, but offenders were intended to be more conciliatory and moderate in their remarks.[608] This change was not MacDonald's doing. According to *01,* MacDonald remained personally faithful to the more visceral, emotive "in-your-face" confrontation that di Furia and Mees had observed in Synanon. The offender had to be brought well outside their comfort zone and be willing to express themselves in an extreme manner,

[604] MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, 1; Ainscough, "Hospital treats sexual offenders".
[605] MacDonald and Nichols, *Annual Report: July 1st, 1975 – June 30th, 1976*, 2.
[606] *Guided Self-Help: A New Approach… July 1973-June 1974*, 6.
[607] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 20.
[608] *01* Interview Transcript, 11-12.

to "truly" get in touch with their emotions. The numerous new therapy supervisors hired at the start of the decade, however, disagreed. They allowed their groups to be less bombastic in their sessions, so long as they remained equally critical. By 1975, the "in-your-face" approach had been toned down.[609] Some of the program staff were unhappy with the change, with one therapy supervisor going so far as to quit. The majority, however, were happy with the shift.[610]

The approach and technique of the Sexual Offender Treatment Program attracted professional notice in the region, who adapted its methods to group programs of their own. These programs, however, were outpatient groups, and they pulled away from the principle of resident leadership toward more behavioral interventions. The first was the Eastside Community Mental Health Center's Sexual Deviance Program, or SDP. It was founded in early 1975 in Bellevue, Washington.[611] It was the first true outpatient program in the state. The architect, Steven Silver, stated almost all sex offender treatment is institutional and inpatient, engendering "the development of dependent and manipulative behaviors" that masked the offender's internal problems, rather than solve them.[612] He included in his footnote to that point the 1971 report on Western State in *Hospital and Community Psychiatry*. There is no other mention of Western State's program in the text. While he views the residential approach of Western State as inimical to treatment, his actual program design and practice is extremely

[609] *01* Interview Transcript, 11-12.
[610] ibid; Schwartz, "Overview", 364.
[611] Silver, "Outpatient Treatment", 139.
[612] Silver, "Outpatient Treatment", 134.

similar, to the degree that it is easier to list the differences than the similarities.[613] Therapy was "staff-guided, patient-led", and revolved around once-weekly group meetings with fellow members. The group votes on who to accept into its ranks and has all newly admitted people read an autobiography on their first meeting. Even the therapy's primary perceived problem – low self-esteem, leading to antisocial acting out – is identical.[614] Eastside's program was the pioneering outpatient program in Washington at the time, and it owed its model to the efforts of the Western State Program. It was an early arrival in what would be a wave of outpatient offender treatment, and one of the few that took inspiration from Western State's approach.

Following the same impulse that founded the Mentally Ill Offender program, the Sexual Offender Treatment Program cross applied its methodology to another group of offenders: drug addicts. MacDonald remarked that the program's model could be extended to other kinds of offenders with "good results" back in 1970.[615] The *Lifeboat* program for incarcerated drug offenders was the first and largest test of that assertion. It began in the summer of 1974. It was originally headed by a Mr. Gene Chontos, who oversaw about thirty patients on Ward R, in North Hall.[616] It was a near - carbon copy of its parent program. Eligible residents were any convicts in Washington prisons serving time for offenses related to their drug addiction, who had between one and five years on their sentence, and who were considered a minimum-security risk.[617] They

[613] Silver, "Outpatient Treatment", 136. The author instead cited Alcoholics Anonymous as the primary influence. While program bore significant similarity to AA, its peculiarities, like having female volunteers socialize with program members, cut closer to the Western State model.
[614] Silver, "Outpatient Treatment", 136-138.
[615] Wojtech, "Volunteers play role in rehabilitation".
[616] *Fort Retorter* I issue 1, 1; George J. MacDonald and Robinson Williams, *Annual Report: July 1973 – June 1974*, Western State Hospital, Steilacoom, WA (1974), 8.
[617] Hendricks and di Furia, "Lifeboat", 4-5.

were evaluated by a chain of three committees, and if cleared, admitted for a sixty to ninety-day observation period.[618] The philosophy of treatment was identical. Most drug offenders were sane and semi-functional but were unable to stop themselves from committing socially unacceptable or harmful behaviors. They believed themselves fundamentally "broken" in some way and unable to change. [619] They were physically addicted to their stress response, but the roots of their habit went beyond the drug to the same fundamental psychological maladjustment that sex offenders had.[620]

Lifeboat was short-lived and unsuccessful. Next to nothing could be found about the program in its first two years. The earliest document found after the program started was the new program member's handbook, written by Hendricks shortly after he was called to the program in the fall of 1976. A later newspaper article claimed he had been tasked with beginning the program "anew", with tighter discipline, suggesting the program had been in turmoil before his arrival.[621] His management, however, did not end the program's troubles. The "guided self-help" honor-system security approach meant smuggling drugs inside or walking away was fairly easy.[622] The program was "grounded" after every escape or discipline infraction, but these lockdowns could only persist for a short time, as the hoped-for progress of the residents would be jeopardized by time spent away from their occupations.[623] Unlike the Sexual Offender Treatment Program, the latter-stage work release portion was not included within the program

[618] Hendricks and di Furia, "Lifeboat", 4-5.
[619] ibid; MacDonald and Williams, *Annual Report: July 1973 – June 1974,* 7.
[620] Hendricks and di Furia, "Lifeboat", 2.
[621] John Gillie, "3 flee WSH drug program", *The News Tribune,* Tacoma, WA (September 12th, 1972).
[622] *01* Interview Transcript, 20; John Gillie, "WSH drug offender program transferred", *The News Tribune,* Tacoma, WA (October 20th, 1977), A1;
[623] John Gillie, "Big 'carrot' lacking for drug offenders – work-release", *The News Tribune,* Tacoma, WA (September 13th, 1972), D1; Hendricks and di Furia, "Lifeboat", 7.

proper by the government's charter. It was instead overseen and run by the Department of Corrections. Hendricks began demanding the offenders on work-release remained ward residents. The Department of Corrections wanted the offenders to reside "in the present work-release program building" on the hospital grounds. They could continue to go to the program's "counseling during their free time", but their work release needed to be under the Department of Correction's oversight and control.[624]

While the two parties bickered, the internal problems festered. Hendricks pushed for the resumption of work release to no avail. A legislative committee was convened in the summer of 1977 to determine the program's future. Its findings are well surmised by a comment from Hendricks in front of the State Senate: "the vast majority" who had graduated the program had likely relapsed.[625] *01*, working in her capacity in the Sexual Offender program, heard of "con behavior", most notably drug smuggling.[626] The state was vacillating on the next move when four of the twenty-five residents escaped in one week in September.[627] One of the offenders, when recaptured, claimed the program was in disarray. Staff supposedly encouraged resident silence to avoid being shut down, tacitly ignoring wrongdoing as recompense.[628] An unknown number of anonymous callers, including one claiming they were a current resident, told the *News Tribune* that the program was a battleground between Corrections and Mental Health, with their treatment by "incompetent" therapists sidelined as they played out the

[624] Gillie, "Big 'carrot' lacking for drug offenders", D1.
[625] Gillie, "WSH drug offender program transferred", A1.
[626] *01* Interview Transcript, 20.
[627] Gillie, "3 flee WSH drug program"; Gillie, "WSH drug offender program transferred", A1.
[628] Gillie, "3 flee WSH drug program".

power struggle.[629] Tellingly, the callers considered the use of therapeutic techniques intended for sexual offenders in the program an undue humiliation of the residents. The sex offender was the "lowest kind" of criminal, and drug offenders should not, in their opinion, be addressed the same way.[630] Hendricks claimed the calls and complaints were due to his increased discipline as administrator, rather than actual problems with the treatment methodology.[631] The state did not wait for an investigation to settle the matter, and transferred the program to the Corrections Division of DSHS in late September.[632] A month later, the program was moved to a "secure building at Eastern State". No staff moved with it. Tom Rolfs, "a longtime corrections department administrator", was appointed as its new director.[633] The "Lifeboat" name and the "self-guided" group approach were canned immediately. Larry Hendricks left the hospital staff in the wake of the scandal, ending his professional affiliation with the offender programs. The program's foray into drug treatment was a bust. It never attracted secondary interest or comment outside the local papers.

A more successful "transplant" was a straightforward one: the creation of an identical sex offender treatment program at Eastern State Hospital. For ten years after the Melvin Briggs scandal, sex offenders in the east of the state who were committed as Sexual Psychopaths were sent to Western State Hospital. For a time, this was manageable, and program staff at Western State were pleased that interest in the

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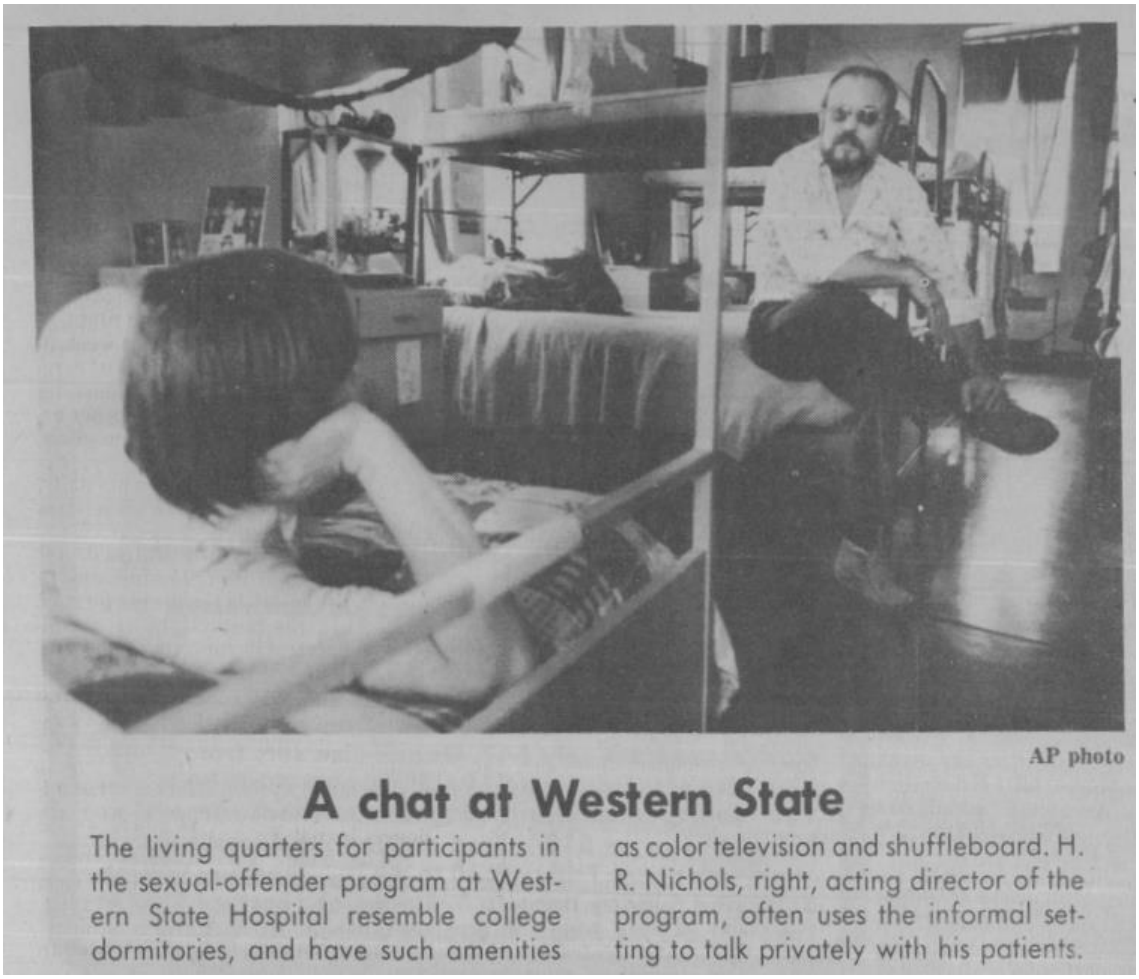
[629] John Gillie, "Man flees drug offender program", *The News-Tribune,* Tacoma, WA (September 8th, 1977).
[630] ibid.
[631] Gillie, "3 flee WSH drug program".
[632] John Gillie, "Drug offender program shifts", *The News Tribune,* Tacoma, WA.
[633] Gillie, "WSH drug offender program transferred", A1. Coincidentally, Mr. Rolfs oversaw the transfer of Mr. [Wilson] to the SOTP while he was the supervisor at the reception center of the Washington Corrections Center.

program was statewide.[634] By 1977, the resident population at Western State had become an unbearable 228 residents.[635] For offenders from the East, enrollment in the program came at serious cost: his family had to move to the Pierce County area, and he had to commit to living in the area through the outpatient portion of treatment. The Division of Mental Health agreed to restart sexual offender treatment at Eastern State, this time under Western State's model, to relieve the population pressure. Two new therapy supervisors were brought on to the Western State program about six months prior, to learn the treatment method and philosophy that Western State employed.[636] In November 1977, these supervisors moved to Eastern State Hospital with a group of volunteer residents originally from Eastern Washington.[637] Saylor and di Furia visited a number of times the first year, than had annual in-person visits in the years that followed.[638] The programs had almost no contact between each other besides these administrative visits.[639] The Eastern State program, left to its own devices, faithfully followed the "self-help" treatment model with a much smaller complement of residents.[640] Around thirty-five residents were enrolled as inpatients at any given time before 1982, and about fifty after 1982.[641]

[634] Williams, *Characteristics and Management*, 3.
[635] John Gillie, "New program may relieve WSH", *The News Tribune*, Tacoma, WA (May 13th, 1977).
[636] *01* Interview Transcript, 13.
[637] Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 14.
[638] *01* Interview Transcript, 13-14; Gillie, "New Program may relieve WSH".
[639] Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 30.
[640] ibid, 29, 35-36.
[641] ibid, 19, 22.



AP photo

A chat at Western State

The living quarters for participants in the sexual-offender program at Western State Hospital resemble college dormitories, and have such amenities as color television and shuffleboard. H. R. Nichols, right, acting director of the program, often uses the informal setting to talk privately with his patients.

Figure 13: Dr. Nichols interacting with a resident, from "The average sex offender may be the guy next door", AP Wire Story, *The News Tribune*, Tacoma, WA (Nov. 25th, 1976), A5.

The program was dealt two major blows in quick succession in the spring of 1977. First, Dr. MacDonald died suddenly.[642] He had been the legal offender program's director for a dozen years.[643] No obituary was found in *The News-Tribune*, making the precise date of death uncertain; according to a May 13th, 1977 *News-Tribune* article, he had died in the "last few weeks".[644] His passing threw the program into disarray. Horace

[642] Gillie, "New Program may relieve WSH".
[643] Ainscough, "Hospital treats sexual offenders".
[644] John Gillie, "WSH ousts 10 from sex-offender setup", *The News Tribune*, Tacoma, WA (May 18th, 1977): A1.

Nichols, who had coauthored the 1976 annual report, remained the acting director until a full-time replacement could be found.[645]

Then, in May, the second of the major scandals of the 1970's broke. According to Nichols, speaking to the press, four residents "threatened" the two senior charges on "CQ" that evening, took the keys, and ran to a waiting getaway car.[646] The four escapees were the headmen of a small marijuana ring inside the program. Nichols stated he had detected their operation and planned a group marathon session that day to confront them, which "would have likely resulted in their expulsion."[647] The escape forced the impropriety into the open, and the program into the public eye. The program was promptly put on grounding, and the residents and staff chose to show they were stern on disobedience. Ten offenders, besides the four escapees, were ejected from the program. Six of the expelled were part of the same therapy group.[648] The escape was extremely reminiscent of an earlier marijuana bust. In April 1976, three men were ejected from the "Aquarius" treatment group for abusing off-grounds privileges to procure marijuana and bring women into the conjugal-visit cottages on the grounds for intimate rendezvous.[649] The reoccurrence of the same problem in a short span was noticed by the press and the government.

The incident was embarrassing enough, but when the four escapees were recaptured in the early morning of May 18th, it suddenly became much worse. One of the offenders, Tyrell, spoke to the press before this trial. He claimed that the treatment

[645] Gillie, "WSH ousts 10", A1.
[646] ibid; *01* Interview Transcript, p. 7.
[647] Gillie, "WSH ousts 10", A1.
[648] ibid.
[649] Gillie, "3 ousted from sex program".

program was in fact a den of vice, of which his own drug trafficking was a small part. As he told it, homosexual affairs between the patients were rampant, and drugs freely circulated. Staff participated in the bacchanal. His accusations ran in the *News Tribune*.[650] The wives of other offenders wrote into the paper, denying his claims. They stated his charges were slander against their husbands whose recovery they could personally attest to. They concluded by asking the public to support the program so their husbands could complete their treatment and rejoin society.[651]

Harlan McNutt, Secretary of the DSHS, ordered an inquiry into the program by the DSHS Investigation Unit. After they interviewed staff, residents and patients, the Unit found many Tyrell's claims baseless. A program graduate, working as a security guard on a different ward, was found to be the perpetrator of an assault on a patient and was taken into custody. No other staff had committing any wrongdoing in the program or the hospital writ large. However, "clear evidence" of sexual affairs between residents was found, and a number of those acts were "coerced". McNutt blamed "insufficient monitoring and control" of the groups, but maintained a positive outlook on the program as a whole: "The value of the treatment remains clearly established; but it is necessary to maintain constant vigilance… to insure there [is] appropriate control."[652] The program had not been able to notice sexual assaults within its own ranks, casting serious doubts on its ability to notice sexual offense on work-release or outpatient treatment.

[650] Roger Howard, "News Release – Illicit Sex and Drug Charges Not Supported by Investigation", 1-2;
[651] Gillie, "Lies, say women".
[652] Roger Howard, "News Release – Illicit Sex and Drug Charges Not Supported by Investigation", p. 2.

The press was not pleased by the revelations. The *News Tribune* noted that two others from the "Legal Offenders" programs had escaped in the same week as these four, and the Pierce County Police Department complained that the staff did not give "timely and complete notification" of escape.[653] To appease the critics, the policy of having "senior charges" conduct night watch duty was ended. Keys were now held by dedicated attendants on a round-the-clock basis.[654] Staff objected that in this case, the escape was violent, and was not achieved by any coercion beforehand or a ward-wide conspiracy. Anyone "[could] be hit over the head", whether they were a therapist, a security guard or a resident.[655] Regardless, the effort was terminated.

In early 1978, for reasons unknown, Nichols departed the program. Maureen Saylor became the program's director. She had been a therapy supervisor since June 1973 and had been the first woman therapy supervisor in the program.[656] Nichols was the last holdout of the early days of the program. The program was now in the hands of a new set of administrators. What new actions they took is difficult to say, as their one conspicuous action was a sudden silence. The 1975-1976 *Annual Report* was the last report the program published. The biennial updates and self-published discussions of therapeutic interventions ceased.

The program returned to the limelight in 1979 with a bang. It started with the last of three major scandals of the seventies, centering around the program's previous

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[653] John Gillie, "WSH ousts 10 from sex-offender setup", *The News Tribune*, Tacoma, WA (May 18th, 1977): A1.
[654] Brecher, *Treatment Programs*, 21; Gillie, "WSH ousts 10 from sex-offender setup".
[655] *01* Interview Transcript, p. 7.
[656] *01* Interview Transcript, p. 2; Pyle, "Sex Offenders"; "Rapist Back In Custody", *Lakewood Press*, Lakewood, WA (March 16th, 1983).

success story, Larry Hendricks. When *Lifeboat* ended, Larry Hendricks was no longer an employee of Western State Hospital. He periodically returned to see his group and visit with the program. During one of his last visits, *01* remembered, he arrived on a black motorcycle, dressed entirely in black leather. A staff member who had been involved in his treatment remarked that "something was going on".[657] In the early morning of May 1st, Pvt. Tolvo Redditt was hitchhiking back to Fort Lewis when he was abducted by Hendricks at gunpoint. Restrained, he was driven in a black van to a wooded location near Roy and pushed out of the car. A mutilated body was visible by a tree. Redditt struck out at Hendricks when he was commanded to lay down beside the body. After a struggle, he seized Hendricks' gun and shot him.[658] Investigation afterward determined that Hendricks also was the murderer of Bertram Zahnie and at least two unnamed men from the San Francisco area.[659]

The program's efficacy was now challenged directly. Larry Hendricks had been in and around the Sex Offender Treatment Program for nearly a decade. He had repeatedly demonstrated his understanding of what drove his offenses personally and of the personality and socialization issues sex offenders demonstrated in general. He had cultivated the discipline necessary to graduate the program. Less than a quarter of people sent for observation before 1975 managed to. His 1975 monograph on the motivations of the sexual offender was the most detailed articulation of the program's understanding of the sexual offender written. He had served for years as a therapy

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[657] ibid, 20.
[658] "Gays' Killer Killed…!", *San-Francisco Crusader* no. 77 (May 16th, 1979): 3.
[659] "Gays' Killer Killed…!"; Hendricks and di Furia, "Lifeboat", 1-2; Susan Gordon, "Can all sex offenders be helped?", *The News Tribune,* Tacoma, WA (June 16th, 195): C1.

supervisor before becoming the director of a group therapy program at Western State predicated on the same model. His return "to outlet" was the failure of the program's most prominent graduate. His case challenged the idea that making the offender understand what was fueling their offenses could change their behavior.

The program, looking inward, came to a measured conclusion about the Hendricks case. The policy of having graduates serve on the staff was terminated, and the idea that an ex-sex offender was the best therapist for a current sex offender was repudiated. MacDonald had considered the hiring of graduates as a natural extension of the group therapy approach. The program reconsidered this, and instead decided that there needed to be a degree of separation between the group and the program staff. The therapy supervisor needed to guide the offender, which did not require personal experience with the cycle of sexual offense. The program did not extend this critique. The Hendricks case was not taken as a refutation of the self-guided group method in general. His failure post-graduation was an exception, rather than the rule. The program made obvious changes in the behavior and attitude of residents. The other program graduates who had been hired on as therapy supervisors did not recidivate and performed well in their various positions within the program. These positive examples were not invalidated by one "error". [660] Accordingly, the program graduates who had previously been hired on were allowed to stay.[661] *01* surmised their view: "Larry was a disgrace to us" – his failure was a breach of trust, the failure of a man, not of the program that gave him a second chance.[662]

[660] *01*, Interview Transcript, 20.
[661] ibid, 5.
[662] *01*, Interview Transcript, 20.

As the Hendricks case broke, Western State Hospital writ large was under pressure. The Joint Commission on Accreditation of Hospitals moved to strip the hospital's accreditation in December 1978. An appeal by the DSHS netted a one-year stay on that threat, giving the hospital until January 7th, 1980 to come up to standard. A Medicare certification team scheduled an evaluation just three days before that date, putting the hospital at risk of losing around two million dollars a year of Medicare and Medicaid reimbursement.[663] The Senate Subcommittee of Social and Health Services did a wider survey of Washington's mental health apparatus in the second half of the year. Western State Hospital was one of their biggest disappointments.[664] Chairman Senator Talmadge chided that "Television and medication [were] the primary treatment modes".[665]

The Hendricks case, like the Ruzicka case, exploded in the public eye. The *News Tribune* covered the story in particular detail. In general, however, the press coverage of the story gave little attention to the program and focused on the sordid details of Hendrick's crimes. The case did not leave nearly the same lasting negative impression that the 1977 escapes and the Ruzicka murders left. The Washington legislature, in contrast, was greatly alarmed. It perceived Hendricks's relapse as the sign of a grievous error. For the first time, the legislature seriously considered ending the program outright. The Senate Subcommittee on Mental Health ordered an investigation of the program's practices. It put two psychiatrists, a judge, and a prosecutor and mental

[663] "Western State Hospital: Fact Sheet and Progress Report", December 26th, 1979, 1. Washington State Archive, Western State Hospital Collection, Administrative Files, Subgroup General Subject Files, Box 37, Accession no. 95-A-213.
[664] Washington State Senate, *Senate Committee… June 27th, 1979*, 63-65.
[665] AP Wire, "Mental Care Rapped", *Spokane Daily-Chronicle*, Spokane, WA (November 15th, 1979), 6.

health professionals from around the state on the investigating committee, aptly named the "Committee for Review of the Sexual Offender Program at Western State Hospital". Dr. Howard B. Kellogg Jr. of Seattle was the chair, giving the committee's findings the abbreviated title of the Kellogg Report.[666] Their investigation started in May with a tour of the program and continued through the summer. It only sought and solicited testimony about the program, which it obtained from a variety of sources, including offenders, their wives, prosecutors, practitioners across the state, and program staff, among others. It did not conduct statistical research beyond the figures provided by the program itself.[667]

The committee released its findings in August 1979. It was succinct but wide-ranging. The committee placed the primary blame for recent events on overtaxation of program resources. The program staff felt they were going through the motions of reviewing new applicants. They were so backlogged in working with those already in the program that they could not properly investigate the new arrivals from court.[668] Treatment had become significantly less effective as screening deteriorated. Staff morale was ebbing, which resulted in correspondingly poor resident engagement.[669] The issue was not solely fiscal. Dr. Kellogg highlighted inadequate training, a "lack of currency" with new trends in "[treating] the sexual deviant", poor protocols for staff replacement, and the overburdening of the directors as significant issues with the

[666] Howard B Kellogg Jr. and the Committee for Review of the Sexual Offender Program at Western State Hospital, *Report to the Secretary from the Committee for Review of the Sexual Offender Program at Western State Hospital*, Olympia, WA (August 15th, 1979): 7-9; Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 26-27.
[667] Kellogg et. al, *Report to the Secretary*, 1-2.
[668] ibid, 5.
[669] ibid, 3-4, 6.

program.[670] The primary problem, however, was the state's overreliance on the program for all sex offender treatment in the state. The program could not continue to be an all-in-one solution for all "treatable" sex offenders.[671]

The committee prescribed both changes in state policy toward sexual offender rehabilitation and changes in the program itself. Their policy recommendations were grand. In a move echoing di Furia's aspirations at the program's start, the report called first and foremost for greater "community" outpatient evaluation and treatment of nonviolent offenders. Dr. Kellogg alleged that Western State's institutional nature made it unnecessarily restrictive for most treatment.[672] The state was spending a lot of money to treat offenders who would comply with a less-restrictive program in a residential facility, and their distance from the community made treatment less effective than it could otherwise be.[673] It further demanded the state found institutional treatment programs to reach offenders not eligible for the Western State program, such as juveniles and the incarcerated. Unless treatment alternatives were established, Western State's program would be packed until it burst. Within the program, the committee asked for a few changes in the hospital's procedures and treatment modality. Admissions needed to become more intensive, and reports to the court had to be more detail.[674] The committee underlined that security was not an issue. Conversely, monitoring and security measures had become too intensive, and were beginning to

[670] Kellogg et. al, *Report to the Secretary*, 7-9.
[671] ibid, 2, 4.
[672] Kellogg et. al, *Report to the Secretary*, 4-5.
[673] ibid, 4.
[674] ibid, 5-6.

obstruct treatment.[675] The program needed to focus on determining what sort of offenders the program was most effective at treating, and refocus their efforts accordingly. The only explicit recommendations were that "Ex-offenders should not be hired as therapists in the future" and that the administrative staff should sit in on group sessions more frequently.[676] The report concluded by reiterating that the program could not be expected to perform under its current burden. The majority of the program's issues would be resolved when the program returned to a sustainable population and funding level, and when the state diffused its current high degree of responsibility among a number of programs. These findings were effectively ignored. No initiatives to create "sister" programs or in any way reduce the population burden were undertaken.

The Kellogg Report's only human target of criticism was the program's administrative staff. In its view, weak leadership and overly rote reliance on "formula" had allowed the fiscal problems to overwhelm the program to the extent that they had. Its summary on "Personnel" read:

> "Finding: Although the committee was very impressed with the commitment of the therapy supervisors and found these first-line staff to be very articulate, it concluded that the entire administration of the hospital was deficient in allowing the morale of the staff and quality of the program to deteriorate."[677]

This paragraph originally stated the administrators in question to be Dr. Voorhees, the then-director of the Legal Offenders program writ large, and Ms. Saylor, the director of the SOTP. However, the paragraphs were rewritten before release, removing their names. The two practitioners, along with the other relevant hospital

[675] Kellogg et. al., *Report to the Secretary*, 6-7.
[676] ibid, 7.
[677] Kellogg et. al., *Report to the Secretary*, 6.

staff, were still named at the beginning of the paper, but they were not explicitly connected to the program's "poor administration" within the body.[678] DSHS secretary Gerald Thompson stated he sought the change to "avoid [claims of] libel".[679] The move met with a flurry of negative press coverage, accusing the Secretary of shielding "bureaucrats" from public review.[680] The program publicly acquiesced they knew of the troubles in the report. For the next seven years, the program staff maintained in the press that the program was overburdened, as it had grown too quickly, and that it needed more qualified therapeutic staff.[681] Later, as questions of efficacy moved to the fore, it would concur that the program's ability to treat offenders was uncertain.[682] Program staff did not mention the anonymous 1976 recidivism survey, instead stating that all previous surveys had been too limited in scope to provide meaningful data.[683] The public, however, was less interested in the report's findings or the program's overall efficacy than in the possibility of a resident's escape. State Senator Beverly Vozenilek mailed a survey about a number of issues to voters in the 28th legislative district of Washington. About seven out of ten respondents stated they sought a "moratorium" on commitments to the SOTP until proper "revisions" in security were

[678] ibid, 1.
[679] AP Wire, "Two Names Dropped from Hospital Report", *Spokane Daily Chronicle,* Spokane, WA (October 6th, 1979); "J.S.", "Keeping the public abreast of the situation", *Morning Tribune,* Lewiston, ID (October 16th, 1979).
[680] ibid.
[681] Gelernter, "Failures cast cloud on sex-offender program", C2; Jan Gildenhar, "Rehabilitation issue: It raises questions of effectiveness and security", *The News Tribune,* Tacoma, WA (January 5th, 1984), B1; Milton, "Western State", A1.
[682] Milton, "Western State", A1.
[683] ibid; Curt Milton, "A story from Western State", *Suburban Times,* Lakewood, WA (October 23rd, 1979).

made.[684] No such revisions were made at this time, but the public's opinion was clear: the program was considered a threat, not a possibility.

A smaller story broke later in the year which suggested program resident dissatisfaction was also growing. The complaints came from the romantic partners of some of the residents. They attested the staff were interfering in the resident's romantic relationships to an unacceptable degree. The intrusion extended, the women alleged, to demands on the offenders to divorce their wives or stop seeing certain women altogether. According to these women, the staff thought they were "no good" for the offender, for one reason or another.[685] The offenders said that their group would refuse to let them progress in the program steps unless they terminated or greatly altered their relationship with their wife. To add insult to injury, the program's couples therapy sessions were increasingly infrequent. The wives alleged that "more often than not", the meeting wasn't held because the therapist wasn't available. They stated they felt expendable, like the staff considered them trouble and would prefer not to have to deal with them, rather than participants in therapy. They also resented the casual attitude the staff expressed toward conjugal visits. The "NPR" room that married couples could spend the night in was the butt of staff jokes. "Everyone on the ward [laughed and said], 'Have a good time!'", according to one woman.[686] The program's disregard of the wives was especially frustrating to them because they thought the program was otherwise very effective: "The change in my husband [was] just incredible since he

[684] "Residents favor offenders program revisions", *Suburban Times,* Lakewood, WA (November 2nd, 1979).
[685] Milton, "Western State", A1.
[686] Milton, "Western State", A1; Milton, "A Story".

started…".[687] The wives went straight to the press with their concerns, prolonging a very bad year in the public eye for the program.

The staffing deficit was worsening. Mr. Fitzsimmons, the author of the 1979 Legislative Budget Office audit of Western State, described the staffing situation at Western State as akin to the desperate situation in the film *Beau Geste*, with di Furia as the Calvary commander holding his distant, outgunned outpost as long as he can. "Staffing… has not been adequate [hospitalwide] for the last seven years."[688] Fitzsimmons stated that this deficit was resulting in poor patient care in the hospital generally. Maureen Saylor, while serving as program director, was tasked to be The 1974 *Guided Self-Help* report had prodded for a full-time staff member to conduct research and evaluate treatment outcomes. A few former offenders had been hired to assist with research endeavors, but shortly after the turn of the decade, they had all left, for differing reasons. The new restrictions on hiring graduates prevented their simple replacement.[689]

One final cut capped off the decade. Gulio di Furia, the hospital's superintendent for fifteen years and a long-time defender of the program, retired from the superintendent position on December 1st, 1979, and took over the position of Clinical Director. He left the position of his own volition, stating he had wished to return to clinical work for some time. He was replaced by Dr. Morgan Martin, previously the

[687] ibid.
[688] Washington State Senate, *Senate Committee on Social and Health Services' Subcommittee on Mental Health: Hearing Transcripts and Written Testimony*: *June 27th, 1979*, Olympia, WA (June 1979): 21-22.
[689] MacDonald and Nichols, *Annual Report: July 1st, 1975– June 30th, 1976*, Staff Directory; *01* Interview Transcript, 21.

superintendent of Eastern State Hospital. [690] While di Furia still had significant clout as Clinical Director, his move ended the administrative beneficence the program had previously enjoyed from the hospital administration.

Western State's program was not the only one in trouble. The Atascadero program had, despite major efforts at improvement, gone down in flames over the course of the 1970's. The program's problems and widespread academic criticism in the 1960's were greeted with legislative disinterest. Escapes were minimal following the unrest in the early '60's, so the California legislature allowed commitments to continue. Atascadero maintained a "remarkably stable" population of ~425 "mentally disordered sex offenders", or MDSO's, through the mid-seventies.[691] A 1971 attempt at refashioning the program with more independence for residents and resulted in the entire staff being summarily dismissed by the hospital administration.[692] It was only in the 1970's, when security concerns reemerged and community hostility intensified, that the legislature became concerned about the facility's efficacy.[693] A number of notorious re-offense cases at the end of the 1970's intensified the situation.[694] The scholarly community remained skeptical of the hospital's devotion to its stated principles. A 1976 survey of MDSOs committed in 1967 found a slightly *higher* rate of recidivism for those discharged from Atascadero than those sent to correctional institutions for both

[690] "Western State Hospital: Fact Sheet and Progress Report", December 26th, 1979, 2; "WSH chief to change jobs", *The News Tribune*, Tacoma, WA (December 1st, 1979).
[691] Dix, "Differential Processing of Abnormal Sex Offenders", 334.
[692] Brecher, *Treatment Programs,* 42.
[693] Brecher, *Treatment Programs,* 42-43; Steve Emmons, "Sex Offenders: A Problem in Search of a Solution", *Los Angeles Times* (August 27th, 1978), M1.
[694] Emmons, "Sex Offenders", M1.

sexual and nonsexual offenses.[695] Paul Burkhardt, the program's director, had little to say. "[We] don't claim any cures".[696] A 1978 evaluation revealed massive problems with hospital conditions and with treatment efficacy. An attempted reform failed, and in 1981, the legislature ended state commitment of MDSOs to mental hospitals. Atascadero was thereafter a facility only for offenders found legally insane or seriously mentally ill.[697] In short, California ran an ever-changing program for two decades that cost a small fortune without denting recidivism, despite attempting a similar approach to the Western State program, predicated on a shared "milieu" philosophy.

Western State was now the only survivor of the first-wave institutional sexual offense programs on the West Coast, and it approached the dawning 1980's in trepidation. In 1974, the program had endured its first major security and confidence breach. The program chose to maintain course, believing that the preexisting model was the best possibility for treatment for the majority of the program residents. The program's foundations, however, were unstable. It had been rocked by repeated scandal and by continuing budget overruns. On a deeper level, the program's policy and philosophy was being challenged by direct evidence to the contrary. The Hendricks murders showed that an offender who had undergone a stay in treatment, then

[695] Dix, "Differential Processing of Abnormal Sex Offenders", 240-242. George Dix, the survey's author, states this may be the result of Atascadero's shorter-on-average period of confinement than corrections.
[696] Emmons, "Sex Offenders", M1; Tom Harrigan, "State's Program to Treat Sex Offenders Faces Scrutiny of Courts and Legislators", *Los Angeles Times* (April 3rd, 1980), B30.
[697] *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender,* ed. Barbara K. Schwartz, U.S. Dept. of Justice, National Institute of Corrections, Washington, DC (1988): 38, 62, 64; Janice K. Marques et. al., "Findings And Recommendations From California's Experimental Treatment Program", in *Sexual Aggression: Issues in Etiology, Assessment, and Treatment*, ed. Gordon C. Nagayama Hall, Taylor & Francis, Washington D.C. (1993): 197.

maintained involvement in the program for almost a decade, could remain a dangerous threat to the population at large.

Bursting: Fear, Overload and Termination, 1980-1986

"I believe treatment is a privilege. If they fail, as far as I'm concerned we can lock them up and throw away the key."

- Maureen Saylor, Program Director, in Jan Gildenhar, "Sex offenders: WSH treatment aims at molester's responsibility and sense of himself", *The News Tribune*, Tacoma, WA (January 3rd, 1984), B-1.

At the time the Kellogg Report was published, the field of sex offender psychology and treatment was undergoing rapid change. The Western State program – inpatient, group-oriented treatment – was an increasingly rare breed. The existence of a rehabilitative prison alternative for sex offenders had dwindled greatly from the heyday of the sexual psychopath legislation in the 1950's. Only nine other states now operated a "formal" program within a mental hospital.[698] Only two of those besides Washington, Florida and Oregon, had more than fifty patients.[699]

At the dawn of the 1980's, it was clear that the program could not continue to as it had before. According to the new batch of experts, sex offenders were a "predator" of habit, with a callous disregard for others and a pathological need to hurt for sexual satisfaction. Self-understanding and socialization were relevant but improving the offender's social skills and mindset alone could not cure their black hearts. The field redirected its focus toward behavioral conditioning and individualized therapy to combat the impulses of the offender directly. The Washington Legislature expected

[698] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 24.
[699] ibid.

significant change from the program in line with these demands, but gave few resources to accomplish this. The Western State program's application of this understanding would result in the program's therapists being allocated more authority and control, inevitably reducing the role of the group in its own treatment. This process would not play out fully, as before it could be completed, further re-offense scandals would lead to a deafening public outcry and the abandonment of the program by the DSHS. The program was ultimately terminated on security concerns, rather than any of its concrete, separate issues. The change in professional opinion that rendered the program obsolete was made exponentially more powerful with the addition of public fear, soon invalidating not only Western State's program, but the concept of sexual offender treatment itself.

The changes in sex offender treatment came from new findings in a number of areas, including clinical efforts, criminology, crime statistics, as well as from a wave of public demand for harsher penalties for sex offenses. The changes in sex offender theory and clinical practice were the first to manifest. What had, as previously discussed, been a field dominated by theorization was suddenly awash in surveys of conditioning, tentatively harnessed to assorted group therapy approaches. The journal *Criminal Justice and Behavior* had a symposium on sex offender treatment in December 1978. The articles in the *International Journal of Offender Therapy*'s 1972 symposium had focused on singular patients or offenders being analyzed, with varying Freudian psychoanalytical explanations given for the offenses. The new articles were almost the complete opposite. Becker et. al's "Evaluating Social Skills of Sexual Aggressives" and Marshall and Barbaree's "The Reduction of Deviant Arousal" went

over the clinic and recidivism-measured efficacy of new aversive conditioning and socialization interventions. These approaches, most of which were conditioning-centric, were new and largely untested. The researchers give clear goals and hypotheses for using their interventions with the particular offenders surveyed, and how a particular therapy might be applied in a clinical setting.[700] Becker et al.'s research, for example, attempted to use timed shocks during deviant fantasies. First, the shocks would be placed near the end, to condition the offender to dislike the deviant behavior. Then, the shocks would be moved to the beginning of the fantasy, which the researchers hoped would associate pain with the offender even thinking about committing the act.[701] One article, "Blame Models and Assailant Research", stuck to evaluating theory, but even then it examined what clinical approaches were "linked" to what model of blame, and how programs could balance programs designed to repair the offender's ability to socialize with offender- based introspective therapy.[702] The actual form of the clinical work these experiments were undertaken in was still given minimal attention. Practical therapeutic approaches, at least, were at long last getting their time in the spotlight.

The new therapies were accompanied by new theories. Nicholas Groth and Jean Birnbaum's *Men who Rape*, published in 1979, was the landmark work that led this new wave. It articulated a new theory of sex offender motivation, based on individual case histories and clinical experience. Dr. Groth had run varied attempts at sex offender

[700] W.L. Marshall and H. E. Barbaree, "The Reduction of Deviant Arousal", *Criminal Justice and Behavior* 5 no. 4 (December 1978), 294-303; Judith V. Becker, Gene G. Abel, Edward B. Blanchard, William D. Murphy and Emily Coleman, "Evaluating Social Skills of Sexual Aggressives". *Criminal Justice and Behavior* 5 no. 4 (December 1978), 357-368; Vernon L. Quinsey and Wayne F. Carrigan, "Penile Responses to Visual Stimuli", *Criminal Justice and Behavior* 5 no. 4 (December 1978), 333-342.
[701] Marshall and Barbaree, "The Reduction of Deviant Arousal", 297-298.
[702] Stanley L. Brodsky and Susan C. Hobart, "Blame Models and Assailant Research", *Criminal Justice and Behavior* 5 no. 4 (December 1978), 379-388.

treatment at the Bridgewater State Hospital in Massachusetts, an institution that would now be labelled a "forensic hospital". Working with Birnbaum, he abstracted his experiences to a "model" of sexual offenders that emphasized the evidence found in individual case studies, which he presented with liberal quotation from the autobiographies of the offenders. He sought to demonstrate the psychic conflicts and personal qualities he believed he saw in offenders. He emphasized that his examples came from offenders he had worked with personally, and had seen throughout their court committed stay, rather than as a private analyst or in a more temporary evaluative setting.

His conclusions greatly differed from those of Karpman, Gebhard, and other previous investigators of sexual offense. Sexual offenders were thought much more sadistic and entrenched in their habits due to a denial of the feelings of others.[703] Groth found that the Western State program's belief that the offender was "yearning" for a mutual, fulfilling relationship, but unable to achieve it, was less than accurate. Groth's interviews with offenders suggested that their socialization problems varied greatly. Some had no desire to establish meaningful relationships with people, while others were socially "well-adjusted" but had little feeling or interest driving their actions.[704] This left them with a motivational gap, as well as a behavioral problem. "Nurturing" motivation in them was thought by Groth to be a much greater challenge than helping someone get in touch with their feelings. Groth was, in short, proposing that the sexual desires of the sex offender held much more weight in their misbehavior than previously

[703] A. Nicholas Groth and Jean H Birnbaum, *Men Who Rape: The Psychology of the Offender*, Plenum Press, New York (1979), 28-31.
[704] Groth and Birnbaum, *Men Who Rape*, 11-13, 38, 41, 46, 60.

thought. While these desires were still thought to be related to their emotional problems and socialization issues, and were triggered by problems handling stress, they were not solely extensions of these problems. The drives became self-sustaining and self-reinforcing. They could not be reduced to a manageable level by targeting the offender's psychological issues alone.[705]

These new theories undermined Western State's belief that group therapy and discipline alone could lead to significant changes in behavior. Karpman, Gebhard, Roth, and the other theorists who had influenced Western State's program considered the crimes of the offender misguided attempts to fulfill the same drives for sex or love and affection that the "average" person harbored. They became along paths that were bizarre, unacceptable or harmful to others because of assorted traumas, which resulted in a pattern of antisocial behavior. Restoration of "normal" means of satisfying these drives was the goal. The Western State Program did not fully subscribe to the theorizations of earlier psychologists, and it explicitly claimed to know little about the etiology of sexual offense.[706] The offender's conscious understanding of themselves and antisocial behavior had led to serious social maladjustment. The offender sought acceptance and affection as well as sexual pleasure when they raped others, and they had to be coached into understanding their needs and responsible means of meeting them. Letting offenders learn, through the group environment, how they could achieve acceptance properly in society would help meet the needs that drove them to offend. As Groth and others made offense-oriented inquiries in the 1970s, this "neurosis"

[705] Groth and Birnbaum, *Men Who Rape*, 214-220.
[706] Denenberg, "Sex Offenders Treat Themselves", 59.

hypothesis was downplayed.[707] Self-conception and sexual desires were increasingly disassociated. The sexual offender had issues with managing relationships, but they were not believed to be the primary motivation of their offenses. They did not seek love or acceptance with rape, but a fundamentally different fulfillment that no degree of interpersonal connection could supply.[708]

Authors differed on what exactly the desire was, and where it came from. Groth, writing with Ann Burgess, used the labels "power" and "anger" as two subsets of rapes of dominance, in which the rapist sought raw power over the victim. The fantasy they employed was a potentiation of the pleasure of their assault, not an internal excuse for it.[709] In *Men Who Rape*, he furthered his argument: the molestation of children was not fixation in a lower level of psychosexual development, but a desire to occupy a position of total control. Whether or not force was used was relevant, but that did not change the fact that all offenders wanted control, not traditional sexual desire.[710] Feminists, most notably Susan Brownmiller, tended to finger a patriarchal, inherently violent formulation of society as the key instigator in sexual assault. Social expectations of men's behavior and repeated undermining of the legitimacy of women's actions and feelings led to some men putting themselves before others in every capacity.[711]

The new theorizations strongly suggested that drastic changes were needed in preexisting treatment programs. The Western State SOTP's major target in therapy had

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[707] *A Practitioner's Guide,* ed. Schwartz, 10-11.
[708] Groth and Birnbaum, *Men Who Rape*, 29-31.
[709] A. Nicholas Groth and Ann W. Burgess, "Rape: A Sexual Deviation", *American Journal of Orthopsychiatry* 47, no. 3 (July 1977): 403-404.
[710] Groth and Birnbaum, *Men Who Rape: The Psychology of the Offender*, 8-9, 107, 142-144, 148.
[711] *A Practitioner's Guide,* ed. Schwartz, 23; Susan Brownmiller, *Against Our Will: Men, Women and Rape*, Simon and Schuster, New York (1975): 385-390;

been the offender's self-conception. The offender was believed to harbor a crippling fear of opening oneself to others and a deep-seated sense of inferiority, and this led him to, "secret", hurtful means of satisfaction. The new theorizations pointed to a much different approach. Sexual offense was now considered deeper-seated and more satisfying to the assailant than previously thought. Rehabilitation could no longer solely target a conflict of character. The sexual offender's negative self-image as a "criminal" and antisocial tendencies were relevant, but they were not the central factor. Creating a healthier self-conception would not stop their offenses. The professional community now believed they had to minimize in the offender a cruel pleasure he found in violating others, as well as condition them to recognize and avoid their cycle of offense. Group therapy alone would not moderate the behavior of most offenders.[712] They could not eliminate deviant arousal with conditioning, but they could make it less satisfying, and "interrupt" the offender's reinforcement of the urge. The offender had to, from then on, manage by conscious effort what treatment professionals believed to be constant, intrusive deviant sexual fantasies and urges.[713]

There was little delay in the acceptance of these new theorizations. The result of the acceptance of this characterization of offenders was a dramatic shift to behavioral interventions and individualized, cognitive-behavioral therapeutic methods in sex offender treatment. This new course of therapy was well-described in Anna C. Salter's

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[712] Jenkins, *Moral Panic,* 185-188; Dany Lacombe, "'Mr. S., You Do Have Sexual Fantasies?' The Parole Hearing and Prison Treatment of a Sex Offender at the Turn of the 21st Century", *The Canadian Journal of Sociology / Cahiers Canadiens De Sociologie* 38 no. 1 (2013), 45-46, 49; Karen Rahm, Robert E. Thornton, and Jerome M. Wasson, *The Sex Offender: A Review of the Literature*, Division of Juvenile Rehabilitation, Department of Social and Health Services. Olympia, WA (October 1984): 20-24.
[713] Salter, *Treating Child Sex Offenders*, 93-94; *A Practitioner's Guide,* ed. Schwartz, 23.

Treating Child Sex Offenders and Victims: A Practical Guide, one of the most popular books of its day on child sexual abuse. Salter's detailed description of therapy methods deemphasized analysis into the offender's "motivation". The theorization of sexual abuse as a cycle is described in some detail, but the offender's character issues are given minimal play. For Salter, the motivation of the offender was irrelevant to their treatment. What makes an offender "aggressive" or "self-effacing" or any other kind of mood or mindset was not discussed.[714] Instead, deviant sexual desire and a fundamental lack of empathy were considered the primary acting principles. These had to be eliminated at all costs. The pattern of offenses didn't matter. Therapy remained as a series of confrontations. However, these confrontations didn't come from other offenders. They came from a therapist, along with exercises assigned to individual offenders that focused on strategies to recognize denial, avoid temptations. Accepting responsibility for one's past was underlined. Embracing responsibility for one's future was not.[715]

The Western State program had identified patterns of offense and typified some aspect of sexual offense, such as the use of an "outlet" for emotional stress and a generally antisocial lifestyle. The new wave of sexual offender rehabilitation took this much further. The offender was now a *Sexual Predator,* a role with a believed specific "track" of behavior. The term "predator" became increasingly common at this time, with explicit connotations of cruelty and an animalistic "need" that was not consciously

[714] Anna C. Salter, *Treating Child Sex Offenders and Victims: A Practical Guide,* Sage Publications, Newbury Park, CA (1988), 122.
[715] Salter, *Treating Child Sex Offenders,* 93-94.

negotiable.[716] Therapeutic interventions with sex offenders had to address every detail of a believed "cycle" of sexual offense common to all.[717] An offender who claimed to have had a passing, inappropriate attraction that pushed them to offend, a situation Gebhard described as common in his survey, was thought a liar.[718] The sexual offender's wrongdoing was thought to preoccupy to the extent that repairing their lives would require non-stop effort and extreme measures of restraint by the offender.[719] Salter and other contemporary theorists did not entirely discard the principles behind di Furia's approach. The day-to-day behavior of the offender was the central object of the therapy. Psychoanalytical theory was soft-pedaled. The sexual offense, however, was recast as the product of brutal desire, freed by weak empathy. It had to be targeted and destroyed by reconditioning the offender using the stimuli that excited them. The unmet social needs and maladaptation of the offender were not totally discarded, and group therapy was given some mention, but the text downplayed the ability or interest of the offender to engage with treatment, and suggested desires of such intense strength that it would take complete commitment to overcome them.[720] In short, a profound change in mindset resulted in a profound change in the field's "best practices" of treating the offender. Dr. Abel's private-practice aversive conditioning went from a niche approach to an essential feature, and the offender was now expected to demand intensive, explicit attention.

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[716] Jenkins, *Moral Panic,* 185-188.
[717] *A Practitioner's Guide,* ed. Schwartz, 69-77; Lacombe, "'Mr. S., You Do Have Sexual Fantasies?' ", 41-45; Marshall and Hollin. "Historical Developments in Sex Offender Treatment", 126-127; Salter, *Treating Child Sex Offenders,*45-47, 51-52; Freeman-Longo and Wall, "Changing A Lifetime of Sexual Crime", 59-60; Rahm et. al., *The Sex Offender,* 20-24.
[718] Gebhard, *Sex Offenders,* 54-55, 78.
[719] Salter, *Treating Child Sex Offenders,* 85-88, 106-107.
[720] Salter, *Treating Child Sex Offenders,* 112-115.

The Pierce County Sheriff's Association Child Abuse Manual from 1983 spoke to the tenor of the times. It was created not for the police, but for the general public. Reporting and preventing child abuse was, according to the introduction, the public's responsibility. The abuse a child was so damaging that waiting for police to detect it would help the child too late. All adults needed to know the warning signs and vigilantly watch for them in all children they came in contact with.[721] Child sexual abuse was given heavy emphasis as the hardest to detect and the most important to watch for.[722] In short, the response of the law enforcement to a believed "epidemic" of child abuse was appealing to the public to assist in their capture and prosecution. The public were no longer asked to make a welcoming community for the released offender, but to assist in finding and reporting rape and molestation to law enforcement. What the justice system will do with these offenders should not be their concern.

Indirectly, the manual attested to the growth of private, outpatient treatment for sexual offenders in Washington State In 1972, Seymour Halleck, evaluating the sex offender field, had complained that a lack of outpatient sex offender treatment was preventing therapy from reaching those who needed it.[723] What treatment programs existed were almost exclusively inpatient, and many, including Western State, refused "volunteers" who had not been tried and convicted of a crime.[724] These programs were challenged by a tide of anti-rehabilitation thought that was circulating in correctional

[721] Pierce County Deputy Sheriff's Association, *Child Abuse and Sexual Assault Manual,* Tacoma, WA (1983), 81-85.
[722] Pierce County Deputy Sheriff's Association, *Child Abuse*, 91.
[723] Seymour Halleck, "The Therapeutic Encounter", in *Treatment of the Sex Offender,* eds. H. L. Resnik and Marvin Wolfgang, Little Brown, Boston (1972).
[724] Denenberg, "Sex Offenders Treat Themselves", 57.

philosophy at the time, spearheaded by Robert Martinson's 1974 essay "What Works? – Questions and Answers about Prison Reform". His paper evaluated rehabilitation efforts conducted under Corrections departments nationwide. His goal was to determine, simply put, what methods and environments worked in criminal rehabilitation and what didn't. Discouragingly, he found "nothing work[ed]" for rehabilitating prisoners, no matter the program's nature, size, intensity, or location. [725] His findings were widely reported, and prompted a backlash against rehabilitative programs within prisons for convicts nationwide.[726] Within Washington, there was never an in-prison rehabilitation program for sex offenders, but the results emboldened correctional authorities to refuse any responsibility for the impact of prisons on a released offender's behavior.

As rehabilitation was shooed away in corrections, it perched onto "community" treatment. Over the 1980's, outpatient or "community" therapy for sex offenders became more popular nationally than the previously dominate inpatient, "residential" approach.[727] This trend began early in Washington. These practices rarely saw patients seeking therapy of their own volition. Most often, a stint in therapy was assigned by parole boards or other court figures following a convict's release as a parole condition. The programs grew with the growth of outpatient mental health and the growth of sexual offense convictions. Because of their "target audience", these programs were strictly outpatient. They did not have inpatient facilities, and were, by and large, not

[725] Robert Martinson, "What Works? - Questions and Answers About Prison Reform", *The Public Interest* 35 (1974), 22-25.
[726] *A Practitioner's Guide,* ed. Schwartz, 149; Robert E Freeman-Longo and Fay Honey Knopp, "State-of-the-Art Sex Offender Treatment: Outcome and Issues", *Sexual Abuse: A Journal of Research and Treatment* 5 no. 3 (1992): 143'; Soothill, "Sex Offender Recidivism", 156.
[727] Marcus Nieto, "Community Treatment and Supervision of Sex Offenders: How It's Done Across the Country and in California", California Research Bureau, California State Library, Sacramento, CA (2004), 3-7.

equipped for patients with severe mental health problems. These programs varied their length and technique, but the overwhelming majority were of the new, behavior modification oriented style. The justice system embraced this move to outpatient treatment. The Western State Program's belief that prison would "harden" the offender and make treatment difficult was ignored.[728]

As Western State's program became increasingly crowded and the waiting list expanded, many offenders sentenced to short terms were directed to community programs instead. The priorities of these programs were, in a word, different than the Western State program. One of these programs was the Incest Treatment Program at the "Comprehensive Mental Health Center".[729] The advertisement was targeted to the offender's wife – the offender was always described as male and a proviso stated that the program was best suited for married couples. The program offered comprehensive therapy, with individual sessions for the husband, the wife, and their child or children, alongside group sessions. Throughout the long-form advertisement, language better suited to customer service than medical advice was used: "We want to welcome you...We are pleased that you have made the commitment to deal with the sexual abuse within your family....You may want to remember [these signs that your partner is lying]..."[730] This program was wholly paid for by the family in question. There was an $150 evaluation fee per adult and fees for each appointment thereafter. "Medical Coupons" could be used by needy families. The advertisement asked any reader who

[728] *Guided Self-Help: A New Approach… July 1973-June 1974*, 3; MacDonald et, al, *Treatment Of the Sex Offender: Ten Years*, 19.
[729] Pierce County Deputy Sheriff's Association, *Child Abuse*, 27-49.
[730] ibid, 27.

could spare the money to consider a sponsorship for a "child" who could not afford treatment. [731] The program gave particular attention in the ad to its skill in calming children. Staff worked with law enforcement to develop a special room, decorated with a colorful mural, for child "interviews" about abuses. The staff claimed they had a set of techniques that made children feel comfortable giving testimony about their abuse, and promised they could ensure the information was complete enough to make it admissible in court.[732] The program was quite large, and saw 387 people for treatment in 1982, just three years after its 1979 founding.[733]

The tide of change was not only sweeping in new treatment modalities. Inpatient approaches were rapidly incorporating cognitive-behavioral approaches as well. Oregon State Hospital's program in Salem, Oregon, was a pioneer in using aversive conditioning and Cognitive-Behavioral "treatment modules". The hospital had attempted treatment for sex offenders back in the 1960's. According to Jenkins, in 1963, a "special facility" had been constructed for those "found to be sexually dangerous to children" at Oregon State Hospital. It was the "first of its kind" in the U.S.[734] This effort appears to have fizzled, as no further mentions were made of a program in Oregon in the secondary literature for two decades. Whether this silence was an accurate representation of the state of Oregon's sex offender treatment is beyond the scope of this paper. The story as it is generally described restarts in 1975. The Oregon Legislature mandated that the Oregon Department of Corrections and the Mental Health

[731] ibid, 29. The "child", of course, was really the offender *and* their family, but the copy emphasized the child.
[732] ibid, 35, 37.
[733] ibid, 29, 31.
[734] Jenkins, *Moral Panic,* 84.

division of the Oregon Department of Human Resources[735] create mental health programs for criminals of all stripes. They developed a number of programs over the next few years, some residential at Oregon State Hospital, others outpatient. Their sex offender treatment program opened its doors in 1979.[736] One of its first directors was Steve Jensen, a veteran volunteer coordinator from the Western State program. [737] By 1981, it was already achieving national notice, including a writeup in the *New York Times.*[738]

The Oregon program took a lot of inspiration from the latter-era Western State program, but its integration of behavioral therapy rendered it drastically different in practice. It was an intensive residential treatment program inside of Oregon State Hospital, a state mental hospital in Salem, Oregon.[739] The offender's outlet was here called the "deviant cycle", and like at Western State, it was not simply the sexual offenses themselves, but a host of behaviors coupled with a negative mindset.[740] The offense was an "active" process, reached by a series of "apparently irrelevant decisions" The other members of the therapeutic group had to learn the characteristics of the deviant cycles of the other group members. The group sessions emphasized "respectful" discussions in group. Offenders gave one another "feedback" rather than issuing confrontations.[741] This was supplemented with a fantasy/behavior log, education

[735] Now the Oregon Department of Human Services.
[736] *A Practitioner's Guide,* ed. Schwartz, 32.
[737] AP Wire, "Oregon Hospital", 75.
[738] ibid; *A Practitioner's Guide,* ed. Schwartz, 32; Robert Freeman-Longo and Roland Wall, "Changing a Lifetime of Sexual Crime", *Psychology Today* 20 no. 3 (1986), 58-62.
[739] AP Wire, "Oregon Hospital Seeks to Cure Sex Offenders", *The New York Times* (November 29th, 1981), 75; Jones, "Women help", F1.
[740] *A Practitioner's Guide,* ed. Schwartz, 103; Freeman-Longo and Wall, "Changing A Lifetime of Sexual Crime", 59-60.
[741] *A Practitioner's Guide,* ed. Schwartz, 103, 106, Rivelane, *Sex Offender Treatment Program Plan*, 9.

modules in subjects like “anger management” and “parenting”, and a number of book reports.[742] Poor self-esteem and socialization were considered major precipitating factors in the offense, and were targeted with particular classes in interpersonal skills. Offenders who did well in the sessions were promoted through a series of six steps, through a work-release phase, then released.[743] The program was much less “group-led”, but it still relied on the ability of the group to correct its members behavior, and it operated entirely within a minimum-security environment in a mental hospital.[744]

The Oregon program made two defining changes from Western State Hospital’s approach: the innovation of the use of the “penile plethysmograph” in behavioral condition and the establishment of a complex outpatient program run in the surrounding community. The “penile plethysmograph” measured the strength of an offender’s erection. A number of previous sex offender treatment programs had used aversive conditioning to attempt to reduce the arousal of the offender to deviant material.[745] The most noteworthy practitioner in the U.S. was Gene Abel, who published a number of pioneering studies on the use of aversive conditioning through the early seventies.[746] The Oregon program tied the two together, the conditioning serving as therapy, the plethysmograph as its test. The offender took “baseline” plethysmograph tests. Program staff determined what deviant fantasies he had by consulting his case history and

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[742] *A Practitioner’s Guide,* ed. Schwartz, 215-217.
[743] ibid; AP Wire, “Oregon Hospital”, 75.
[744] AP Wire, “Oregon Hospital”, 75.
[745] Robert L. Geiser, *Hidden Victims: The Sexual Abuse of Children*, Beacon Press, Boston, MA (1979): 31-33.
[746] Gene Abel, Donald Levis, and John Clancy, "Aversion Therapy Applied to Taped Sequences of Deviant Behavior in Exhibitionism and Other Sexual Deviations: A Preliminary Report", *Journal of Behavior Therapy and Experimental Psychiatry* 1 no. 1 (1970): 59-66; Brecher, *Treatment Programs,* 54-56; William Marshall and Clive Hollin, "Historical Developments in Sex Offender Treatment", *Journal of Sexual Aggression* 21 no. 2 (2015), 126.

measuring his response to certain images. When they had found what images in particular aroused him, they began forcing the offender to view the images over and over again, this time with a "putrid odor" piped through a tube into his nose. These sessions happened twice a week. The plethysmograph was used to track how much a particular stimulus was dulled over time, by hopefully showing weaker and weaker erections from the same pictures / types of pictures.[747] The only other program that could be found which tracked the results of aversive conditioning with a plethysmograph was an effort in Wormwood Scrubs in England, which took place at around the same time.[748] Otherwise, it had only been tested in experimental settings by researchers such as Abel. The staff had to build their own plethysmograph from scratch.[749] The combination achieved rapid popularity within sexual offender treatment, and by 1987, it was used in almost every program that used conditioning, earning an entire chapter devoted to it in the defining work *A Practitioner's Guide to the Treatment of the Sex Offender*.[750] The machine was believed by staff and patients to be foolproof: "I knew there was no way to beat that machine. A man could fool the program, but there is no way to lie to your own body."[751]

The second major innovation was the gradual outpatient program, later labelled the "containment" model.[752] The program ran on a minimum term of 15 months.[753] Oregon's Sexual Psychopath statue was, surprisingly, still on the books until 1980, but

[747] AP Wire, "Oregon Hospital", 75.
[748] Marshall and Hollin. "Historical Developments in Sex Offender Treatment", 127-128.
[749] *A Practitioner's Guide,* ed. Schwartz, 32; Schwartz, "Overview", 364.
[750] ibid, 58, 85-93.
[751] AP Wire, "Oregon Hospital", 75; *A Practitioner's Guide,* ed. Schwartz, 32, 85.
[752] Schwartz, "Overview", 373.
[753] AP Wire, "Oregon Hospital", 75.

the program did not use it.[754] The program instead screened volunteer offenders from corrections who had less than two years left before parole. The offender had to, among other things, assure staff he had no intention to leave the state upon completion of the program.[755] Once accepted, the offender entered the program for at least the remainder of his sentence. His positive development in his treatment did not accelerate his release.[756] The "steps" allowed for graduation to work release, but they did not supersede the inmate's sentence. When the inmate had completed their sentence *and* reached work release in the program, they began working in the community while still living at the hospital. The phase was considered "crucial", and they remained full-time participants in the program while their progress was tracked.[757] When they reached the discharge stage, the offender was asked to live within a certain distance from the hospital.[758] They had a complicated set of parole requirements and had to meet with a parole officer at least once a month. The courts and the hospital, therefore, were both kept aware of his activities, and were able to monitor his ability to return to society.[759] The program's combination of cutting-edge treatment and a stepwise reintegration pleased both the program staff and Corrections, resulting in minimal escapes over the program's lifespan, participation by the justice system, and a claimed ~14% recidivism rate.[760] These advances were rewarded. Through the 1980's, the program was

[754] *A Practitioner's Guide,* ed. Schwartz, 158.
[755] ibid, 32.
[756] ibid.
[757] ibid.
[758] Schwartz, "Overview", 364-365.
[759] *A Practitioner's Guide,* ed. Schwartz, 32, 213-214.
[760] ibid, 32, 54, 65.

considered a success by the public, the legislature and the profession, for effectively combining security and later surveillance with treatment.[761]

Oregon's advances gained it national renown and wide public acceptance. In 1983, a couple years after its founding, it appointed Robert Freeman-Longo as the program's director. Under his tenure, the program maintained its forward momentum in pursuing new treatment modalities. He was one of the early adopters of the Relapse Prevention treatment philosophy, a group-centered approach that sought to define the offender's cycle of violation and teach him strategies to leave it and avoid it for good.[762] His efforts to codify this and other behavioral interventions led to a series of impromptu meetings of the program clinicians and private practitioners from the area. This ultimately led to the creation of the Association for the Treatment of Sexual Abusers, which remains to this day the preeminent association of sex offender treatment providers.[763] In Barbara Schwartz's defining survey of sex offender programs, conducted in 1987, it is mentioned again and again and described as an innovator in almost every capacity.

Western State's program, in comparison to it and to other programs nationwide, seemed outmoded. From 1970 to 1980, the actual therapy undertaken by the groups changed little. There were a number of program innovations, most notably the "buddy" system, but not therapeutic ones. Following the Kellogg report's criticism on this fact,

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[761] ibid, 32, 37.
[762] *A Practitioner's Guide,* ed. Schwartz, xiii; Freeman-Longo and Wall, "Changing a Lifetime of Sexual Crime" 58-62; Robert E Freeman-Longo and Fay Honey Knopp, "State-of-the-Art Sex Offender Treatment: Outcome and Issues", *Sexual Abuse: A Journal of Research and Treatment* 5 no. 3 (1992), 145; Schwartz, "Overview", 364.
[763] Schwartz, "Overview", 370.

the program worked to come into line with the field's new findings. The program added masturbatory reconditioning to its therapeutic repertoire in 1982 and aversive conditioning ala Oregon in 1984.[764] The masturbatory program was akin to others developing around the country. Offenders presented detailed description of an acceptable masturbatory fantasy. On staff approval, they masturbated alone in special on-clinic "lounges", narrating the whole time into a cassette for later staff playback and analysis.[765] The aversive conditioning program was functionally identical to Oregon's. The offender was sat in a chair in front of a projector. Sexually explicit pictures of children and/or women in peril were projected, accompanied by a foul smell, to associate the stimulus with discomfort.[766] Western State was only a few years behind the curve when it implemented therapies. Professional opinion on sex offender treatment had shifted so drastically in the last decade, however, that their absence was increasingly unacceptable. For some practitioners, a program without aversive conditioning may as well not exist.[767]

The addition of these modalities brought the program closer in line with the mainstream of sex offender treatment. In the process, however, the authority of the residents in the treatment group was eroded. The nature of aversive conditioning and masturbatory reconditioning precluded meaningful group input and oversight, weakening its authority. As discussed earlier, the program had previously assigned a

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[764] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 35.
[765] Maureen Saylor and M.M. Vitols to Lyle Quasim, memorandum, July 27th, 1983, "Masturbation"; Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 18.
[766] *02* and *03,* Interview Transcript, 5; Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 35.
[767] Salter, *Treating Child Sex Offenders,* 130: "By itself… insight-oriented therapy is unlikely to be effective."

"buddy" for almost any situation, including meetings with therapists. The goal of this practice was to ensure honest communication between the therapy supervisor, the resident and the leader, and to give the group leader the maximum degree of insight available into the resident's behavior.[768] For both masturbatory and aversive conditioning, the group leader's presence in the session with the resident would not only be extremely uncomfortable, but it would not offer much insight. The new programs also demanded more frequent meetings with therapists, and the program began phasing out having the group leader or another "buddy" present for these sessions. The offender was expected to report back to their group about their behavioral sessions, but without the buddy as a "witness", many were less than forthright.[769] Alongside this, the therapies were hard to discuss on a meaningful level in group. They sought to modify the offender's subconscious. Practitioners talked through the process with the offenders, but the actual mechanism of therapy was based on the offender's response to negative stimulus, not on any conscious realization.

The new therapies weakened the group's authority, but these losses were an inadvertent casualty of implementing a new, non-group treatment modality in the program. One other major change, however, was an intentional and explicit deprivation of agency from the treatment groups unrelated to the rollout of behavioral thearpies. In 1984, the program ended group voting on observation candidates. Groups could no longer choose, or get a say in choosing, what offenders would be kept beyond observation. The program switched to having a separate, 30-offender "observation"

[768] *01* Interview Transcript, 22-23.
[769] ibid.

group for new residents, which operated away from the others. This new group ran through sessions like the others, but the admittance of an offender was entirely on the decision of the program staff, and the group they were reassigned to once they were admitted had no say in the matter.[770] One of the key facets of the group – evaluating the new offenders – was taken away. The group was increasingly reverting to an arena for therapy, with "membership" being granted at the discretion of outside authorities, and with the responsibility of treatment increasingly delegated to the program staff, rather than to the group members themselves. One of the few things that remained the same was the continued use of volunteers for psychodrama sessions, which remained much as before through 1985, albeit with a much lower public profile.[771]

In a strange twist, the program was rapidly becoming the dominant population of Western State Hosptial. Deinstitutionalization in Washington had slashed Western State's "civilian" patient population over the 1970's. Meanwhile, Western State's sex offender resident burden intensified. In 1977, the hospital's average daily population was down to 821, about 400 less patients than 1972. Of these, 204 were sex offenders, and another 135 were mentally offenders, making a total offender population of 339. Only 482 of the 821 "average daily" patients were nonoffenders.[772] What was once a program in the hospital was increasingly the primary function of it. The problem was worsened by a lengthening of inpatient treatment stay from an average of 15 to 20

[770] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 14.
[771] ibid, 16.
[772] Office of the Governor, *State of Washington Budget, 1979- 1981 Biennium,* Olympia, WA (December 1978), 421-422.

months to an average of 24 months.[773] Setting up the sister program in Eastern State had helped for a time, but at the rate offenders were being referred to the program, the population would soon surpass those levels regardless.

As a stopgap to the increasing program population, the program instituted a waiting list for offenders who were referred to the program by sexual psychopath evaluations. The list began in 1980.[774] By the end of the year, there were 59 offenders waiting for evaluation. By the end of 1982, there were 145. While the offenders waited to be evaluated, they were held in county jails, worsening preexisting jail overcrowding and angering local law enforcement.[775] The percentage of offenders that were declared sexual psychopaths and put on review by the program remained large. The program had, at the start of the 1970's, evaluated over 80% of sex offenders convicted of a crime in Washington. As of 1983, the number they observed had been reduced to 38%, but the massive increase in reporting and imprisonment for sexual offenses meant the actual number of offenders observed was only slightly smaller.[776]

Over the last five years, program expectations on the staff-to-patient ratio had significantly changed. The average group size in 1983 was twenty people. MacDonald had considered a perfect number of men in the group in 1969.[777] Now, numerous observers and program staff claimed that groups of this size were overlarge, both for staff and residents. One article stated with alarm that the resident, evaluating members

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[773] Brecher, *Treatment Programs for Sex Offenders*, 16; Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 18; Gildenhar, "Sex offenders", B-1.
[774] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 14.
[775] State of Washington Sex Offender Policy Board, "Review of the Special Sex Offender Sentencing Alternative", Office of Financial Management, Olympia, WA (December 2013), 9.
[776] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 20.
[777] Gelernter, "Failures cast cloud on sex-offender program", C2

of his group, was supposed to keep track of 19 other residents and their habits. The 1983 McGovern report stated that new therapy supervisors were needed as soon as possible to maintain an effective therapy environment.[778] On a more practical level, the program could no longer keep pace with the number of offenders seeking commitments for observation. The courts maintained a constant, heavy flow of offenders for observation, and the state kept the purse closed.

Hiring new supervisors and keeping them was hampered by the positions' extremely low wages. In 1971, the position of Therapy Supervisor I, a starting position for new staff, had a salary of around $800 a month.[779] In 1983, the same position earned around $1,300 a month, >$600 below the previous salary adjusted for inflation.[780] These proportional decreases held for all classes of Therapy Supervisors. The decline in wages made it difficult for the program to attract quality candidates. A number of old hands left for better pay and conditions elsewhere, and some of their replacements departed after just months with the program.[781] For similar reasons, the lack of support from the state government severely hurt staff morale. Tim Smith, a therapy supervisor who became assistant program director, left the hospital in 1981 because he viewed the program's relationship with the courts as "untenable".[782]

As conditions worsened, the problem worsened. Therapy supervisors were being assigned their own groups after only six months with the program and little outside

[778] Gildenhar, "Sex offenders", B1; Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 28, 38, 69.
[779] MacDonald to Walsh, "Personnel Needs", 7-8.
[780] Gelernter, "Failures cast cloud on sex-offender program", C2.
[781] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 28; *01* Interview Transcript, 24-25.
[782] Gordon, "Can all sex offenders be helped?", C1.

experience.[783] The "disruption" of high turnover was thought especially disastrous on the rehabilitation of the "insecure" offenders, who took it as rejection.[784] Training these new hires without a full complement of experienced personnel was something the program was totally unequipped to do. MacDonald had created a specific position for the program with few parallels in the Washington mental health system, yet neither he nor his successors create a manual or training protocol for therapy supervisors.[785] Further, there was no higher education program in sex offender education. All new hires effectively had to learn by experience and by the guidance of their colleagues. When the experienced staff began to leave, there were fewer and fewer old hands for the new arrivals to learn from.[786] What this meant was a sharp decline in quality of care. In one horrible case, *01* remembered that two "young women therapists" became romantically involved with a resident in their group. The groups involved knew of the transgressions, but the members were afraid to approach other staff because the women controlled their future in the program.[787] The relationships continued until one of the residents came forward. The therapists in question were let go. The residents were asked if they wanted to continue with the program, and one asked to be sent back to jail.[788]

Costs continued to rise, following the program's population. In 1980, the cost per patient per day of the program in direct costs – the costs of employing the staff for the program and securing equipment specific to it – was ~$11.50. The cost of the

[783] *01* Interview Transcript, 25; Gelernter, "Failures cast cloud on sex-offender program", C2.
[784] Gelernter, "Failures cast cloud on sex-offender program", C2.
[785] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 27.
[786] *01* Interview Transcript, 24-25; Gelernter, "Failures cast cloud on sex-offender program", C2. Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 27.
[787] *01* Interview Transcript, 24-25.
[788] ibid.

program *in toto* – incorporating the cost of maintaining the ward, its prorated share of Western State's general expenses on food and medicine and other supplies, and other vital but nonimmediate elements – was $43.20. In 1983, these costs began to spike, reaching $15.84 for direct costs and $58.66 *in toto.* The estimates for 1985, prepared for the December 1985 audit by the Legislative Budget Committee, were a staggering $30.58 in direct costs and $71.17 *in toto.*[789]

Western State Hospital's program limped along through 1982, with public interest fading in the absence of sensational news. In early 1983, the holding pattern was broken. James Lee O' Neil, a resident, violently raped a number of women while out on work release the previous fall and winter. The Pierce County Sheriff suspected him in a total of a dozen cases, and he was ultimately charged and convicted of two counts of first-degree rape.[790] The charges came as a shock to program staff. The offenses were committed within the short, supposedly fifteen-minute interval O'Neil had between leaving the hospital and the start of his work shift. Before entering work release, O'Neil had undergone "two batteries of intense interviews with therapists and appeared in Superior Court", according to procedure.[791] While the offenses were ongoing, his group, the last line of defense, did not notice a change in him that the program architecture believed they would.[792] O' Neil was able to continue his assaults until he was caught red-handed. The three women assaulted later sued the state,

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[789] Robert Krell, *Sex Offender Programs at Western and Eastern State Hospitals: A Report to the Washington State Legislature,* Legislative Budget Committee Report No. 85-16, Olympia, WA (December 1985): 22-23.
[790] Marlowe Churchill, "Arrest of WSH patient shocks therapists who treated him", *The News Tribune,* Tacoma, WA (March 5th, 1983); Carey Quan Gelernter, "Failures cast cloud on sex-offender program", *The Seattle Times* (March 7th, 1983), C1.
[791] Churchill, "Arrest of WSH patient".
[792] Gelernter, "Failures", C2.

claiming that the state and the Program were negligent in allowing him on work release.[793] These lawsuits were given lots of press coverage and their results were front-page news.[794] Ultimately, the parties settled for a total of $485,000.[795]

The program was promptly hit with another series of negative reports in the press. This time, however, the criticisms began to stick. To a large extent, however, it was for all the wrong reasons. The O' Neil case was a failure of the program to perform as either treat an offender or understand and predict his offenses. He did not "escape" the program. The newspapers, however, focused overwhelmingly on security, and implied that all offenders were like O' Neil – biding their time, waiting to violate others, and seeking the quickest route to do so. One piece asked rhetorically: "[This case] is leading the public to wonder once again whether it is too easy for a rapist or child molester to escape jail by going to Western State…" Ms. Saylor argued that the program was not a "cushy alternative" to jail. The author made it clear she was unconvinced.[796] Much of the rest of the article expressed concern about the lack of evidence for, and research in, sexual offender treatment.[797] The "success stories" that had run in the 70's were gone, replaced by a flurry of articles and reports that sharply criticized the program. Sexual offenders were repeatedly intoned as untrustworthy, dangerous deviants who were barely kept in line by maximum-security prisons and who were one trigger away from a rape spree.

[793] Gildenhar, "Rehabilitation issue", B1.
[794] Teresa Cronin, "Rape victim to get $135,000 in WSH work-release case", *The News-Tribune,* Tacoma, WA (May 14th, 1985), front page.
[795] Gordon, "Can all sex offenders be helped?", C1.
[796] Gelernter, "Failures", C1.
[797] ibid, C2.

The *Lakewood Press*, the local paper that replaced the *Suburban Times*, was especially vitriolic. It claimed that the program, variously "infamous" or "controversial", had been opposed for quite some time in the area. The program's continued existence was insinuated to be the result of tone-deaf bureaucrats trying to protect other government employees, jeopardizing the community in the process. The paper's single greatest concern was program security, with all other questions on sex offender treatment being lower-level points of interest. [798] The public was, in short, more concerned about the possibility of future escapes of sex offenders than of the program's accomplishments and failures so far. The arrival of the theory of the habitual, difficult-to-cure, marauding sex offender made the program seem a time bomb, rather than an opportunity. For the next three years, public agitation over the program would remain constant, with a similarly angry press following beside.

The state's reaction was initially more muted. The program was tasked with performing an internal audit, again with the help of Dr. McGovern, and was ordered to maintain grounding for six weeks on the authority of the Head of the DSHS, Alan Gibbs.[799] McGovern's second investigation found that conditions had deteriorated significantly since the 1979 Kellogg Report and the First McGovern Evaluation. The program had remained much as it was, treatment-wise, despite explicit recommendations to change. However, McGovern argued this was not because of disinterest in implementing new methods. Instead, "untenable circumstances", notably

[798] Bob Donohoe, "Area leaders set to discuss Western State", *The Lakewood Press* 3 no. 18, Lakewood, WA (May 1st 1985), Front Page; Grace T. Eubanks, "No change on WSH sex offenders' program", *Lakewood Press,* Lakewood, WA (October 17th 1984), 1, 7; Grace T. Eubanks, "Sex unit may be gone from WSH by mid-87", *The Lakewood Press,* Lakewood, WA (February 5th, 1986), 2.
[799] Gildenhar, "Sex offenders", B1; Gildenhar, "Rehabilitation issue", B1.

very low salaries, had resulted in the program losing "key staff". What staff were left had their hands full administering treatment, rather than researching up-to-date techniques.[800] The report concluded by commenting that refocusing the program to lower-risk offenders was well-advised, but that nothing could fix its problems except better staffing and time for those staff to improve treatment.[801]

The changes in therapy were accompanied by a significant increase in outside demands on program security. A special security staff now monitored the offenders at all times on the recreation fields and in the gymnasium.[802] This increase in staff resulted in a mammoth spike in treatment cost. The program's "direct treatment costs", which was in the main staff salaries and pay, went from $889,756 in Fiscal Year 1982 to $1,139,000 in Fiscal Year 1983 then to $1,560,599 in Fiscal Year 1984.[803] The same program that had rejected a perimeter fence just over a decade ago had installed cyclone fencing around its recreation area.[804]

The hospital, pressured by the state to do something, expelled 28 residents who had made unsatisfactory progress.[805] The state, however, chose again not to grant the program any assistance, financial or otherwise. Commitments continued to arrival at an unsustainable rate, even with the program's negative publicity. As of October 1984, there were 217 offenders in the program, 27 on work release or outpatient and 190 inpatient.[806] The program continued course as best it could.

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[800] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 28.
[801] ibid; Gildenhar, "Rehabilitation issue", B1.
[802] ibid, 40.
[803] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 21-23.
[804] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 63.
[805] Gildenhar, "Sex offenders", B1.
[806] Grace T. Eubanks, "No change on WSH sex offenders' program", *Lakewood Press,* Lakewood, WA (October 17th, 1984), 7.

The concern was notably "local". O'Neil's assaults had occurred entirely within a short radius of the hospital.[807] The public had shown intermittent resistance to the program since the Zuricka escape, most of which was concentrated in a few outspoken advocates. Shirley Winsley, later a Lakewood District Representative, was one of the first. She went before the Senate Judiciary Committee in 1975 asking that the program be moved to Corrections.[808] It was not until the early eighties, however, that opposition among a few developed into fervent rejection and materialized as political opposition. Unsurprisingly, it was the residents of Steilacoom and Lakewood, the two towns that surrounded Western State Hospital, which mounted the strongest opposition. The public outrage manifested itself in numerous town hall meetings with the program staff. These meetings began in the wake of the O' Neil in The tenor of these meetings became more hostile as the decade wore on. In one noteworthy incident, "…the wife of the late Larry Hendricks" came to a meeting in October 1984. She asked if program graduates were "no longer… employed in the program".[809] Lang Taylor, a therapy supervisor, assured her the program no longer believed that it took a sex offender to cure one, and that the initiative had ended.[810] Another woman told reporters she had been assaulted by a released resident and wanted the program moved to a prison as soon as possible.[811]

The program's problems were exacerbated by the arrival of a new, drastically different sentencing procedure for all offenders. In 1981, the state legislature authorized

[807] Churchill, "Arrest of WSH patient".
[808] Grace T. Eubanks, "Sex unit may be gone from WSH by mid-87", *The Lakewood Press,* Lakewood, WA (February 5th, 1986), 2.
[809] John Ellingson, "WSH sex-offender program worries Lakewood residents", *The News Tribune,* Tacoma, WA (October 4th, 1984).
[810] ibid.
[811] ibid.

the creation of an independent body, the Sentencing Guidelines Commission, to establish a system of standards regarding the sentencing of various crimes.[812] The commission was established to create an entirely new protocol for sentencing offenders that would replace the parole board for most cases. The state believed long terms of post-sentence observation had proved ineffective and expensive. Crime had to curtailed by other means.[813] It was three years before the committee unveiled its new defined-sentence system. The system, in brief, weighed the criminal's history and the seriousness of the current crime in a formula. After completing the formula and arriving at an "offender score", the judge arrived at a range of sentence length and, if applicable, a set of acceptable alternatives to a jail term. For example, for possessing or distributing child pornography, the defendant "scored" a point in their "offender score" for all adult felony convictions before this trial and half a point for all juvenile felony convictions. For a "0" offender (no previous convictions), the sentencing range was 15 to 20 months. For a "5" offender, the sentence was 41-54 months, and for a "9 or more" offender, 87-116 months.[814] Most offenses had a similar scale that was "tight" for its minimum sentences and wider for "higher-scoring" offenders. The judge's choice was limited to a sentence length within the suggested range or, if the guidelines permitted it, a prison alternative. In our example, the judge could choose a 90-day confinement followed by a maximum of two years community supervision if the defendant was a first-time

[812] ibid, 11; *Sentencing Guidelines Implementation Manual,* Sentencing Guidelines Commission, Olympia, WA (June 1984), v-vi.
[813] *Sentencing Guidelines Implementation Manual,* v; Lieb, *Washington's Sexually Violent Predator Law,* 10; "Horrors Seen in New System Without Parole", *The News Tribune,* Tacoma, WA (June 22nd, 1984).
[814] *Sentencing Guidelines Implementation Manual,* III-76.

offender.[815] The change significantly reduced a number of sentences for the majority of offenders, at the expense of possible early release on parole: "do the crime, do the time".[816]

The execution of the Sentencing Guidelines Commission's recommendations occurred in steps for the first half of the decade. House Bill 1247 was the step which amended the laws and sentencing provisions defining the sexual offender. It followed the recommendations of the Sentencing Guidelines Commission with only minor deviations. The "sexual psychopath" classification was eliminated, but the procedure was retained.[817] There were a few modifications. The offender, the court or the state could make a motion for an evaluation to determinable their suitability for treatment. Both Western or Eastern State's program were included as suitable programs.[818] The judge sentenced the offender to a term of confinement. The evaluation period for the was shorted to thirty days. The offender did not have to be certified as insane or any other specific legal or medical classification.[819] From that point on, the admission process was effective the same as before. The hospital was still unable to "permanently" reject an offender from participation.[820]

The act itself stood to have little impact on the program's continued operation in of itself. The new sentence lengths it commissioned, however, were a problem. For

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[815] *Sentencing Guidelines Implementation Manual,* III-76.
[816] Janice Roscoe and Dr. Lowell L. Kuehn, "Treatment of Sex Offenders in Washington State: A Policy Memorandum", The Washington State Institute for Public Policy, Olympia, WA (April 1985), 2.
[817] Lieb, *Washington's Sexually Violent Predator Law,* 9; *Sentencing Guidelines Implementation Manual,* I-25, I-26; *Revised Code of Washington* 6 Title 71 (1986), 16.
[818] *Sentencing Guidelines Implementation Manual,* I-25, I-26;
[819] *Sentencing Guidelines Implementation Manual,* I-25, I-26; Riveland, *Sex Offender Treatment Program,* 2.
[820] *Sentencing Guidelines Implementation Manual,* I-25, I-26; Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 24.

more "minor" sexual offenses, such as indecent liberties and incest, it gave sentence lengths as low as twelve months. This was not enough time for an offender to enter the program, meaning that many of the low-risk, first time offenders the hospital thought were the best treatment candidates were now disqualified.[821] The community at large was, of course, similarly upset about the short sentences, believing them inadequate punishment for sexual assaults.[822] The state, regardless, maintained course.

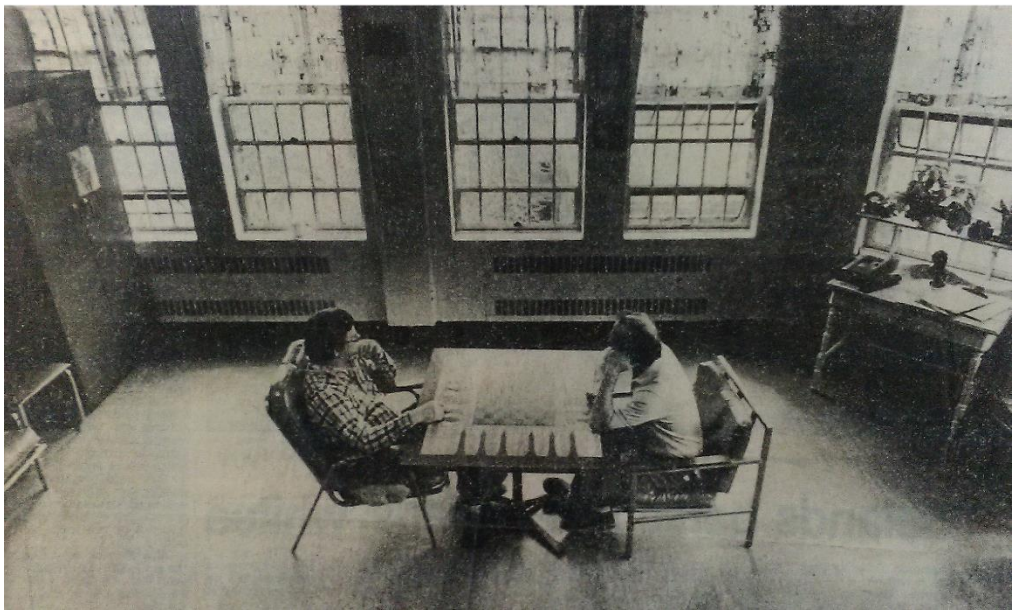

Figure 14: Two residents in the program play checkers. A bunk bed is seen left. From Cary Quan Gelernter, "Failures cast cloud on sex-offender program", *Seattle Times* (March 7th 1983), C2.

Opposition to the program was building in a number of corners. The larger Department of Health and Social Services distanced itself from the program. A 1984 annotated literature review on sex offenders was drafted within the Division of Juvenile

[821] "Sentencing law does equalizing state asked", *The Spokesman-Review*, Spokane, WA (October 20th, 1986), A4; Jan Gildenhar, "Rehabilitation issue", *The News Tribune*, Tacoma, WA (January 5th, 1984), A1; Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 65-66.
[822] Gary L. Eldridge, "Sentencing Guidelines Inadequate", *The News Tribune*, Tacoma, WA (May 4th, 1985), A4; Gildenhar, "Rehabilitation issue", A1; Roscoe and Kuehn, "Treatment of Sex Offenders", 1.

Rehabilitation. Its paragraph on "psychological therapeutic techniques", distinguished from drug therapy and behavioral modification therapies, gave a one-line description of group therapy, citing three one-off attempts. The program at Western State is not mentioned.[823] In the legislature, the situation was worse. Sexual assault was a hot issue. Over thirty bills, resolutions and memorials about the topic were introduced in the 1984-1985 legislative session seeking to modify the state's procedures surrounding it.[824] The strongest opposition came from an increasingly unified Lakewood Chamber of Commerce. The business owners were convinced that, regardless of the efficacy of treatment, habitual criminals had to be handled away from populated areas. They were risking the health and safety of bystanders by maintaining the program in the Lakewood area, and it had to be ended.[825] In spring of 1985, they adopted a resolution demanding the state move the program to a prison. With the help of District 28 Senator Stan Johnson, the group "arrang[ed] a private meeting" between the Chamber and state officials on May 8th, 1985, at the hospital. The participants included Karen Rahm, secretary of the DSHS, Lyle Quasim, director of the Mental Health Division of the DSHS, and Superintendent Hamilton.[826]

The program's last blow was dealt in February 1985, when its last newsmaking escape surged into the headlines. David Jay Sterling, known as the Hazel Dell Rapist,

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[823] Rahm et. al., *The Sex Offender,* 3-4.
[824] Roscoe and Kuehn, "Treatment of Sex Offenders", 1.
[825] Jack Pyle, "WSH 'grounds' 218 sex offenders", *The News Tribune,* Tacoma, WA (May 9th, 1985), A1; Jeff Weathersby, "Slow Transition of sex program worries officials", *The News Tribune,* Tacoma, WA (d. uk,? March 1986?). B2; WSH supt. talks about changes", *Lakewood Press,* Lakewood, WA (d. uk,?., 1986), 2.
[826] Bob Donohoe, "Area leaders set to discuss Western State", *Lakewood Press* 3 no. 18, Lakewood, WA (May 1st, 1985), Front Page; Jack Pyle, "Put sex offenders in state prisons, business group says", *The News Tribune,* Tacoma, WA (April 18th, 1985), B-4.

had been tried and convicted of a string of violent rapes in October 1982 and sentenced to five consecutive life terms. The term was suspended while he was sent to be evaluated for SOTP eligibility at Western State Hospital.[827] The staff rejected him as unfit for treatment, but the Clark County Superior Court judge, Thomas Lodge, overruled their rejection. He was sent back to court two more times by the program staff, who sought his move to prison on the grounds that he was a noncooperative escape risk. Sterling's defense and the courts sided against the hospital, and he remained in the program despite the staff's objections.[828] He made little progress in his two years of commitment. On February 28th, 1985, Sterling ran away from his "buddy" in the hospital gymnasium and escaped the hospital.[829] A national manhunt began. It took the authorities until January 1986 to find Sterling, following a four month stint on the FBI's Most Wanted List.[830]

The repercussions were severe. The Hazel Dell rapes had caused a local panic, and the escape of their perpetrator enraged the Washington public. The 218 residents of the program were grounded, and stayed grounded for months.[831] Work release was halted, the wards were locked, and meals were brought to the residents.[832] Two other program residents who had been committed to the program despite internal objection

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[827] *David Jay Sterling v. State of Washington,* Clark County Superior Court, Clark County, WA, Case No. 82-1-00425-1.
[828] *David Jay Sterling v. State of Washington,* Clark County Superior Court, Clark County, WA, Case No. 82-1-00425-1; Jeff Weathersby, "Escaped rapist put on most wanted list", *The News Tribune,* Tacoma, WA (September 30th, 1985).
[829] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 40.
[830] Bruce Taylor, "Lawmakers focus on sex-crime escapees", *The Seattle Post-Intelligencer* (March 9th, 1986), B7; Weathersby, "Escaped rapist".
[831] Pyle, "WSH 'grounds' 218 sex offenders", A1.
[832] ibid.

were sent back to court.[833] George Nagayama Hall, acting director of the program, resigned from that position later in the year and became the supervisor of the program's "psychological services".[834] Saylor returned as director.

Senator Phil Talmadge had been chairman of the Washington Senate's Mental Health Subcommittee in 1979, when it ordered the Kellogg Report and oversaw a larger investigation of the hospital.[835] In 1985, he had moved up in position, to Chairman of the Senate Judiciary Committee. The Sterling escape prompted him to look into the hospital once again. "Skeptical" of the hospital's claims on reduced recidivism and sharing the security concerns of a number of his compatriots, he asked the Legislative Budget Committee for an audit of the program.[836] In the meantime, a bill was introduced in the Legislature to allow the program staff to fully control who was admitted into the program. It also demanded that the hospital provide "complete security". The bill passed the House, but Talmadge introduced a striking amendment which eliminated the security clause, and the bill died in dispute. The result was that any action on the program was delayed until after the audit came in.[837] Why Talmadge did this is hard to figure, as he was one of the sharpest critics of Western State Hospital and the program in general.

The new push to end the program had an ally in the standing Western State Hospital Superintendent, Dr. Darrell Hamilton. He sought the end of the program as it stood, and its replacement with a more rigorously controlled research program. He

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[833] ibid.
[834] Hall, *Sexual Aggression*, xvii; Taylor, "Lawmakers", B7.
[835] AP Wire. "Mental Care Rapped", 6.
[836] Gordon, "Can all sex offenders be helped?", C1
[837] Donohoe, "No help for WSH officials this year".

believed that small-population investigation of treatment modalities was what the field needed. “If we’re going to keep [sex offender treatment] in a hospital, let’s study it clinically and hopefully come up with some answers”.[838] However, he repeatedly stated that closure, especially in the wake of the Sterling escape, was a valid option. Talmadge and many others were not of the same mind. In their view, the time for experimentation in treatment method had come and gone, and the justice system did not need a program which tested each offender by trial and error. Superintendent Hamilton disagreed on that point, but he agreed with them that a program within a prison was preferable, especially if the audit showed poor results.[839] Attorney General Ken Eikenberry argued that the offender’s frequent recidivism showed they were already “hardened” to the extent that mattered to the public. “Operational” security was more important that the concerns of “treatment professionals”.[840] Talmadge surmised his position as, “If we find the program doesn’t do any good, why have it at all?”[841] The Western State Program as it stood was openly on trial, but the entirety of sexual offender rehabilitation was being put to the question. The existence of meaningful sexual offender treatment in Washington in the near future was predicated on the legislature’s findings.

While the legislature awaited the audit results, the program was hogtied by perpetual grounding. Grounding had been initiated by the staff “approximately one-half hour” after Sterling’s escape. After two weeks of meetings, the staff settled on a series

[838] ibid.
[839] Nancy Bartley, “Chief says Western State lacks security for sexual psychopaths”, *The News Tribune*, Tacoma, WA (March 6th, 1985), A1; Gordon, “Can all sex offenders be helped?”, C1.
[840] Ken Eikenberry, “Presentation / Comments – Sex Offender Programs”, in Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 92.
[841] Gordon, “Can all sex offenders be helped?”, C1.

of changes to increase program security. Outdoor and off-ward recreation was limited to higher "step" offenders than previous. Outdoor recreation was moved to "a particular fenced area" for offenders below step four. Recreation staff would be given walkie-talkies. Lastly, two "high-risk" cases were sent back to the courts.[842] On March 14th, Dr. Gordon Hall, the Acting Program Director, implemented these changes and sent word of them to the Superintendent and to Lyle Quasim, the Director of the Mental Health Division of the DSHS. Dr. Hall asked for grounding to end for all but Sterling's group.[843] Hamilton and Quasim disagreed with Dr. Hall and ordered grounding to continue. The ground procedure was informal, but it appears to have followed some chain of command as Dr. Hall did not disobey Superintendent Hamilton.[844] The program implemented their planned changes and successfully rid the program of all offenders the staff believed were not Grounding continued, and the program's offenders were confined to their ward 110 days.[845] Superintendent Hamilton described the grounding to the press as an essential stopgap. It kept the community safe from a "failing" program whose residents were a serious threat to the community. He explicitly asked the public to agitate the legislature to reform or dismantle the program, to prevent the issue from being delayed any longer. "If [the public] wants something done, then let's do it. Take those (sex offenders) [sic] away. Take the program away. Make the program different. Whatever." In the same article, he "vowed" not to lift grounding until "the hospital staff [was] confident the community is safe".[846] In light of his

[842] Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 40-41
[843] Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 41.
[844] ibid, 42.
[845] ibid, 41.
[846] Gordon, "Can all sex offenders be helped?", C1.

rejection of Dr. Hall's request to lift the grounding, he clearly was more interested in certain safety than what program staff thought appropriate. An editorial published in advance of the report thanked Hamilton for putting the community first and seeking more than "perfunctory" measures from the legislature on a serious issue.[847]

As the legislature waited on the audit's completion, the grounding continued. In late July, the first offenders were allowed outside, into an "approximately 50 by 150 foot" enclosed space that had been approved by the DSHS. From then on, offenders got an average of 45 minutes outside a week.[848] Therapy supervisors complained that offenders felt they were being punished for something they had no control over.[849] In a more distressing trend, some offenders applied to transfer to community treatment placement. As only the "best" offenders would be accepted to a community program, the program was now bleeding its most engaged and most senior members.[850] Dr. Hall appealed to the Superintendent and the DSHS for the grounding to stop, but he was again rejected.[851] Meanwhile, the Mentally Ill Offender program, which was "nearly identical" in size to the SOTP program, was not grounded. About half the program residents judged ready for socialization regularly spent time outside, in the cafeteria and in other "public" hospital areas.[852]

The auditor wrote to the Secretary of the Department of Social and Health Services to ask why the SOTP grounding was being continued for so long. The

[847] "WSH chief is on right track", *The News Tribune*, Tacoma, WA (June 19th, 1985), A8.
[848] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 41.
[849] ibid, 42.
[850] ibid, 41-42.
[851] ibid, 42.
[852] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 45-46.

secretary's response to his letter made it abundantly clear that the Department of Social and Health Services was not interested in supporting the program any further, even once this incident was over. Krell's primary questions inquired whether recreation time was a "patient's right". The secretary denied that it was. In the details of their response, however, the secretary veered into much different territory.[853] He accused the program of leeching staff and resources from other wards in the hospital, resulting in a "diminution in the quality of care for the mentally ill". The program had been budgeted for a .22 to 1 staff to patient ratio, but it operated at a .4 staff to patient ratio because the recent security concerns demanded more ward attendants and security personnel.[854] It was, in his view, a parasite on the hospital's general operations. Yet, when the auditor asked:

"Q. Specifically, what must be accomplished in order to end the grounding?"

The secretary replied:

"Ending the grounding requires… staffing improved to… at least .7 to 1 staff-to-patient ratio, [to be] accomplished by increasing the staff or reducing the population; and…[granting] statutory program authority to [accept and reject individuals]".[855]

This was a double bind. The program was obviously not going to get more funding from an underfunded Department that accused them of diverting resources from the "real" mentally ill. The problem could not be addressed by cutting back on commitments, either. They would have to begin intensely screening all referrals if the number ultimately admitted was cut in half. This would require the observation process

[853] ibid, 43-45.
[854] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 31-32, 44.
[855] ibid, 44.

to last longer and would make the waiting list grow all the faster. Then, when the number of program residents dropped, the program would become less financially "efficient" and earn fresh legislative censure. The Department had made a standard the Program could not meet. Their second demand was more reasonable, but the auditor argued it made the program wait until the winter legislative session, prolonging the grounding for months, and did not address the program's real issues.[856]

In the meantime, staff waited. The increased staff that the grounding demanded, and the sudden deprivation of the hospital of its offender labor force, resulted in massive cost overruns for both the Program and Western State. The audit's projected Direct Treatment Costs for the program in Fiscal Year 1985 was ~$2,434,000, an almost $900,000 increase from the year before. The cost of the new janitorial staff hired during the grounding resulted in a further ~$550,000 increase in the program's share of general hospital cost. The program was hemorrhaging money on security initiatives that worked against its treatment plan and which deprived it of the program's best means offsetting costs.[857] In September, the auditor called a therapy supervisor to discuss affairs. The supervisor simply responded: "The morale is gone."[858]

The Legislative Budget Committee Audit was released in September 1985. It was the most comprehensive survey of the program in its history. The author, Robert Krell, analyzed its staff levels, cost, security protocols, and efficacy, noting when possible how it had changed in recent years. The audit listed a number of points of failure both within the program, and attempted to place their origin. Krell then triaged

[856] ibid, 5, 45, 72.
[857] ibid, 22-23.
[858] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 47-48.

his findings based on what was within the program's capacity to fix, what was the responsibility of higher agencies, and what was a problem of the field at large that only time and treatment improvement could solve. It concluded with a decidedly mixed opinion of the success of the program's methodology, the cause of its current problems, and the value of continuing its initiative.

The audit conducted the first independently-sourced review of recidivism in the program's history. Its findings were even worse than that the rising figure of recidivism that the program had volunteered. All other surveys of recidivism, including the "forgotten" 1976 survey, had been based solely upon data collected by the program itself. Robert Krell was the first to seek data from law enforcement, notably consulting the FBI for arrest data and outstanding warrants outside of Washington. He began by noting that "neither [Eastern or Western State] maintains or collects on a continuing basis data pertaining to client recidivism", despite being explicitly asked to do so by the Senate Committee on Social and Health Services in 1980.[859] As a comparison, the chance of rearrests and conviction for sexual offenders leaving the Department of Corrections was put at 27.8%.[860] The auditor began with the data used by the Director of the Division of Mental Health in creating his presentation.[861] The survey was limited to "offenders successfully discharged" between 1970 and 1980, and was conducted by requesting criminal history information from the FBI and the State Patrol. Those whose records could not be located were excluded, leaving 210 cases as examples. The

[859] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 27, 32.
[860] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 49.
[861] ibid.

Director stated that 25% were rearrested for a sexual offense, 18% convicted and 15% re-institutionalized.[862]

Evaluating this data, Krell did not tabulate arrests, and instead focused on convictions and re-institutionalization. He found that the known low chance of a single graduate facing a new conviction for a sexual offense was 26.7% and that facing a conviction for any other offense ("other than minor offenses such as disorderly conduct") was a known low chance of ~8.5%. Re-institutionalization for those convicted of a sexual offense had a known low of 21.9%.[863] The auditor consulted Dr. Hall to determine why the figures differed and discovered that the sex offender program only observed re-offenses committed in the first five years following the release. In the director's figures, this eliminated eight new sexual re-offenses and eight new nonsexual offenses, dropping the proportions of each significantly.[864] Even accounting for these changes, the recidivism rate reported by the Director was significantly lower than the auditor's. The auditor could not determine a methodological difference that accounted for it.[865] The Department of Corrections data, which issued the "comparison" figure of 27.8% for those released from a Washington State correctional facility, did not consult FBI documents or other national police agencies, meaning offenders who moved to another state and reoffended would not be included in their percentage.[866] The auditor chastised the DSHS for this "baseless" misrepresentation of the program's efficacy. Krell further noted that this concerningly high figure was from a program that was very

[862] ibid.
[863] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 50.
[864] ibid.
[865] ibid, 52.
[866] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 57,

selective. Of the offenders who entered the observation, only just over 20% would successfully graduate the program.[867] A program that was already very particular on who entered was seemingly unable to significantly improve on recidivism. Krell demanded the program, if continued, conduct more exacting and frequent surveys of recidivism in the future.[868]

The remainder of the report, however, pointed to a program that had been in continuing crisis for years. One of the largest what had been the programs argument for years – that the program Krell found that contrasting of the Eastern State program to the Western State program revealed how much of Western State's issues emerged due to outside demands, and structured his paper around contrasting the two programs on various issues. The two programs, on his analysis, were extremely similar in their treatment philosophy and clinical setting.[869] In fact, Eastern State was behind in the field compared to Western State. Eastern State's program staff had sought training in newer approaches, but did not receive any resources from the DSHS.[870] Accordingly, the program was still wholly centered on the therapeutic group and had integrated none of the novel behavioral methods.[871]

The defining difference, however, was that the Eastern State program was better-funded and better-staffed. The issue of funding was straightforward. Eastern State was budgeted ~$30,100 per year for each offender, while Western State only got

[867] ibid, 58.
[868] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 57, 74.
[869] ibid, 14-15, 29-30, 65.
[870] ibid, 38-39.
[871] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 36.

$25,976 per year.[872] The staffing issue was more nuanced. Western State had seen a large increase in aides and security staff over the last half-decade, resulting in a staff-to-patient ratio of ~.4 as reported earlier.[873] The Eastern State program had fourteen full-time staff and fifty-two residents, resulting in a staff -to-patient ratio of ~.29.[874] However, the audit argues vigorously that Western State is understaffed.[875] The reason is because the program had a number of aides and nurses, but not sufficient therapeutic staff. As the offenders were not acutely mentally ill and could take care of themselves, nurses and aides contributed little to their treatment.[876] There were instead being used as pseudo-security. Eastern State had 5 full-time therapeutic program staff for 52 people, resulting in a therapeutic staff-to-patient ratio of ~.09. The Western State program, meanwhile, had 13 full-time therapeutic staff for 218 people, making a therapeutic ratio of ~.06.[877] Further, the therapeutic staff at Western State were burdened with administrative tasks, limiting the time they could interact with residents.[878] Some therapy supervisors had to oversee two groups, making any kind of personal engagement impossible. The quality of the staff was also found to be lacking, for the same reasons discussed earlier: poor educational opportunities, little on-the-job training, and high turnover. [879] In contrast, four of the five staff at Eastern State had over five years experience in the program.[880] In short, Western State had it bad both ways. It got

[872] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 3, 21-22.
[873] Kellogg et. al., *Report to the Secretary,* 7.
[874] ibid, 21-22.
[875] ibid, 38-39, 69.
[876] ibid.
[877] ibid, 38-39.
[878] ibid, 37.
[879] *01* Interview Transcript, 24-25.
[880] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 38.

less money per resident, and its proportionally larger complement of support staff meant the lower funds were spread thinner without therapeutic benefit.

The consequences of this were numerous. Since 1982, the Eastern State Program had seen only three escapes, and two of those offenders had returned to the program within a day.[881] In the same span, Western State had seen nine escapes.[882] Staff morale at Eastern State was "good". In Western State, it was "extraordinarily low".[883] The program's security was praised as "remarkably effective" for the majority of residents.[884] Recent deterioration in the security climate was argued to be the result of the program's internal decay and offender dissatisfaction and Eastern The Western State program had been neglected and overburdened by the legislature, and it needed to make significant financial and personnel investments to bring it back to its previous excellence.[885] If the programs were continued, Western State program was encouraged to look to and talk with the Eastern State program to guide its return to excellence.[886]

Krell's conclusions were, in fact, much the same as the second McGovern report, and to an extent, the Kellogg report.[887] The program's problems were not rooted in a fundamental issue with its treatment philosophy or the clinical setting. The problems were diffuse. Alongside this, a number of policy changes were recommended, most notably a lowering the population cap, redeveloping the treatment methodology in

[881] ibid, 59.
[882] Nancy Bartley, "Chief says Western State lacks security for sexual psychopaths", *The News Tribune*, Tacoma, WA (March 6th, 1985), A1.
[883] ibid,
[884] Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 62.
[885] ibid, 69.
[886] ibid, 32, 74.
[887] ibid, 3, 28, 39.

line with current best practice, and enabling the hospital to reject certain offenders.[888] The audit insisted the program, if retained, be given a much larger budget.[889] As a warning against a hasty decision to cut costs, Krell underlined that underlined that eliminating the program would not cut costs by much in the long run. Sex offenders were not compelled to stop offending by a jail sentence. Their future trials and incarcerations could be avoided with an effective rehabilitation program. Further, the escape rate from low-security facilities was high. Without improving jail security, they were as likely to escape from there as from Western State.[890] However, he conceded that the program was running at serious cost with poor results, and "there [was] little justification for continuing the status quo".[891] The programs would disappoint until the legislature committed to major investment of time and money. The audit's first seven recommendations suggested a number of possible actions for the legislature to take on the programs, with varying costs, but with the ultimate goal of wholesale program

[888] Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 64, 77,
[889] ibid, 72.
[890] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 59-60, 68-69, 71.
[891] Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 72.

overhaul. Recommendation 8, the last, suggested that if the legislature did not wish to intervene, it was best to cut their losses and end the programs entirely.[892]

The audit's results on recidivism were widely publicized within Washington. Its conclusion regarding the program's overall efficacy was not. As the story saturated the local press, it became clear that both the Western and Eastern State programs would not

Figure 15: A political cartoon run in the Lakewood Press, sharply critiquing security at Western State. From Bob Donohoe, "Area leaders set to discuss Western State", *The Lakewood Press* 3 no. 18, Lakewood, WA (May 1st 1985), 1.

survive the winter. Senator Talmadge, speaking to *The News Tribune,* remarked that October that "it seems the Western and Eastern State programs cannot be justified… it's

[892] ibid, 8, 72-73.

time to move them out."[893] He promised to sponsor the needed legislation in January.[894] The *News Tribune* promptly followed in November with an editorial that praised his efforts and asked that any new treatment programs be founded within a prison.[895] The Department of Corrections was not pleased with the idea of gaining custody of offenders if the State expected them to attempt treatment. As of 1986, there were no state-run programs for sex offender treatment within Washington prisons.[896] Corrections was not of a mind to start one. "...[D]ifferent legal and philosophical expectations" prevented an effective treatment program within prison, according to Robert Trimble, the department's Deputy Secretary.[897] Corrections was designed for and equipped to handle the confinement of convicted criminals, not their rehabilitation. The Department "contend[ed]… [the] DSHS…can provide the necessary security at the two mental hospitals to continue the programs there", and offered to advise the hospital on building a more effective security system and protocol.[898] Correction's "solution", however, was not acceptable to Western State. It was already complaining that the restrictions on work release were disrupting the resident's progression of responsibility. Increasing security more would challenge the fundamental principle that the group, not outside actors, were responsible for minding their behavior, and would discourage self-

[893] AP Wire, "Relocating sex convicts to prison urged", *The News Tribune,* Tacoma, WA (Oct. 27th, 1985), B-6.
[894] ibid.
[895] Editor, "Treat sex offenders in prison settings", *The News Tribune,* Tacoma, WA (November 3rd, 1985).
[896] Peter Callaghan, "Sex Offenders can be treated in prison, therapist says", *The News Tribune,* Tacoma, WA (February 26, 1986), B-16.
[897] Peter Callaghan, "Prison official doesn't want sex offenders", *The News Tribune,* Tacoma, WA (January 31st, 1986), B1.
[898] Amos E. Reed, "Response to Audit" (November 5th, 1985), in Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 88-89;

discipline and empathy by making it the security guard's job the offender behaved. Superintendent Hamilton took the same point from another angle: "…there is no way to increase security here". [899] Western State was still a mental hospital, and enforcing heavy restrictions on the entire patient population was not acceptable. Besides, it was too little, too late.

The DSHS's dim view of the program as a parasite had been part of the reason the program was put on trial in the first place. They made no effort to defend it or its staff when the judgement fell. When the initial audit report was published in September, Director Quasim demurred on the program's hardships, saying that community safety was more important.[900] He did not address the auditor's criticisms of the DSHS. A full reply by the DSHS was appended to the report before its December publication. It did not discuss the program's grievances about its extended grounding, even in passing. It concentrated on the argument that their demand of drastically increasing the staff-to-patient ratio reflected the reality of treating sex offenders. The Department argued that they had attempted to obtain major increases in staffing and funding for Western State Hospital writ large earlier in the year, but they had been rebuffed. Not only the SOTP was at risk of collapse because of threadbare budgets, but the whole state hospital system. It was not the only mental health program trying to make do with drastic underfunding, and it couldn't expect special treatment.[901] The author made no statement on what the Department would do, or try to do, going forward regarding the Program or

[899] "WSH supt. talks about changes", *Lakewood Press*, Lakewood, WA (d. uk,?, 1986).
[900] Rick Seifert, "Program at WSH assailed", *The News Tribune*, Tacoma, WA (September 24th, 1985),
[901] "DSHS Additional Comments to the Audit Report of the Sex Offender Program", in Krell, *Sex Offender Programs at Western and Eastern State Hospitals,* 85-87.

the Hospital. The author made no comment on why the Department made patently unfulfillable requirements on a program in crisis. The comments were little more than a defense of honor, made for their own benefit. They wanted the program gone.

Once the legislative session began, the process moved quickly. Governor Gardner gave his approval to Talmadge's proposal later that November, and Talmadge introduced the bill, State Senate Bill 4736, the second week of January. It was referred to the Senate Judiciary Committee for evaluation.[902] A competing bill was introduced by the DSHS, which would have allowed the programs to continue with "non-violent" offenders only. It received little support or interest.[903] A final public hearing on the bill took place before this committee on Friday, January 31st, 1986. Again, the Lakewood Chamber of Commerce as a unit came to testify the community's desire to see the program ended. More significantly, Senator Johnson asked the DSHS and the DOC to provide fiscal estimates for the cost of handling their proportion of offenders over the coming year. The DSHS quoted $463,000; the DOC quoted $222,000. Johnson told the Lakewood Press that "[the savings] were not lost" on the committee.[904] The Senate duly passed the bill and sent it to the House.

There, some political games began between Talmadge and another Democrat, Representative Dennis Braddock, vice chairman of the Ways and Means Commission. Braddock opposed the post-release counseling requirement the bill included. He contended that post-release supervision was against the spirit of the recent Sentencing

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[902] "Sex offender program may be moved to prison", *News Tribune,* Tacoma, WA (January 8th, 1986); Rick Seifert, "Gardner backs removal of sex offenders from Western", *The News Tribune,* Tacoma, WA (January 11th, 1986);
[903] ibid.
[904] Eubanks, "Sex unit may be gone from WSH", 1-2.

Guidelines Act revisions and would add a great deal of unnecessary cost for little gain.[905] Talmadge argued back that the Sentencing Guideline Commission had recommended post-release sentencing for sexual offenders, as a special exception. Senator Johnson and Representatives Winsley and Sally Walker of Lakewood's District 28, all Republicans, claimed the whole affair was interparty politicking, and begged their party to ignore it and pass the bill.[906]

The debacle continued up until March 11th, 1986, the day of the first vote and the second-to last day of the legislative session.[907] Democrat anger over the internecine conflict between Tallmadge and Braddock and the "general confusion" of the closing days of the legislative session resulted in this vote going against the bill, 67 to 27. The following day – the last of the session - Tallmadge worked with the Senate to force the bill's return to the House, and Johnson, Winsley, and Walker rallied their fellow Republicans to support the measure. Their efforts succeeded with a reversal of the original result, 72 to 26, and the bill was sent to Governor Gardner, with the post-release supervision clause attached.[908] Gardner signed the bill, but vetoed the much-debated community supervision clause, on the grounds that the reason he supported the bill – keeping the community safe from possible escapees and premature releases – was rendered irrelevant by an "outpatient" clause.[909]

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[905] Rick Seifert, "Bid imperils move of sex offender program", *The News Tribune*, Tacoma, WA (March 11th, 1986), B1.
[906] ibid.
[907] ibid.
[908] Rick Seifert, "Western State to lose sex-offender program", *The News Tribune*, Tacoma, WA (March 13th, 1986), B1.
[909] Riveland, *Sex Offender Treatment Program Plan*, 2, 36.

The program's fate was sealed. All sexual offenders charged on or after July 1st, 1987 were to be placed in the custody of the Department of Corrections. The Department of Corrections' concerns about being made unduly responsible for "treatment" were, according to them, satisfied by the final bill. They were directed to develop a separate plan for offender rehabilitation, which eliminated their perceived liability to determine a "cure".[910] The Western State program was given license to maintain course with those offenders who were already in the program and those who were scheduled for observation. All residents were required to be out by July 1st, 1993.[911]

Washington State, however, was not finished with the concept of sex offender rehabilitation. The Western State principle of "self-guided" therapy, however, was something they preferred to leave behind permanently. The law transferring custody of offenders to Corrections demanded the Department of Corrections create "a treatment program in a correctional setting" to replace the previous one.[912] A proposal to meet this end was issued by the Department of Corrections in January 1987. The program proposed a part "residential", part "outpatient"[913] program at Twin Rivers Correctional Center in Monroe. It cited a number of professionals and programs, in and out of state, it consulted while designing its program; of these, the only Western State SOTP staff member was Dr. Hall.[914] The report text only mentions the Western State program once.

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[910] Rick Seifert, "Panel OKs switch for sex-offender program", *The News Tribune,* Tacoma, WA (February 6th, 1986), B1.
[911] Callaghan, "Prison official", B1.
[912] Chase Riveland, *Sex Offender Treatment Program Plan*, Department of Corrections, Olympia, WA (January 1987): i.
[913] The offenders would be housed in the prison's general population and visit the center for classes and activities.
[914] ibid, 100-101.

It is dismissed in passing in the "History" section at the beginning of the report as "ineffective".[915]

The program design shared a number of therapies with Western State, but it explicitly took a drastically different approach to the offender. The very first program objective is Security.[916] All of its security measures come from without. The program did not attempt to make residents accountable for, or even cognizant of, their role in maintaining the program. The second objective is "Integration of Clinical Treatment Within a Corrections Environment", which means the standardization of sentencing and resident classification. The "step" system is out, instead replaced by a clear duration of treatment that is determined by the offender's sentence, not their conduct. The offender's progress is effectively irrelevant: "Favorable treatment recommendations… will not override the authority of the classification process."[917]

In a familiar measure, the residential program population would be broken down into groups of about 14 men apiece, with a counselor and their aide directing therapy. This group would meet three days per week in a two hour session.[918] The idea that the offender must possess the initiative to change was still present. However, the program underlined that this is not a "self-guided" treatment approach in any way: "There will be no inmate-directed or self-directed programming".[919] All evaluation of the offender came from a state authority. "Systematic behavioral assessment" with a penile plethysmograph, accompanied by orgasmic reconditioning and covert sensitization, was

[915] Riveland, *Sex Offender Treatment Program Plan*, 1-2.
[916] Riveland, *Sex Offender Treatment Program Plan*, 11.
[917] ibid.
[918] Riveland, *Sex Offender Treatment Program Plan*, 22.
[919] ibid, 33.

given an equal share of time – six hours a week – to group therapy. The results of the conditioning efforts were discussed in one-on-one therapy, not in the group. An additional four hours a week would be devoted to "treatment modules". These are "classes" on assorted topics, including emotional management, life skills, and relapse prevention. The resident's modules were picked for them by the staff, although they could participate in more modules voluntarily, if they wished. [920] Similarly, the staff provide each resident a "individualized plan with measurable objectives" for their treatment. These changes were tracked by their individual therapist and by "assignments", primarily written reflections. These assignments were submitted to the staff, and their fellows did not see them.[921]

The Twin Rivers program was not a "sentencing alternative." This program was a program within a correctional facility, and its duration was integrated into a sentence, not substituted for it.[922] The program's length is set at six months for the "educational" stage and twelve months for the "residential" stage.[923] If a convict is given a sentence with a minimum of four years before release, they will go to prison for two and a half years before entering the program. Work release was a part of the program, and was proscribed to the last six months of "an inmate's incarceration" with "close community monitoring" in a "Phase II or Phase III work release facility".[924] While the proposed program had some similarities to Western State's SOTP, the two were wholly different

[920] ibid, 21-23.
[921] ibid, 23-24.
[922] ibid, 16-17, 20.
[923] ibid.
[924]Riveland, *Sex Offender Treatment Program Plan*, 11, 24, 29, 31. A "Phase II" or "III" work release facility was a business which had an explicit contract with the Department of Corrections to use work-release inmates as labor.

on a therapeutic level. The new program obviously different priorities and a much different understanding of the sexual offender than the Western State model. The "community of rebuilding" that Western State built is over. The offender was in no way answerable to his fellows. The individual entered and left at the pace and decision of overhead staff. The other participants were irrelevant to this process, and had no say who could join their therapeutic group. The classroom environment encouraged, if not demanded, that the offenders ignored one another and focused on a figure of authority before them. It was individual treatment from a genericized model. The group was little more than an audience to each other.

The program took its fall right as the new wave of sexual offender treatment methodology and research began to bear fruit elsewhere. By the time of the 1985 audit, there were dedicated residential sex offender treatment programs in 15 states.[925] Outpatient treatment began to grow massively, with CBT / Relapse Prevention oriented clinics soon proliferating well beyond any previous high-water mark. *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender*, published in 1988 and edited by renowned expert Barbara Schwartz, marked the crest of this new wave of sex offender treatment. It included contributions from a baker's dozen authors, representing a variety of programs and practices.[926] Among the numerous approaches described, the Western State program was lauded as an innovator in a nascent field and a landmark in the practice.[927] The "self-guided group" approach was out-of-step with the field's shift

[925] Krell, *Sex Offender Programs at Western and Eastern State Hospitals*, 23-24.
[926] *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender,* ed. Barbara K. Schwartz, U.S. Dept. of Justice, National Institute of Corrections, Washington, DC (1988): xv-xvi;
[927] *A Practitioner's Guide,* ed. Schwartz, 29, 103,

toward behavioral reinforcement, and was accordingly little-discussed, but the program's cultivation of group accountability was highly praised.[928]

Its primary status in the work, however, was not as a clinical example of a treatment approach, but as a cautionary tale of the fundamental instability of sexual offender treatment. Between the three authors that discuss the program, a core narrative emerges which is an effective summary of the view of the program's end from the outside. A handful of high-profile escapes of violent offenders had upset the public. They sought the program's immediate termination in the interest of security. Western State had failed to meaningfully track the efficacy of its treatment for decades. It had few immediate successes to point to. The much greater than expected recidivism statistic revealed by the audit painted the program as wishful thinking, not meaningful treatment. The legislature sided with the public, and fear prevailed.[929] Other programs were warned to maintain frequent contact with the media as prophylaxis against sudden changes in public opinion, and to keep detailed figures available about treatment results. The era of benevolent ignorance that had birthed Western State's program was over. An outpatient, post-incarceration model had become the dominate mode. Inpatient sex offender programs nationwide were now fighting an uphill battle to justify their existence to the state and the public.[930] The authors reminded the reader that their program could be next without the proper precautions.

The conclusion of those authors and practitioners was a fairly precise summation of the circumstances that felled the Western State program. There was more

[928] ibid, 36.
[929] *A Practitioner's Guide,* ed. Schwartz, 2, 36, 38, 62.
[930] *A Practitioner's Guide,* ed. Schwartz, 52-53, 62.

going on, however, that showed serious disturbances inside the program, both practical and theoretical, which were threatening to end meaningful treatment. The program became increasingly overburdened after the turn of the decade, pushed beyond its already strained population limit. Lengthening terms of commitment only exacerbated this problem. The program lost many of its most experienced staff due to dissatisfaction and low pay, and no meaningful training program existed for new arrivals. The program's central principle of resident leadership was being displaced by the cognitive-behavioral advancements pioneered elsewhere. The integration of these elements violated the principle of group-therapy and resident leadership. The program was not, however, in total disarray. The twin drives of behavioral intervention and "guided self-help" could yet have been reconciled. However, the program did not get the time to accomplish this goal. The Western State Hospital Treatment Program for the Sexual Offender was ended for the same reason it was begun: a wave of public fear about sexual offense led to a demand for long-term incarceration of sexual offenders, in the interest of snuffing out the crimes as soon as they begun.

Postscript: Sexual Offender Rehabilitation / Commitment in Washington Today

CORRECTION: Sexual predators--A headline in Thursday's editions erred in saying that a new law in Washington state would mean that so-called sexual predators could be kept in jail indefinitely. They would be confined in locked treatment centers.

- Editor, *The Los Angeles Times* (May 11th 1990), A3.

The new wave of fear about sexual offenses was not a short-lived backlash. The public became quite committed to the rejection of sexual assault on principle. All treatment from here on in was heavily predicated on Washington did not look back from its elimination of the program. Following two shocking cases, Washington's policies on sex crime became some of the strictest in the nation. The state drafted a new indefinite commitment statue, but this time around, the state explicitly prevented even the veneer of care from garnering its "commitment centers". Sex offender treatment in Washington today is wholly predicated on outpatient care, conducted as a condition of release on parole. Its "inpatient" approaches within its correctional facilities receive little notice or discussion, and are obscure to the extent that almost no information could be located discussing their operation.

As of February 1986, the Western State program was "holding until relieved". The law gave the program a long half-life. Offenders who were charged after July 1st, 1987 were to be referred to corrections; offenders charged or referred to the program for observation before then were to be evaluated and, if eligible, integrated into the program as before. Those that the program accepted were entitled to go through a full course of treatment within the program. Offenders that were on the waiting list for observation as of July 1987 were still eligible to enter the program. The waiting list that had been a serious problem for the program now became its lifeline.[931] Saylor decided to remain the clinical director until the program's end.[932] At the same time, Corrections' attempts to transfer members of the Western State population to their facilities were

[931] State of Washington Sex Offender Policy Board, "Review", 9.
[932] Maureen Saylor and Mark Weinrott, "Self-Report of Crimes Committed by Sex Offenders", *Journal of Interpersonal Violence* 6 no. 3 (September 1991), 286, 302.

frustrated by internal delays. W.L. Kautzky, deputy secretary of the Department of Corrections, sought approval from the legislature to transfer 120 of the "sex criminals" that remained at Western State in February 1988. Those offenders were not moved, however, as the Twin River center was not yet complete. It would not be ready until October of 1990.[933] In early 1990, the program was still carrying a triple-digit population figure because of this deferred termination. Saylor, reinstated as director, and Dr. Mark Weinrott analyzed sex offender reticence by surveying the remaining Western State Treatment Program population.[934] Their demographic data was of a great deal of interest. 168 residents at the time of the survey. The proportion of rapists had risen to around 40% of program members. The program now accepted "approximately two-thirds" of offenders who underwent observation. had risen to "approximately two-thirds". The majority of this figure, however, were nearing the end of treatment. By 1991, the vast majority of remaining residents graduated to work release or had been kicked back to corrections. By 1992, all of the program members had reached outpatient status.

The fadeout of Western State's program was masked by a massive upheaval in Washington State's handling of sexual offenders. Without the Western State program, the options available to judges were limited to the specific sentences dictated by the Sentencing Guidelines Act or the use of a community, outpatient Sentencing Alternative program. The latter was intended for low-risk, first-time offenders, and had very limited security measures. It was available for only a small group of qualified offenders,

[933] Lieb, "After Hendricks", 475; Scott Wilson, "State plans to relocate sex offender program", *The News Tribune*, Tacoma, WA (Date Unknown).
[934] Saylor and Weinrott, "Self-Report", 286, 289, 300.

meaning that most offenders ended up going to Corrections via the sentences imposed by the Guidelines. The sentences for first time convicts of some violent sexual offenses were as short as a year. With the elimination of parole for the vast majority of cases, even chronic recidivists were released with little community supervision or reintegration. Two back-to-back cases in the same year resulted in the rapid reversal of this situation. Earl Shriner was an intellectually disabled man with a 24-year criminal background, primarily including child molestation and property crime. Close to the end of his current ten-year prison sentence, he told his cellmate about his plans to molest and kill children when released. He drew diary entries detailing his plans and described a fantastic vehicle equipped with cages that would hold the children he kidnapped. Prison officials heard of his plan and sought to have him civilly committed for mental illness. The court rejected their argument, as Shriner had not committed a "recent overt act" against another inmate or in any other way committed a detainable crime. He was released as scheduled in 1987. In May 1989, he raped and castrated a seven-year old boy, leaving him for dead in the woods.[935]

Shriner's case was greeted with a wave of public anger, but in November, it was dwarfed by three child murders which enraged the public. Westley Allan Dodd was caught attempting to kidnap a child in a Camas, Washington movie theater. Under interrogation, he almost immediately confessed to the brutal murders of three young

[935] David Boerner, "Confronting Violence: In The Act and In The Word", *University of Puget Sound Law Review* 15 (1992), 525; La Fond, "Washington's Sexually Violent Predator Law", 671, 678; Jenkins, *Moral Panic,* 191; Roxanne Lieb, *Washington's Sexually Violent Predator Law: Legislative History and Comparisons with Other States*. Washington State Institute for Public Policy, Olympia, WA (1996), 1.

boys in the area.[936] Police investigating his home found a diary filled with repeated appeals to Satan, asking for "a long, happy life as a pedophile, with plenty of action" and other, more specific assistance in carrying out his crimes.[937] Dodd had been before court for indecent exposure and molestation throughout adolescence and convicted twice of serious offenses in five years prior to his murders, included a count of "attempted indecent liberties" when he had kidnapped a child. He was repeatedly given minimal sentences and released on the condition that he seek therapy, with little monitoring of his progress by authorities and no communication between law enforcement agencies when he moved across state lines.[938] The story became a cause célèbre for the indefinite commitment of sexual offenders. Numerous legislators calling for reform of the Sentencing Guidelines for sexual assault were soon joined by Dodd himself. After a short period of vacillation, he abandoned any effort to defend himself, pled guilty, and openly sought his own death. He went to court to block appeal proceedings against his own death sentence filed by various civil liberties groups. From his jail cell, became an active advocate for punitive, security-oriented sexual offender policy and sentencing.[939] He repeatedly stated that he was incorrigible in his desires and his cruelty. In his final court brief, he stated that "If I do escape, I promise you I will kill and rape again, and I will enjoy every minute of it." Reporters from across the country

[936] Boerner, "Confronting Violence", 526-528; Roxanne Lieb, *Washington's Sexually Violent Predator Law: Legislative History and Comparisons with Other States*. Washington State Institute for Public Policy, Olympia, WA (1996), 1.
[937] Tom Philbin, *I, Monster: serial killers in their own chilling words,* Amherst, N.Y., Prometheus Books (2011): 62-63.
[938] Timothy Egan, "Illusions Are Also Left Dead As Child-Killer Awaits Noose", *The New York Times* (December 29, 1992), A1;
[939] Boerner, "Confronting Violence", 529-530; Egan, "Illusions"; Jenkins, *Moral Panic,* 193.

gave him headline coverage, making his case national news.[940] Ultimately, he was successful in pursuing his own death by the noose. On the 5th of January, 1993, he was hung in Washington State Penitentiary as a crowd cheered outside.[941]

Figure 16: People standing outside Washington State Penitentiary, cheering the execution of Westley Allen Dodd on the night he was hung. Source: Therese Frare, AP Wire (January 5th, 1993).

In the face of overwhelming public pressure, the Washington State Legislature moved quickly. With the approval of Governor Gardner, it created a Task Force to evaluate the standing law and to hold a number of public hearings on what course to take. The Task Force was staffed almost entirely with representatives from Corrections

[940] Egan, "Illusions Left Dead"; Jenkins, *Moral Panic,* 193; Micheal Kroll, "Interview With A Monster", *The Chicago Tribune* (January 07, 1993); Olivia B. Waxman, "Lessons of the Gruesome Case Behind One of America's Last Legal Executions by Hanging", *Time* (January 5th, 2018), http://time.com/5062940/westley-allan-dodd-execution-history/.
[941] Waxman, "Lessons"; Jenkins, *Moral Panic,* 193.

and victim advocacy organizations, with a handful of representatives of sex offender treatment also present. No members of the defense bar and no academics were on the Task Force. After hearings that focused overwhelmingly on community anger, the Task Force submitted its proposal to the legislature. The bill was passed in days, without review, and was signed into law as the 1990 Community Protection Act.[942]

The 1990 Community Protection Act, slightly modified, is still in effect today. It allows civil commitment of persons following their prison term. Under the law, prosecutors or the Attorney General can initiate civil proceedings "for" any person who has been convicted of a "sexually violent" crime and is nearing the end of their sentence, who was declared not guilty by reason of insanity, or who was declared unfit to stand trial for a sex offense. If a probable cause hearing agrees with the prosecutor, a judge can obtain a 45-day confinement for the "purpose of an evaluation", which then leads to a jury trial predicated on the belief that the person in question will reoffend "beyond a reasonable doubt" if not confined. The underpinning demand for this civil commitment is that the person in question have some sort of "mental abnormality" that predisposes them to these crimes, and makes it unlikely that any sort of community rehabilitation would suffice to render them fit to reenter society.[943] A person does not need to be diagnosed with any particular mental illness, or any illness at all, to be confined under this act; they must only be asserted to have this undefined "abnormality" to such an extent as to be unmanageable in the community.[944] A unanimous jury ruling

[942] La Fond, "Washington's Sexually Violent Predator Law", 673-676, 682-683; Jenkins, *Moral Panic,* 192, 194; Stuart Scheingold, Toska Olson and Jana Pershing, "The Politics of Sexual Psychopathy", *University of Puget Sound Law Review* 15 (1992), 816-818.
[943] Office of the Attorney General, "Sexually Violent Predators".
[944] "The Predators of McNeil Island", *Here Be Monsters,* Podcast audio, April 20th, 2016.

is ostensibly the final requirement to go ahead with confinement, but as a hung jury allows for indefinite confinement regardless, it is effectively a "guilty until proven innocent" trial. Despite a number of constitutional challenges on its fairly patent conflation of criminal and civil confinement it has survived as the groundwork of a now fine-tuned program to hold "Sexually Violent Predators".[945] The legislation also created the first publicly accessible sex offender registry in the nation.[946] The constitutionality of civil commitment programs for sex offenders was upheld in the 1997 Supreme Court case *Kansas V. Hendricks,* and the program has continued with minimal oversight since.[947]

From 1980 to 1990, Washington's outlook on sex offenders flipped outright. The troubled "sexual psychopath" who was believed curable by a mindful group of his fellows was replaced by the marauding "sexually violent predator".[948] The laws and programs of the state changed in accordance with this new mindset. Inpatient sex offender treatment was dramatically amended as per the Riveland plan, creating a tentative, control-oriented therapy environment that restricts freedom as much as is possible. The Community Protection Act was, in some ways, a "mild" form of what the community demanded. The State Senate passed a bill that same year which legalized mandatory castration for sex offenders, stating their constituents had demanded it.[949]

[945] Lieb, *Washington's Sexually Violent Predator Law,* 1-2; Office of the Attorney General, "Sexually Violent Predators".
[946] Lieb, *Washington's Sexually Violent Predator Law,* 3.
[947] 521 U.S. 346 (1997).
[948] La Fond, "Washington's Sexually Violent Predator Law", 663-664.
[949] Scheingold et. al., "The Politics of Sexual Psychopathy", 817.

Not only was the Western State program gone, but any attempt at a program like it was doomed to immediate public outrage and closure.

The era of the SOTP was over. What has replaced it is, instead, a Special Sentencing Alternative. Like the SOTP, it is a court-assigned treatment protocol that enrolls the offender in a treatment program as a condition on their suspended sentence. In general, the offender still spends a year in prison, rather than the full length of their sentence, before entering treatment. All the actual treatment is outsourced to independent therapists, who receive a special license from the State of Washington.[950] The programs are overwhelmingly behavioral, conditioning-approach therapies run by private practitioners. Steven Silver's Northwest Treatment Associates remain in business, and remain attached to their behavioral model. The offenders also have to accept certain restrictions on lifestyle, meet with a probation officer, and perform any acts of atonement the court decides is necessary.[951]

The continued existence of even this drastically reduced mandate of treatment is in jeopardy. The state has added increasing restrictions on the use of the SSOAA throughout the 1990's and 2000's. Most notably, in 2004, the SSOAA was restricted only for offenders who "[had] an established relationship or connection to the victim", dramatically reducing the number eligible.[952] Accordingly, courts have significantly reduced their use of the statue. "Between 1986 and 2004, as a portion of all sex offenders sentenced, SSOSA… declined from approximately 40% to 15%".[953] Sex

[950] Ted Dale, "Sex Offender Treatment Provider Directory – June 2018", *Washington State Department of Health,* DOH 695-021.
[951] State of Washington Sex Offender Policy Board, "Review", 19-20.
[952] ibid, 17.
[953] State of Washington Sex Offender Policy Board, "Review", 21.

offender treatment in any form is losing ground in Washington public policy. What it is today is nothing like what Western State pioneered forty years ago.

As of 2014, 294 offenders are civilly committed under Washington's Sexually Violent Predator Law for an indefinite term. The majority are committed to the Special Commitment Center on McNeil Island.[954] More recent data on confinement numbers could not be obtained, as the state releases a bare minimum of information on the program. The facility is classified as a civil confinement center of "medium-level security" but was built and outfitted as a Supermax-level prison. The only difference in its operation at present is a reduced number of staff.[955] Its water supply is brown enough to stain clothes.[956] As of March 2016, only 97 offenders designated as Sexually Violent Predators and sentenced to the confinement facility have been released. Releases have accelerated in recent years, but only because "newer" Class Three predators have begun to pile up in less secure facilities.[957]

The Special Confinement Center is overseen by an offshoot of the main Department of Social and Health Services, the Rehabilitation Administration. The primary form of rehabilitation that the facility offers is optional sessions of group therapy, which amount to around 5-8 hours per week.[958] In 2008, only 51% of committed offenders attended these sessions, because previous offenders who had

[954] Office of the Attorney General, "Sexually Violent Predators".
[955] Martha Bellisle, "'It Cannot Be Good for Anyone': Sex Offenders on Secluded Puget Sound Island Say Water Is Making Them Sick", *The Seattle Times* (September 25, 2017); Roxanne Lieb, "After Hendricks: Defining Constitutional Treatment for Washington State's Civil Commitment Program", *Annals of the New York Academy of Sciences* 989 (2003), 480-482.
[956] Bellisle, "'It Cannot Be Good for Anyone'".
[957] "The Predators of McNeil Island", *Here Be Monsters,* Podcast Audio (April 20th, 2016).
[958] "The Predators of McNeil Island", *Here Be Monsters.*

completed the full course of the therapy were denied release anyway.[959] A 2016 midpoint evaluation of a Rehabilitation Administration-wide mission plan proposes the supposedly novel option of seeking a psychologist from Western State Hospital to visit for therapy sessions.[960] There is a minimum of treatment personnel, as the majority of the center's budget goes toward security.[961] Washington, using an incredibly similar indefinite commitment statue, has created the opposite of the Western State program. Western State Hospital housed offenders in a minimal-security environment with high demands on treatment participation under threat of expulsion. The McNeil Special Commitment Center houses offenders in a maximum-security environment, makes minimal efforts to provide treatment, and no effort to see offenders participate. The offender that doctors once hypothesized was "maladjusted" has been removed from society outright for the longest stretch of time the state can manage. The Sexual Psychopath has returned.

[959] John Q. La Fond, "Sexually Violent Predator Laws and the Liberal State: An Ominous Threat to Individual Liberty", *International Journal of Law and Psychiatry* 38 no. 2 (2008), 167-168.
[960] John Clayton, "Rehabilitation Administration Strategic Plan 2015-2017 – October 2016 Midpoint Report", Washington State Department of Social and Health Services, Olympia, WA (2016): 40.
[961] John Clayton, "Rehabilitation Administration", 41, 44.

Conclusion

The end of the Sexual Offender Treatment Program at Western State Hospital was the fall of one of the largest residential treatment program for sexual offenders in the nation. Its closure precipitated from factors outside of its control as much as particular events within the hospital. It marked the end of a unique approach to sexual offender treatment, and the end of one of the last prison alternative programs of its size for sex offenders. Its termination came as sex offender treatment nationwide took off, but in a drastically different form and in a drastically different treatment environment. Sex offender treatment today is predicated on behavioral modification of individuals through aversive conditioning and CBT approaches. Its policies and principles are gone.

The program had two histories, as it had two lives. Its first history was its history in the eye of the public and the state, and its second was its internal theoretical and practical development. Its political history showed a vacillating degree of state support and public acceptance, with the operating principle being how much attention was given to it at any given time. Washington's creation of a psycho/legal classification was part of a national trend of legislation that sought to soothe the public's fears of child molesters by promising indefinite detention. The justice system, for unclear reasons, used the statue to a much greater degree than most states, resulting in a large number of sexual psychopath commitments to Western State hospital. di Furia and Mees created the program in response. Their initial perceived success was accompanied by a generally optimistic view of the possibilities of psychiatric care for criminals. A new director, MacDonald, arrived just after a child murder in Spokane left Western State's program the designated "center" for all treatment efforts in Washington. The

program's population grew massively under his tenure, and it achieved significant public renown in Washington. The staff were able to manage the growth until his death in 1977.

The next two directors, Nichols and Saylor, saw a declining budget and departing staff. The state still expected highly of the program and committed large numbers of offenders accordingly. However, conditions were deteriorating. The program's previously good rapport with the public was rapidly displaced by fears about security. Further, a general pessimism about sex offender treatment became pervasive in legal policy circles. State investigations became more frequent following the 1979 re-offenses of Larry Hendricks, a program graduate and longtime therapy supervisor. The investigation's calls for better funding and staffing were not heeded by the state. Meanwhile, the national trends in sex offender treatment had shifted decisively away from group therapy toward CBT and conditioning-derived approaches. A number of less-than-flattering portraits of the program emerged in the course of their investigation, but legislative consternation was not followed by action. A changing current of public opinion on sexual offense resulted in escalating demands for highly-punitive and highly-secure responses to sex offenders. Exaggerated concerns about the program's security were inflamed by politicians riding on a wave of "law and order" rhetoric, backed by punishment-oriented sentencing reform. The foundation of any government program is the public's belief and interest in its outcome. By 1985, the Washington public did not believe that sex offenders could be treated, and had long been doubtful they deserved the opportunity. The state now prized security over rehabilitation. The continued risk of keeping offenders in a low-security facility, however slight, conflicted

with the state's goal of community protection. Therefore, despite advice in numerous reports, the program was closed and replaced by strictly outpatient sex offender treatment modalities.

The program's "internal" history took a much different route. Under the leadership of di Furia and Mees, the program was established as a means to an end. Inpatient group therapy was the new prescription for a number of psychic ailments, and the sexual offender was thought to be dealing with problems of adjustment common to most non-psychotic mental illness cases. The maladjusted sexual deviant could learn how to socialize, deal with stress, and form attachments properly by talking about his feelings in a group. By giving the offender leadership of the agenda, they would take the line of inquiry to the subjects of interest. Further, the residents dramatically increased the intensity of the group, resulting in a "confrontive" atmosphere that gave the offender "no place to hide" his emotions. The arrival of MacDonald resulted in a significant reevaluation of what it meant for an offender to lead his own treatment. MacDonald saw the group as a key element in fostering a positive self-image in the offender. The group corrected him, often viscerally, but it also gave him a receptive audience to his changes. Along with Williams, made a massive overhaul of almost every element of the program, seeking to potentiate the offender's exploration of a new, "responsible" mindset and lifestyle. When the population dramatically increased, the program simply expanded laterally The program staff emphasized continuing treatment over documenting and researching it, making the program's method difficult to follow. Only when the program had been challenged by dramatically worsening estimates of recidivism and by the horrific "relapse" of one of its most visible graduates did it begin

modifying the program. New theories of sexual offense and the behavioral revolution in sex offender treatment challenged the principles the program operated under. The program sought to integrate its recommendations in stages, which by and large resulted in a "hybrid" of behavioral conditioning and the "self-guided group" which proved internally divided and ineffective. When the program was shuttered, it was given a brief memorial as a pioneer, then buried in a lead coffin by a profession which had abandoned its understanding and approach.

The program's single greatest failing was its failure to document itself. MacDonald in his 1968 historical survey stated that "[a]lthough the program has earned a reputation for getting good results among judges, prosecutors and parole officers, it had sooner or later to begin collecting and evaluating data systematically and objectively."[962] The program never fulfilled this goal, a point that MacDonald by and large was responsible for. Its self-evaluation was sporadic and spotty until the very end. The best internal survey of recidivism, taken at the program's height, was quietly tucked away, possibly because its figures suggested a much higher rate of reoffense than the program previously advertised. Western State was not a research institution, but even by the standards of a clinic, its follow-through on treatment efficacy and communication with outside parties was poor. Much clearer evaluations of treatment practice and *how* treatment proved effective, if it did at all, was sorely needed for the field. The program failed to provide them, even as pressure from the state mounted. Its thin staff resources made accomplishing this demand difficult, but even considering the difficulties, the task should have been given a higher priority.

[962] MacDonald et. al., *Treatment of the Sex Offender: Ten Years,* 9.

The establishment of the incurable predator and the end of the program was accompanied by the deletion of sex offender treatment from popular discussion. Throughout the 1960's and 70's, the Sexual Offender Treatment Program at Western State Hospital had a significant presence in local newspapers, and the coverage was largely positive. Particular offenders, given pseudonyms, described their time in the program for the reader. Photos of groups meeting concluded by noting the possibilities of reintegration into everyday life, as changed people. This included both rapists and child molesters. Prominent failures got significant attention, and the program's efficacy was broadly questioned, but the principle of engagement and treatment seemed to have sound support. In the early 80's, the press became increasingly critical, but it maintained an active interest in the program's activities. When commitments ended, sexual offender rehabilitation in Washington disappeared from view. The Twin Rivers program received almost no press coverage before the Shriner case. The Sexual Violent Predator commitments at McNeil have been covered a handful of times in recent years, but it has not had anywhere near the attention Western State's program received. Child sexual abusers no longer received any press coverage beyond their arrest, on the ideological grounds that there was nothing to discuss.

A major issue in retrospect was the absence of any degree of treatment for the program's "rejects". The intensity of a full-time, residential therapeutic group centered on confrontation was too much for many, and they either dropped out or failed to qualify. The State of Washington did not meaningfully investigate treatment possibilities for non-qualifying criminals in the program's lifespan. This lack of interest received occasional comment. Charles Morris, writing in the largely positive April 1974

evaluation, noted that ~250 offenders were not amenable to the program's method of treatment. "[These offenders] comprise a group with serious sexual pathology who probably should be receiving some form of special attention in a program somewhere".[963] The legislature was not ignorant of the "gap". Staff pointed to the program's selectivity frequently in reports, and the rising prison population of sexual offenders was noticed by policy advisors. Only a handful of programs, such as the outpatient program at the Eastside Community Mental Health Center, were put in place before the program ended. They were strictly post-release outpatient programs. Some prisons allowed informal efforts by volunteers, such as psychotherapist James Patterson's sessions at Monroe Reformatory in Fall and Winter of 1985-1986.[964] However, these efforts received no funding or support from the government, and doing much more than a group meeting and some written assignments was almost impossible due to limitations on inmate participation. [965] In Washington, while the Western State program ran, failing out was the end of the line.

As a field, sex offender treatment has made little effort to seriously analyze its past. Western State Hospital's program and program philosophy is absent from the modern sexual assault literature. Only a handful of programs – Atascadero, New Jersey's ROARE – have escaped this fate. The self-guided group has been discarded as a practical approach to sex offender treatment. In the majority of accounts it is dismissed with all other treatment approaches conducted before the rise of cognitive

[963] Charles Morris to Milton Burdman, memorandum, April 19th, 1974, "Facilities and Program for Mentally Ill and Sexual Offenses – Progress Report", 8.
[964] Callaghan, "Sex offenders can be treated in prison", B-16.
[965] "Roscoe and Kuehn, "Treatment of Sex Offenders", 1-2.

behavioral therapy. Often they only get, collectively, one sentence.[966] The lack of inquiry into the Western State approach is because of two major points: two very poor recidivism percentages found at the end of the program, and because of the program's lack of a clear cognitive-behavioral element. One of the major studies of recidivism, conducted by seven of the biggest names in the field, stated flatly that all programs before 1980 "would not meet current standards".[967] This deserves reconsideration. No program can function when it is given a maximum number of "patients" and a minimum of funds. Western State's method allowed for a degree of resident involvement few programs can match. The recent call in the sex offender treatment literature for a more emphatic, "listening" therapist suggests that this program, if in that capacity alone, has something to offer the modern therapist working with this difficult population.[968] The Western State Program cannot and should not be revived outright. Its emphasis on group accountability, group belonging, and offender participation, however, should be reexamined.

[966] Marshall and Hollin, "Historical Developments in Sex Offender Treatment", 126; Lane Council of Governments, "Managing Sex Offenders in the Community", 26.
[967] Soothill, "Sex Offender Recidivism", 154-155; Michael C. Seto, et. al., "First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders", *Sexual Abuse* 14 no. 2 (April 2002), 169, 173.
[968] Marshall and Hollin, "Historical Developments in Sex Offender Treatment", 126, 130-131.

Appendices

Appendix A: James Ruzicka Confrontation, in Denenberg, "Sex Offenders Treat Themselves", 62.

This excerpt narrates a group session confrontation of James Ruzicka, referred to within the article as "Bill". It has been included in the interest of showing what a confrontation looked like, and to suggest the difficulty of gauging an offender's honesty.

"While the meeting broke up for coffee refills, the two co-leaders worriedly discussed a man who had been behaving peculiarly in recent weeks. They decided to confront him.

When the group reconvened, a leader asked: "Bill, why do you think no one likes you?" Taken aback, Bill denied that he felt that way. But several members began berating him loudly: "Come on, Bill. Cut the crap. What's up?" For twenty minutes, Bill held out against the verbal assault. Suddenly, his face red and his voice choked with angry sobs, he blurted out accusations of mistreatment by other members. He had gotten the worst work assignments, he said, and unfair blame for messy conditions in the dormitory. He felt the others were being cold toward him.

The room was quiet. Then one of those who had aimed the verbal barrage at Bill said soothingly: "How can we better understand you from now on?"… Although the group had recognized danger signs in Bill's case, it turned out that therapy was not enough. It was he who was apprehended…"

Appendix B: A Psychodrama Session with "Al", quoted from Laurel Butler's "The Role of the Citizen Female Volunteer…", 8-9, in *Handbook for Volunteers.*

This excerpt describes a psychodrama session between a program volunteer and a program resident.

"...Al sat quietly in the group. His grayish hair, protruding stomach, and downcast eyes gave the feeling of despair to the onlookers. Al felt that he could no longer appeal to women because of his appearance and age and as a result had turned to little boys for his sexual satisfaction. A role play situation began as the woman volunteer began to approach Al as a woman and began to tell him that she was interested in him as a man. This evolved into a scene where she played the part of a woman that Al had previously been interested in. A general conversation continued but almost came to a standstill when the woman mentioned she had two little boys. This really put Al into a fluster because this brought back all of Al's fears and all the hurt he had caused in the past. At this point the role play almost fell apart, but the volunteer persisted and Al continued. During the situation Al hugged the volunteer and began to realize that he was still attracted to women and could be accepted by them. It became clear that Al still had heterosexual inclinations. This was a positive step for Al because he could now improve his self-image and begin the move away from relations with little boys. He now had the realization that this was possible."

Appendix C: Interview with "01", conducted on June 26th, 2018. The interview has been edited to remove identifying names; otherwise it has been left wholly intact. JG is John Giacoppe, the author of this paper.

JG: How long have you lived in the Washington area?

01: My entire life. I was born in Seattle.

JG: Okay. What was your experience in the healthcare profession before Western State?

01: My undergraduate work is in nursing, I have a bachelor's of science degree in nursing. I achieved that in 1962. I went into the Army Nurse Corps six months after graduation in 1962, uh, and served on active duty in the Nurse Corps from 1962 to 1965. After that, I worked as a public health nurse in Tacoma / Pierce County Public Health, and then from there I went to work at Western State Hospital and worked as a psychiatric supervisor, a psychiatric nursing supervisor, from September of 1970 to June of 1973, I think that's right. After that, in June of 1973, at Western State, I became what was then called a "therapy supervisor" and was responsible for providing treatment for a group of sex offenders at the hospital. I continued to work in that capacity till the program, till I finished my work with the program in 1994, I don't know if you want more after that or not.

JG: We'll get there in a moment.

01: Okay.

JG: You just stated how long you worked for Western State, it was, uhh, about -

01: 25 years.

JG: 25 years.

01: Almost 30. It was, what was available in retirement at that time. I have PERS 1 retirement. I have five years in the military, including my student nurse time, and so I have twenty-five years of actual duty at Western State and five years of military counted for five, so it was thirty.

JG: Okay, so during your time as a psychiatric nurse supervisor, umm, what did you know about the sex offender treatment program? Was there much overlap, or?

01: Well, that's an interesting question, because when I first went to the hospital in September of '70, my first position was in Geriatric Admissions, it was a head nurse on the admissions ward, and, oversaw the patients and providing treatment planning, etcetera. Interestingly, at that time the sex offender program placed with the consent of the hospital and the units, sex offenders who were in treatment in work positions around the hospital. One young man worked on our ward, I think, three or four days a week from eight in the morning 'til noon every day. So, I became familiar with the program through him, and talking with him. And then, I went from that unit in… let's see… it was September of '71, I believe September…. date's not really important,

JG: Mhmmm.

01: but '71, I went to what was called South Unit and was a Psychiatric Nurse Supervisor, and was also responsible for supervising what nursing staff were on the sex offender program. So I regularly sat into program meetings, sex offender program meetings, staff meetings, what have you, so that I became very interested in the program. In conjunction with that, I was also working on my master's degree at Pacific

Lutheran, with a major in psychology and the, the sort of… what's the word I want to use…. and the direction of that degree was learning theory.

JG: Mhmmm.

01: And what impressed me about the sex offender program is that, their way of doing business, if you will, really was learning theory based. And so, uh, I was almost finished with my, with the requirements for my master's degree, when a position for a Therapy Supervisor III opened up, and I filed for it, met the criteria, and was appointed, and kind of as an aside, I was the first woman therapist that was ever hired by the program. In fact, there weren't very many women therapists throughout the country that were working with sex offenders at that time. That was right after the ERA, the Equal Rights Amendment, passed in Washington State, so that changed what state programs could and couldn't do, and prior to that they had always said well, it's not a good place for women, it's too threatening, blah blah blah, so that changed with the E.R.A.

JG: So when did the E.R.A. pass in Washington?

01: Okay, let me think… maybe '72, I'm not sure. But probably the fall, the legislative session of '72… unfortunately in never really passed,

JG: yeah, nationally…

01: the national Congress…

JG: Well, it did the job in this case.

01: Yes, it did, it did. Opened up some doors. I was the first but not the last.

JG: That's good. Glad to hear that.

01: So that's how I got into working with sex offenders. It was not what I planned to do. In fact, in that period of time, actually even through the eighties, very

few people went into…. there were no programs in school, in that regard, so most people kind of fell into it, or got interested or learned about it, and decided to get involved. That certainly was the case with a lot of my colleagues, both locally and nationally.

JG: That brings me to my next question about that. When you joined the program proper, you said as a Therapy Supervisor III?

01: Yes.

JG: Was there a training program for you, upon entry, or did they…

01: No, there wasn't. There was no training program per se. They were one of the few programs in the country at that time that was doing… inpatient sex-offender treatment in a hospital facility. The only other one that I believe I'm aware of at that time was a program in Hollywood, Florida that was run by a woman named Jerry Boozer [Dr. Geraldine Boozer], and I can't remember how to spell that name,

JG: Mhmmm,

01: but there weren't that many programs.

JG: Did the Bridgewater program exist at that time, or?

01: It may very well have but that was in prison.

JG: It was a correctional facility, yes.

01: Mhmm.

JG: Umm, You were on this program for a fairly long time, so I imagine you went through changes in the ward, but, what was the general size of the ward and what did the ward look like during your tenure?

01: Well, the ward, the size of the ward depended which ward we were on, because since the program grew over time. The ward we started on had three groups, and the groups were about fifteen to seventeen offenders, they lived on the ward, their group room was on the ward, as was the same thing for the two other groups, and each group had a person that was called a therapy supervisor that was involved with the program. The program's title at that time was at "Guided Self-Help Treatment".

JG: And that would have been in '73, it would have been "Guided Self-Help Treatment".

01: Well, it was even before then, but it was in '73, definitely.

JG: And, I know at some point the population reached over 100 people, would that have been…

01: Well, at the time…. in 1983 there were 200 sex offenders in treatment in the various wards at Western State. And, there were… I think the 200 included the work release population which went out during the day to work or go to school and was involved with their group at night. And there were also about thirty, maybe more, outpatients that were back living in the community that came in once a week, meeting with their group and therapist.

JG: So the 200, then, would have lived, effectively, in the hospital….

01: Within the hospital, within the program. But it was… in…. I'm trying to remember…. One of the buildings no longer exists. The program actually, I think, it started in a ward, in a building called North Hall, which has subsequently been torn down as I understand it. It was an old building, and then it was on the top floor, W-1, of one of the general psych buildings that was sort of "across the street" from the other

one. And as I said, we started with a ward… no. There were three wards on the first floor of North Hall, then a big ward at the top of the psych building across the way. We eventually took over another full psychiatric ward during my tenure at the hospital, and that ward was larger, so I think there may have been as many as… (counts under her breath)… as many as six groups on that unit…. 'cause it stretched forever….

JG: So that would be six groups of fifteen to seventeen people.

01: Yes, but, well, there were… (counts again)… six one place, uh, three… So we're talking, we probably had at one time about twelve groups. That would be nice if I could find that bloody… I can't copy some of – this was an old publication, 1983… uhh, and I don't remember who did this, whether it was our research people, or whoever, but…. oh!... I guess I did this…. [hands **JG** a pamphlet]

JG: Oh, woah!

01: Somebody did it, my name it is on it as…

JG: A participant.

01: Well… uh …. yeah, I dictated it, so I guess I did it.

JG: I see.

01: And this is one in '79 that I put together, I was invited to the Propwood conference in Cambridge, England, so this is another I could also copy for you…

JG: I'd be very much interested, yes.

01: Alright, we can do that when we're done.

JG: Excellent. Alright.

[Pause.]

01: Go ahead.

JG: So, so yes. To ask again, did these wards have any…

01: You can just have one of those [handed me a study.] M_ ** that's in Oregon, he and L_ ** got a grant to do research at the program, and I assisted them so they'd put my name on it, too, they were generous enough to do that.

JG: Yes. Could you move a little bit closer to the microphone?

01: Yes, that better?

JG: Yes, that's fine. Ok, so, um, were the wards any more "secure", so to speak, did they have more security precautions than most of the remainder of the wards on [sic] the hospital?

01: That changed over time. The doors were locked, uhh, when I first started working the program. The doors were locked. There were very few nursing staff, there was maybe a nursing staff, licensed practical nurse who went between various wards to give out whatever medication might be ordered, and then, there was a group charge on the ward for each group. This was a member who had reached a point in treatment where he oversaw the resident's work on the unit, was responsible for some of the job placement in, in the hospital per se, and sorta, he kinda, the three group charges, if there were three groups, were sort of responsible for what happened during the day on the unit when there little or no nursing staff…

JG: When I've been reading the literature, I've heard them refer to patient leaders, would that be the charge you're speaking of, or something different?

01: It would have been resident leaders. We didn't call 'em patients.

JG: Resident leaders, okay. You called them residents.

01: They were called residents.

JG: So they were not referred to as patients.

01: No they were not.

JG: Noted. Residents.

01: That was done on purpose, I think, by Dr. diFuria, who started the program in ’65… God, what did I do with this… I had, actually, a journal article that was in one of the psychiatric journals about the program and I had that somewhere, uh, and all of that stuff was in there [points to file] and I don’t know where it’s gone.

JG: He wrote, he wrote a handful of them that I saw, because there was one he wrote with Hayden Mees…

01: That’s the one.

JG: Yeah, and they had one describing their critiques of the law, then one about the program itself.

01: The program itself, I think, is the one that I’m talking about.

JG: And then diFuria wrote another one with MacDonald. Is it [Mack] or [Mick]Donald?

01: [Mick]Donald. It’s M-A-C.

JG: Yes. In 1970 or ’71.

01: Dr. MacDonald came to the program in ’68, or some – ’68, ’69, is that right? Yeah…

JG: He must have been there somewhat earlier, because I saw, there was a television documentary, or some sort of documentary made about the program that was filmed in 7[6] – not seventy, ’66. And he’s on the ward, he’s in it.

01: Okay, he came… He and Dr. diFuria had known each other in times past, and he was brought to the program to more… to further develop it…. what was his first name? I don't remember…

JG: George, I believe.

01: George, yes, George MacDonald. And he was the clinical director until he died… '78, '79…. somewhere in there, I think. Probably earlier than that, yeah. But anyway, around that time.

JG: Umm, would you say, was diFuria ever effectively clinical director of the program or was he primarily a higher-level administrator?

01: At one point, he was kinda the clinical director or developer of the program, and then I believe, in concert or later, he was appointed superintendent, and that's why he, the program was starting to grow, and that's why he brought in Dr. Mac from elsewhere to take over the program.

JG: Umm, would you say that diFuria and MacDonald had effectively the same vision for the program, or was there some difference?

01: It's hard to say, but I think they both were interested in a non-psychiatric approach, because a lot of other places, and even the hospital itself at one point, prior to the advent of the guided self-help model, had been because they had to, sex, quote "sex psychopaths", were committed to the hospital, first for ninety-day evaluation, then for treatment, but there was really no treatment…. they stashed them, they placed them in a locked ward, and they all were there… somebody once told me they had more nursing staff or more staff on that ward than anyplace else, because they were kinda afraid of the sex offenders. I'm not, you know ... and as a general rule, uhh, in the time that I

worked for the program, and we had, uhh, what we would now call "low risk" people and "high risk" people… I never, uhh, I never feared for myself; most people that worked there did not… they [the sex offenders] were not overtly aggressive, violent people. It wasn't like the civil – the mentally ill offender program, where they did the NGR, the Not Guilty by Reason of Insanity Evals,

JG: Mhmm.

01: when you had people that had pretty severe mental illnesses, and until they got them under control, there might be some behavorial acting out. Rarely, rarely, there was one report about the time I was involved, maybe a little before, of a guy walking to the nurse's station and exposing himself. And her response was, "Put that thing back in your pants and go back and do you work!" And so that's what he did. And that was the end of it. He didn't do it again, and that's the only time I can recall… any sex offending in the unit occurring. So…

JG: So, by and large the patients kept…

01: The residents, yes.

JG: The residents, forgive me, I'm…

01: Part of what made it work was that they really did have responsibility for one another. They went together as buddies, they left the ward in a small group to go to the jobs, there was always a more senior member, step four and above, who was with them, until they earned step four themselves, and I really believe they felt a responsibility, and it was expected they would confront behavior if they saw [it], and if somebody was doing something they weren't supposed to be doing, then they'd have a special group. You could hear that ring out over the ward: "East Group, Special Group."

And, they'd all come in, they'd have a meeting, and talk about what went on. And they genuinely, genuinely had a sense that they were responsible for each other and for each other's success. And so, with that in mind, that kind of changes the dynamic. And whereas, you know, in prison, if you told about somebody else's behavior, you'd be a snitch,

JG: Yeah,

01: Uhh, we kind of crossed out all those words, you didn't use them. It was being a responsible group member if you thought enough of somebody else to point out their behavior to them.

JG: Mhmm. Could you go over the steps, of, not of advancement for the residents, but the steps of responsibility, you just made mention to it?...

01: I think I actually have, somewhere in here… 'cause I was lookin' at it this morning, and I don't know where I saw it….

JG: It's quite fine.

[Pause]

01: It must be in… It's somewhere, I just am not finding them.

JG: I see.

01: Well, we've got "Step of Progress for Work Release" – yeah, this goes back to '79, yeah, and they were modified over time, but… and they were changed as well, when things got more secure, because the community got concerned about them, the legislature got concerned about them. When I first came to work in the prog ram, the group charge carried the key to lock and unlock the door during the day. And, there were two guys that sat "CQ" at night, uhh, in order to make sure they stayed up,

JG: Yeah.

01: to make sure that everything was okay, and so they were really in charge of the ward. There might be a nursing staff, LPN…

JG: When you say "guys that sat CQ", you mean, residents.

01: Yes,

JG: Residents.

01: Residents that sat "CQ". Usually, well, they had to be step four, but usually they were more advanced, step six of seven. And they stayed up and did head check, and made sure everything was going well.

JG: Yeah.

01: After there were…. like four guys escaped together one night; they over, they overcame the guys, and went out the back door, and were taken away by people they'd set up to be there with cars, and after that, uhh, the division of Mental Health, the Public, the Legislature said "No no no, we can't be having this going on, to…"

JG: To monitor.

01: Not that the staff couldn't be hit over the head as well, but…

JG: Do you know what year that was?

01: [pause.] Post… I wasn't director yet. It would have been sometime between '75 and '77, I think, that happened.

JG: Mhmm.

01: So… things gradually whittled away as the program became more prominently known, ended up in the paper more frequently, etcetera.

JG: I'll ask you a few more questions about that in a little bit.

01: Okay.

JG: Umm, so we've already discussed, hmm... Can you walk me through an average day on the ward, at the beginning of the program, then closer to the end of the program, in its phase-out period?

01: Okay, sure. At least, from the time that I came there, they would get up… five or six o'clock. Uh, there - There was a definite time. I think they had to be up by 5:30, but I wouldn't swear to that. Let's see…

JG: I have a schedule, and I believe it's five-thirty, because they have to be, um, they have to eat breakfast before their work shift starts at seven, and breakfast only started being served at six-thirty, if I remember correctly…

01: Yeah, over at – they went over to the main hospital dining hall, as a group, escorted by other residents.

JG: So they ate in the main dining hall.

01: They ate in the main dining hall, yes. And, then, when that was done, uhh, they would come back to the ward, and then the men that were going to other wards to do janitorial work would be escorted by two members that were at least step four and above and dropped off at the various groups and then they'd come – the men who often were group charge – would come back to the ward themselves. So then, the men that were usually in observation, the early stages before when they first came in for treatment, or first came in for observation, then they would stay on the ward all day, uhh, or all morning. They'd do some of the work on the ward, the janitorial work, the cleaning, the whatever. And then when lunchtime came along, whenever that was – 11:00, 11:30, whatever – then the, uh, the men who were on other wards were brought

back to the ward and then they went as a group again the lunch, and then after lunch they came back to the ward, and I should add that any time they were in or out, they had a book that they signed their name in and out, the date, the time, etcetera. And then, the guys that were gonna be on the ward, …. I'm trying to remember this - they might go back to their job in the early afternoon, but then would be brought back. The guys that stayed on the ward stayed on the ward. And then there was a group [session] every afternoon from… from two… to five?

JG: Mhmmm.

01: …uhh, and dealing with whatever they needed to, some of it was reading a guy giving his autobiography, sometimes it would be a step of progress -

JG: And this would have been the group therapy session?

01: Yes, it was group, it was a group therapy session. They took the notes for their group. They had a secretary appointed, and that guy took notes. And they taped…

JG: The session, yes.

01: Each session as well. Someone else was assigned… The therapist was not necessarily in the group all afternoon. We did, we may have stepped in, we may have monitored if we needed to be there, but a lot of it really was guided self-help. Then, late afternoon, the dinner…. They'd come back to the ward after dinner… then, then they'd have group, from seven 'til they were done. So that could be ten o' clock, eleven o' clock, depending on what they had to deal with. Sometimes they had more stuff to do. Umm, Tuesdays nights they did not have regular group. People that were married, or part of a couple, would be involved in couple's therapy with a therapist, and the other guys had that night off. That was Monday, Wednesday Thursday and Friday, uhh, was

that pretty – was that afternoon group, evening group. Except on Tuesdays. Saturday there was no group. Sunday, evening, there was a group, but there was also - visitors could come on Sundays. That, that was visiting days, people who were approved visitors.

JG: Okay. Did residents have their own rooms, or were they two to a room, or three to a room?

01: They… sometimes more than that, there was a large dormitory, uhh, and, you might have as many as… maybe eight guys, in the dorms. Six to eight, it depended on the size of the room, and at one time… we were using, uh, bunk beds. But, uh, when they divided it up, then guys could have kind of some, you know, like a sheet or something, down, so have some privacy. But, there was – candidly, there wasn't a lot of… fuss for privacy. Being open like you are in military barracks, so that people know what other people are doing so they can help 'em out if they need to, uh, what have you. So, yeah. The only people that really had individual rooms in what we call the "short hall" were work release. And they did have a small individual room, that was probably smaller than this office, but all that was in it was…. a small chest of drawers, it might have been, maybe… from here to there [pointing to walls].

JG: So about, 8 feet by 12 feet?

01: Maybe, if that. Anyway, they had a bed, chest of drawers, a place to put their clothes, any personal things, a bedside table, and that was it.

JG: Okay. Um. What was your uniform, or did you have one?

01: No uniform.

JG: No uniform.

01: No, the sex offender program did not wear… uhh, I didn't have – well, even in the psychiatric hospital, when I was a part – when I was in geriatrics, I had to wear, white.

JG: Mhmmm.

01: But when I went to the psych uniform nobody wore uniforms, in the psych unit. You just dressed in street clothes. And that was the same thing at, in the sex offender program.

JG: Mhmm. Did the residents have a dress code, or?

01: They had, you know, most of them during the day wore jeans, or khakis, but mostly jeans and t-shirts, or jeans and long-sleeve shirts – it just depended on what they had.

JG: Mhmm.

01: They generally brought clothes from home. Uhh, there was also, a kind of a clothes shop that was, you could go in and pick clothes out at another part of the hospital. Or folks could bring stuff in to them, etcetera.

JG: Mhmm. Okay.

01: So there was nothing to designate this as the sex offender program. There are some places where sex offenders wear particular color jumpsuit, so it got everybody, including the other convicts, know who you are.

JG: Yeah.

01: This is - they were treated like the rest of the hospital, there was no uniform for anybody else in the rest of the hospital,

JG: So why them?

01: Including the staff, you can tell who was who. [Meaning unclear in-context, but did not have time to clarify.]

JG: Okay. Umm, we just described how there were generally, not always but generally, two umm, therapy sessions a day, or two group meetings.

01: Yeah.

JG: One in the afternoon, and one in the evening.

01: Yeah.

JG: Did those differ in content in any way, or…

01: Well, the evening session was longer, but there was also – that was where requests for a new staff, for a greater… am I close enough?

JG: Yeah, you're fine, I just wanted to check the battery on my laptop.

01: Uhh… closer to, … what was the question again?

JG: Oh, um, How did the afternoon and therapy - evening therapy sessions… [differ?]

01: Okay. Afternoon dealt with… sometimes reading the autobiography, any confrontations, any therapy that somebody would ask for… "I'm having a trouble" - they'd tell the leader of the group, there were two leaders, two resident leaders in each group, uh, and then they, the guys were supposed to let them know at the beginning if they needed to talk about something. Other residents could bring in something, a confrontation, what have you. Uhh…

JG: And what, precisely, was a confrontation?

01: Well, it would be, you know… let's see if I can think of one… "You're not doing a very good job keeping your area clean. You're not helping out." Somebody might have thought somebody was fantasizing just by the way they were behaving…

JG: Mhmm.

01: Uhh, you know, somebody maybe on the ward that they worked on might have been over associating with a staff person.

JG: Mhmm.

01: The ward – there were more women who worked on the ward than man, although there were some. But most of the nurse's aides, and, uhh – of course, nurses were women, and these guys, they were not mentally ill, they, in comparison to some of the patients that people were dealing with on their ward, they just seemed like everybody else. So we really had to keep track of what was going on, because there were a couple of incidents, more than a couple, were somebody got involved with the staff. So one of the rules was, very definitely, you cannot be involved in a personal, intimate relationship with any staff. It was technically against the hospital rules, but –

JG: More importantly, it was against their treatment.

01: Yes, it absolutely, absolutely was. Not appropriate.

JG: Yes.

01: So kind of, that sort of stuff, and sometimes if the therapist had something they wanted to talk about or deal with, they'd go into group and address, address that as well.

JG: And so, as you were describing, the therapy supervisors were not, were not in on every session.

01: That's correct.

JG: They were not asking questions. So patients – sorry, I apologize – residents would be asking each other questions? [unintelligible movement]

01: Yes. There'd be the group leader, and then somebody else could ask a question, or they used to talk about "running a line of therapy" on somebody they thought needed help. And so someone would bring it up. Or the leader would say "Okay, Joe, so what is it you want to talk about in regard to Frank?" And so he'd bring it up, and other leader- other group members, if they felt like they wanted to say something – it's kind of like a group therapy session, when you're in a regular, "outside" -

JG: Yeah.

01: You know, you talk to each other, you point stuff out, you offer help, that kind of thing.

JG: Yeah.

01: At one point, about the time that I started there, some of the groups were still operating in a really pretty heavy duty "confrontation" manner, you known, sort of like the old –

JG: Like Sysanon, [Synanon] or?

01: ?Sedranar??? I think was the drug program here, and then there was one down in California that was sort of the basis for, for, a lot of self-help stuff, and theirs really was self help, they didn't have a…

JG: A program.

01: A treatment person that would be in there monitoring them. So it was pretty confrontive, and several of us that were new to the program over time started doing something differently. So we modified the really "attack" stuff and modified the definition, 'cause if you look at the definition of confrontation in the dictionary, it does not say screaming and yelling at somebody.

JG: Was there - was there a lot of raised voices?

01: And so pointing out – Oh yeah, screaming sometimes. Rah-rah-rah-rah…

JG: Because I heard it described at confrontational,

01: Yeah.

JG: and then in the documentary they're all very soft-spoken. So, it's a bit of an incongruity but you're saying it definitely was.

01: At one point it got- particularly if somebody wanted somebody to tell the truth, you know – "don't lie to me, tell me the truth, I saw you", blah blah blah blah.

JG: Yeah.

01: But that kind of stopped … probably in late '73, early '74, that was sort of, the end of that. And it didn't mean that was going on in all groups. But there were some groups that, uh, that did that. [Pause]. Stopped, though.

JG: Yes. Okay -

01: And we started, as time went along, were it could be allowed, we started spending more time in group. It was easier to be there most of the afternoon, 'cause that was, working hours, uh, some of us would come back in the evening,

JG: Mhmm.

01: to see how things were going, and I lived within a little over a mile from the hospital, so it was very easy for me to drop in and see what's going on. And again, we have the, the tapes.

JG: Yeah.

01: And you know, from time to time, you'd track the tapes to see, okay, well, - and it didn't happen very often, where there might be some gap, uhh, not often, I don't ever remember having to confront that but somebody else I remember did,

JG: That there was a gap in the tape.

01: Yes, gap in the tape.

JG: Like, where they would have erased it –

01: Like the Nixon tape.

JG: Yes. Oh, I see. That is, that is surprising.

01: But the thing was, there was the…written, the written -

JG: Written minutes.

01: minutes. So you could very easily… but sometimes the tape recorder didn't work as well as it should. But that was rarely, rarely a thing I can remember, remember having to deal with. But that's why the minutes were there, and it was only on special occasions that I would pull the tape off, er, tape in to listen to it to see, uh, if the minutes… were -

JG: Were accurate.

01: were accurate, and the minutes were often more detailed than the, the tape.

JG: Um, so you did not listen to the tapes that often, you merely – or rather, you did it to confirm the minutes.

01: Pretty much. It was depending on time, because the group leaders would bring the minutes of the meeting into me, first thing in the morning, and I would take time to go through 'em and write comments, and that was one thing I would address when I went into the afternoon, was, you know, comments on the good stuff, the not so good stuff, whatever. And, uh, so the minutes really did give us decent information on what was happening when we weren't there.

JG: Ok. Excellent. Umm, how often were you in contact with the Eastern State Program, upon its re-foundation?

01: Well they didn't refound, they never had one. They, we had -

JG: Well, they had a commitment process in the early fifties, because it -

01: Well, but that's what everyone had. It's just like Western had. That was when…

JG: It was not a program, it was merely…

01: No, they, and - they might go into the same ward as the NGRI [Not Guilty by Reason of Insanity] people. Uhh, they might be distributed to different wards, but there was no program.

JG: Mhmm.

01: That was kind of what happened, uh, at Western, uh, before the program started, but in reality they had a lot of people being supervised without much of a program. It was more medication induced, and… It was the minority of people that got medication, during, uh in Sex Offender Program during the time when I was there. They weren't psychotic. Somebody was depressed, really depressed, then they might get an

antidepressant, but medication use, other than for medical stuff prescribed by the medical doctor, was really pretty min-

JG: Very minimal.

01: Very minimal, yeah.

JG: Mmkay. Ummm.

01: So, Eastern State may have done that other thing, but, we were so big, and we got people from Eastern Washington once the Sex Offender Program started up in the late sixties, uh, and we were getting so large that between our hospital and the division of Mental Health, ah, there was a decision made to develop at least two groups over at Eastern State at that time, and two people, the people that we had from Eastern State, they didn't - weren't forced to but many opted to go over to Eastern State because their families and friends were closer, and we got, trying to remember - I think we hired two people a little before all of that, I think six months before, so they got used to the program and what was happening, uh, and then, those two people went over to Eastern State as the directors for, - or is it the leaders, or the therapists for those two groups.

JG: Uhuh.

01: During that time, after it opened, the first year, I think, several of us, and by that time I was director of the sex offender program, we went over two or three times, they might come back and talk, uh, so it was about a year, sometimes maybe, maybe once a year for a couple of years after that at their request.

JG: Yes. How did you responsibilities change from therapy supervisor to director? I imagine there was, obviously, some steps in the middle of that…

01: Well, princip-… as a therapy supervisor, I was principally responsible for the intake, evaluation and treatment of the people in my group. Because I was a Therapy Supervisor III, I was the supervisor for the ward, where there were three other, er, two other therapists. But, then, when I was appointed Director, uhh, initially I tried to keep my group, but it became ridiculous.

JG: Yes.

01: Because I was responsible for, uh, overseeing the whole program, uh, making sure that stuff was happening as it needed to be, I was, I headed up the staff meeting, I was also required to go to senior staff, uh, where a lot of the final decisions got made about the sex offender program, and residents, and then at one point the mentally ill offender, and I had more responsibility for communicating with the Division of Mental Health. If they wanted a report, I was usually the guy they came to. I was hiring, and monitoring evaluations for the therapists, etcetera.

JG: Yes.

01: I far preferred being a therapist to an administrator.

JG: Mhmm. Was there ever a program for the mentally ill offender at Western State?

01: Yes. Yes.

JG: When was that, uh, founded?

01: [thinks, clicks tongue] Uh, ’74? ’75? And that’s the program that took over a goodly part of North Hall. Dr. MacDonald was the clinical director for that as well. They adopted our model, so there was a therapy supervisor in charge of a group, but

because we were, because they were dealing with mentally ill people, there was a ward psychiatrist, there was more nursing staff,

JG: Mhmm.

01: They had [a] psychologist attached to the program, um, and the, uh… competency and NGRI program became part of that unit as well .

JG: Mhmm. So, there was a significant degree of, not control but more monitoring, for the mentally ill offender unit, but it's still predicated on the same principle of -

01: But not so much self-help, because there was a therapist in their group all the time.

JG: Mhmm.

01: They didn't have so much group hours as we did, and they really had difficult - they didn't have group leaders the way we did. They'd appoint somebody, the staff would appoint somebody, and their level of functioning would really kind of determine what went on. The professional that came into the group that would sort of lead the group and direct it.

JG: Mhmm. Uh, was there a significant difference between the way you approached treatment for offenders against children and offenders against adults?

01: No.

JG: Okay. Just that question, um –

01: Not any more than I do now in private practice. But although, not for adults, no. There's a difference between how one provides treatment for adolescents in private practice, and adults –

JG: But in terms of the target of their offenses, no.

01: No.

JG: As we previously stated, there were some escapes under your tenure.

01: While I was there, yes,

JG: Yes, what was it like being on the ward while a patient was at large?

01: You mean, gone somewhere?

JG: Yes, gone somewhere. What happened, what was the protocol?

01: Well, um… initially, um… when I first started there, 'cause sometimes people left the grounds and came back again.

JG: Mhmm.

01: And that was apparently a function that happened in the early days of the program and it was still kind of in effect in middle '73, when I went to work there there. But, umm, the first really huge, I say big escape was a rapist, and he was a level four. He had taken a group of residents to their jobs at the noontime, and then never came back to the ward. And… we started looking for him, went out on the grounds, and he wasn't there, but there was no policy in those days, you would notify the superintendent -

JG: And what year was this?

01: [pause] Early '74. But no policy to notify Mental Health, DSHS or the public, because there was still a sense, because nine out of ten times, someone came back.

JG: So it was better to avoid –

01: But this was also a group - there was a group of people that the Associate Director under MacDonald had made arrangements with Department of Corrections to take a select group of people that had been sent to the Department of Corrections because the prosecutor refused to file on them. In those days, the sex psychopath law said that, the, it was the responsibility, or purview, of the deputy prosecutor to file on and say, "Alright, we're gonna put this guy up for an evaluation period or observation period" –

JG: [unintelligible] responsibility of the deputy prosecutor?

01: The deputy prosecutor was the only one who could file a sex psychopath petition. The judge couldn't do it, the defense consul couldn't do it. And so, one of the criteria seemed to be that the guy had to more or less admit what he'd done and be willing to engage in treatment. Now we had guys that came and said, "Well yes I did it, but I had…" they hedged things. And, so there were a group of more … hardened criminals, and more rapists. Now I remember having a couple rapists in the group when I first started, but there were fewer rapists and part of was prosecutorial discretion. And so, uhh, the guy that escaped was a rapist.

JG: Mhmm.

01: And he had committed some rapes in West Seattle, and part of King County but then was sent to prison. So, he and some other guys that were rapists were sent to us by Department of Corrections, and at that time, DOC was part of a DSHS agency. So there was Division of Mental Health, Department of Corrections, etcetera, so they were all part of DS-

JG: Under the umbrella.

01: Yes, under the umbrella of DSHS. So it was easier, you didn't have to go back to court to switch somebody. So this guy happened to be one of those people, and… he just didn't come back.

JG: And he had a, so-to-speak, a company car?

01: No, no –

JG: Or what was it? He was on foot?

01: We don't, I, I - I honestly don't remember now, but he was on foot. I think, he took a bus? I don't know how far he went, he took a- he ended up in Seattle. And it was after that, he committed – I think two new rapes, up in Seattle. I hate to swear to it, but I think he may have murdered one of the younger girls. They were preteen, teen girls. They found their bodies… a while, not a long time, but they found their bodies, they were missing. Then there was manhunt put out for him, I don't remember where they caught him, but he was readjudicated in King County, and then went to Walla Walla.

JG: Mhmm. Noted. So, that was -

01: That was the first one. And so that took away some of the privileges. Guys were not allowed to be out on, even level four, they changed what they could and couldn't do, so they had to be in twos as well, uh, etcetera.

JG: Mhmm.

01: So that was the first big change. And there were a couple, and of course that made a major paper,

JG: Yeah.

01: you know. That was the proverbial doo-doo hit the fan.

JG: Yes. Umm, and how did the other patients react to –

01: Other clients or other residents?

JG: Other clients or other residents, my apologies.

01: Well, they were very upset. And of course we grounded the entire program, which meant nobody got out of the place.

JG: So no work release.

01: No – well… maybe work release could go, it depended at that time. But, the ward, the whole program was grounded, and then sometimes the program may have come off of grounding but not the group.

JG: Mhmm.

01: Because we were doing work within the group structure to see "how did that happen", "what did you know", "what had you seen", all of the above.

JG: Yes.

01: And he was just, he was just slick. The only thing I remember about him is that you could look him directly in the eyes and you didn't feel like there was anything there.

JG: I see.

01: Kind of like that psychopathic…

JG: A Lack of… feeling.

01: Yeah. Not much feeling or certainly not much empathy for… anything.

JG: And, I imagine that the residents would process this in their group sessions, you know.

01: Yeah, well, yes. And well this whole thing, of course - when the group was grounded, they'd be in group from after breakfast – they didn't leave the ward, breakfast was brought to the ward, and from the time they finished breakfast and cleanup in the morning till noon, and then again in the afternoon and in the evening until the therapist, the therapist felt they had… adequately addressed the issues and maybe came up with some proposals about "what now", and then in order for them to come off group completely, that [coming off group] would have to be approved in a program staff meeting.

JG: Okay. So they, they would, would offer proposals, in terms of –

01: Well, they would say "this is what we want to do", and then in my group I would approve it, then we'd even talk about putting that into place, uh, and then I'd review, there was a… what did they call that? – there was a meeting once a week on Wednesday morning, that was all the therapists, the - the clinical director, the psychologist, and the group leaders, met to discuss the program, to discuss issues, and the leaders would then present their positions,

JG: Mhmm.

01: because they were asking to come off grounding and they had to present their positions of why they'd thought, why they'd solved the problem.

JG: I see.

01: And they might get told "No, you're not done, go back."

JG: So, so they'd, they would have to argue, in a sense, and present themselves. Um, what would be parts of their proposal, as to why? Would it be in terms of "This is

the way the sessions are going, I'm seeing a marked improvement in, um, resident involvement", or -

01: Well, what it might be with him, what I'd remembered is that people had seen things they didn't know they'd seen. It wasn't like he was trying to throw a -

JG: A chair through the window.

01: A chair through the window, or go down the building in sheets or something like that. It was that they just kinda recognized that he wasn't with it as much. And I, I actually don't remember, I don't recall anyone actually disclosing something that they might have come forward with. It was sort of, everybody was surprised. The whole program was devastated because they knew, particularly after the bodies were found and it was, you know, it was a statewide hunt for him…

JG: Yeah.

01: I think, I don't remember, but I think he even went into Oregon and did something as well. But, uh … in fact he may have gotten caught in Oregon and then was brought back to, uh… adjudicated there, went back to Washington, came back to Washington, but he's probably locked up for the rest of his life. He's, I think he's still at Walla Walla.

JG: Mhmm.

01: And he was probably in his mid-to-late twenties when all of this happened in '74. So he's probably kind of an old man now.

JG: But there was a bit of a media circus about it.

01: [Pause] Yes there was, but not as bad a circus as happened later on.

J: And that actually does bring me to something I wanted to ask about. I understand if you do not want to talk about this, but, umm… what can you tell me about Larry Hendricks?

01: Oh ho ho!

JG: Because…

01: That's okay, I don't mind talking about it.

JG: That was…

01: I have certainly talked about it to any number of people.

JG: Yes.

01: But, Larry Hendricks was a graduate of the sex offender program.

JG: When did he, when did he come into the program, if I may ask?

01: That was before my time, and in fact, I think he was probably on work release or outpatient by the time I was working there.

JG: So he would have been in the program for quite some time before your arrival?

01: Several years, I think so. I, I'm trying, I can't remember who his therapist was, but that's irrelevant. So, um. He was… a good program member, he was a good group leader, he was… intelligent, articulate, and…. my recollection is that his offenses had involved minor males, boys, like teens between… eleven to fifteen males.

JG: Mhmm.

01: I'm not aware that any of his offenses involved adult males, but we didn't do polygraphs in those days, and so he could have gotten away with stuff that never came to light,

JG: That never was disclosed.

01: … because when we was caught, he had been raping and assaulting adult males up and down the West Coast. But he… was fine. And then, he went to work, he got out, he went to work for a while, and at that time the sex offender program was hiring… ex-residents, or people who had graduated, uh, that had… the academic, who, they didn't have master's degrees, but they..

JG: They had an academic background.

01: They had that, psychology, sociology, whatever… and had gotten a reference. But, I don't know why that started, but I suppose it was similar to a mistaken belief about alcoholics as well… it takes one to know one.

JG: Mhmm.

01: And, umm… Was it then, that… [unintelligible]. I'm trying to remember when Larry was arrested, because he was a therapist for a while…

JG: Was he, was he arrested before? Because what I -

01: He was arrested about five years after he'd had anything to do with the program.

JG: Well, because, from what I know, he was involved with the *Lifeboat* program, then he was –

01: What's the *Lifeboat* program?

JG: The *Lifeboat* program was a program at Western State which treated drug offenders on a similar –

01: Oh, oh oh, yeah, he was, I see, I don't remember it being called *Lifeboat.*

JG: That's the only name I know.

01: I never heard that name, but anyway, he was =

JG: Just a short point, in '79, he tried to kidnap someone and took them to a wooded area -

01: That was when he got arrested.

JG: Well, he was shot.

01: Well, I know.

JG: Oh.

01: I know. Well, I don't remember. He didn't stay with the drug offense – he went from us, and then they were looking for therapists for the drug offense program, it was another unit of the legal offender unit, and they took Larry, and another man who was a sex offender treatment person, I mean he was a professional -

JG: A graduate?

01: No, no, a professional. Don't know if they had two, or - I can't remember. I remember Larry and the other guy, and, um… There was a lot of con behavior, because everybody that was in the drug program was from prison.

JG: Mhmm.

01: That's where they got 'em.

JG: Yeah.

01: So there was a lot of con behavior. I think there was probably drug smuggling. There was a bunch of garbage in the program. That's what ended that. I'm trying to remember, Larry may have come back to the main hospital, but I think he was working on an adult psych ward, and then he just left the hospital altogether. He owned, he and another guy owned an antique shop in Downtown Tacoma, and, uh, we didn't

see him anymore. I mean he would once in a while, drop by. And I didn't know him, I didn't know his background as well as some of the therapists that were there before. Uh, and I know one of them got concerned when he came one day just to visit and he was dressed all in leather, black leather and was riding a black motorcycle, and so I can remember that particular person, it wasn't his therapist but had known him through treatment because he was one of the top three clinical people, and he said "something's going on there, I don't know what it is, I'm concerned."

JG: Yes.

01: And then of course, I don't know how long after that, but all of this…

JG: Mhmm.

01: But he had been graduated from the program at least five or six years by the time he had…

JG: Reoffended.

01: This happened, yeah. But he didn't come around anymore, and actually that's one of the things that was… there was an open invitation, that if you had successfully completed the program, you could come back to the program, your group, whenever you were experiencing problems, and every so often one of the group members, some of them had even been in that group, East Group, before I took it over, would show back up, and they'd want to talk about what was going on, they'd just come to help out, because they thought there were some issues they could help with. So… the invitation to come back was well known, and many guys did take advantage of that when they felt themselves slipping or what have you.

JG: Mmkay.

01: So, Larry was a disgrace to us, I think it was the Larry situation that forced – no longer having ex-sex offenders or… graduates… Those of us that came after that practice had been initiated were kind of "uhhh", but for a long time it was fine. There was two guys, there was Larry and another guy, but there had been…. one, two, three, four…. four or five guys, no, I'm forgetting… five or six guys, that had been sex offenders that became therapists at one time or another, either already were or were therapists after I had started there.

JG: Mhmm.

01: Of that group, one of the guys was, was a therapist… Very good guy, liked him a lot, he had some advanced school stuff, he went to the director, he said "Look. I don't want to do this stuff, it's too much, I don't want to hear all this garbage, you know, I need to keep myself together, it's not helping my rehabilitation", and so he became part of the research department, because he had a flair - he knew mathematics and what have you,

JG: Yeah.

01: And so - But he, he's fine. He still is. He never did anything. He was, never did anything - Never reoffended, never did anything

JG: Mhmm.

01: …to cause problems for the program. There was one other guy, who had been before I had started who was caught for… exposing himself. And that had been his original offense. But he'd gone a good ten years with nothing going on. But exposers are very difficult people to treat, particularly if they have done a lot of it. It's kind of a

compulsion, or obsessive-compulsive kind of behavior, not in the sense of handwashing,

JG: But…

01: so he, he did… he got arrested, we didn't know about it, but he came to the guy who had been his therapist, told him right away, and I think he got a misdemeanor, but he said "No, I'm gone." You know, and he wouldn't have been back.

JG: Yeah.

01: And we had, after that, there was another guy who came to work, but he decided it wasn't his cup of tea, and he moved to eastern Washington, started a business that had nothing to do with sex offenders or treatment. And then there were two other guys… (another one?) reoffended after he had left the program. He didn't want to operate the way we were operating.

JG: Yeah.

01: We're not so, confro-, we were not so confrontive.

JG: Oh.

01: Also, he didn't feel that people were being really held accountable for their behavior. And so, he left, and then the last guy… quit. [Pause] But he had also… stupid, stupid stuff. He didn't offend in the classic sense… Do you know who Gene Enerson was, who used to work King -

JG: [shakes head]

01: – she was one of the nighttime people on King TV for many, many years. I think she, she lived on the waterfront somewhere in Seattle, I can't remember whether it

was Elliot Bay, Puget Sound, Lake Union, wherever it was… and she saw this guy lurking, you know, because

JG: Yeah.

01: there is no private waterfront in Washington, per se, and thought it was kind of weird, and he had sent her a weird letter, it wasn't "I love you, I want to be with you", but, I don't remember what it was in regard to now. So she called the cops, and they arrested him, and he had to go get mental health treatment, 'cause I remember when that happened. But… at the point of Hendricks, we didn't get rid of the guys that were already there.

JG: But you stopped hiring.

01: We stopped hiring. It became a, um… hospital policy, a DSHS policy.

JG: Mhmm.

01: And, uh, as the people were left, we did not fill them with somebody new.

JG: Mhmm. Alright. Thank you for covering that.

01: Yes, that's one of the wilder times – the Hendricks stuff.

JG: Yeah, I can imagine. Did you think you could tell a patient who was recovering from a patient who still harbored an intent to reoffend? [pause] I imagine it's difficult.

01: Well not by looking at them!

JG: [chuckles]

01: They were the extreme… One of the things that I really liked with the program is that… people went with a buddy, and it was usually, somebody that might be a group leader, a group charge, or whatever - to sit in… when I needed to do like a

history or an intake with a guy, one of the group leaders would come in, and somebody else. The group leader would come in with a guy, uh, and that was true of talking to any staff. If they wanted to get their medication from the nursing staff, they had to take a buddy in with them, uh simply to combat that whole thing of: "01 said I could do this". Because the guy that was a group leader that in there, was kind of writing stuff down as we were talking. And then that was one of the afternoon things. So and so went in to see 01 today. She did his social history, blah blah blah. He asked her about blah blah blah. Then you might ask the guy, they might ask the guy to tell them what she said. But with the leader in there, it was real hard for the guy to say, "01 told me I could do that."

JG: Yeah.

01: And that was something that was part of the program from before. And that continued almost as long as, uh, as it was running. It altered a little bit when there were more psychologists floating around, uh, because they didn't like the idea of another group member being in there. I was one of the people that protested, I said "You're undermining the program rules and values". And so some of those guys did, Some of them did then say, "Oh, well, Dr. So-And-So said." And the if it was my group, I would always go in and say, "Tell me, did you tell So-And-So this happened? "Oh, well, no!" Well this is again another reason why we like to have somebody else in the room, but things that were important or things that had existed for a long time… Toward the end, changes occurred because the program was shrinking in size, we weren't getting new people,

JG: Yes.

01: people got discharged, or not discharged… [pause] they did get discharged, but they were, not with, not positive. They'd be, what we used to say, they'd get kicked out and sent back to court, because they all had these sentences, they had their – part of their sentence was that they'd enter and successfully complete the program, all phases, and if they didn't –

JG: They would face the sentence.

01: then they would go back to court, they had to go back to the judge, and see the judge. That often meant they went to prison. So, anyway…

JG: Yes. To get to the questions about the later years of the program… What do you think was the public of the program, uh, throughout? You've made mention that there was changing public opinion, it seems, in the eighties, or was there kind of a heightened awareness of the program, and the public, for whatever reason –

01: A little bit of both, I think, because the program was highly regarded when I started work there, and was highly regarded through the seventies…

JG: Amongst the professionals or amongst the public?

01: Well, the, most of the press that got in really talked about the positives of what had gone on. We actually got… somebody who had been a therapist working as kind of the PR person, and he would seek out and get interviews for people to learn about what had happened, uh, with the program. Then in the early 80's, uh… we had a few more problems, it wasn't all re-offenses, uh, maybe somebody that was on work release that was out in the community, didn't come back, an occasional person, on outpatient, may have reoffended, at one point, when I had all that data, I could show you how… in relationship…. to prison people, how few escapees we actually had and

even how few offenders. But, you know, as the whole business gained popularity, then [pause]… I gotta be outta here at noon.

JG: Oh.

01: Um, gained pop - It's ten to twelve. Gained popularity, or, interest in the whole sex offenders, sex of f- Well, Ted Bundy, that.

JG: Yes.

01: That was in the eighties, well he was actually active in the seventies, up in Seattle, in Issaquah, that's when he did a lot of his stuff up there but he was arrested in the early eighties, so that came out. And so once it was a part of the public consciousness, then everything we did, the newsmedia wanted.

JG: Mhmm.

01: And we got to the point, aside - then it would be filtered through DSHS, and if somebody wanted to talk to me, they had to go through the higher-ups in order to get in with a camera. In the early days, we could…

JG: It was much more open in terms of -

01: Well it was, and, uh, the superintendent… at the time, in the seventies, after the Ru- well, it's public knowledge, the Ruzicka thing, that was the guy that ran in '74.

JG: Yeah.

01: Uh, Dr. diFuria put my nose in front of the camera, and I think there was some politics involved, 'cause I was the first and only woman working there at the time, perhaps it would go down a little easier from a woman, etcetera, and I don't know that that was the case, but that certainly would have been the -

JG: So you were speaking to the press about it, was it on television or -?

01: Yeah, television. Oh yeah, yeah. On television. You know, and once, particularly during that phase, I remember talking to KING-

JG: Pardon me, you said you spoke to which television stations?

01: KING, KIRO, KOMO, those were the main ones, there were no other ones that came beating on the door then, those were the main three.

[Long pause].

JG: In the interest of time, I will cut that there.

01: If you, if you'd like to do this over the phone, I'd be willing to do that, too, to finish up, if that helps you.

JG: That will probably work out – I'll letcha know. Let me see if there's anything else I need to discuss right here.

[long pause.]

JG: What – what was – what were the conditions of the hospital in terms of cleanliness, upkeep and staffing levels across the program's history?

01: I think the…. At one point, we were getting too may referrals. It's one of the things about being a, quote, "successful" program. The judges, from the 70's on, used the program as a better alternative for sex offenders than prison,

JG: Mhmm.

01: uh, so, if at all possible, they would send them to us… and then in addit- so in addition to that, it just seemed like, you know, "new group here", "new group there", and in fact one time I remember saying we don't want to add more people, we've gotta get therapists in here and get them trained before we add new groups, etcetera. And my

opinion is that at one time, we started new groups and added new therapists before they were properly trained.

JG: When would you say about that started?

01: ’83 on. ’82, ’83 on…

JG: Insufficient training before…

01: Well, they were -

JG: Experience…

01: There wasn’t. People were brought in. They had to have a certain degree of education and experience. We preferred they had at least a year of group therapy experience, etcetera. But usually somebody in the past had been brought in and would have six months with another senior therapist, with that person’s group, learning the process, etcetera. And so, we ended up – that didn’t work as much – and while it wasn’t so much reoffending, things were looser,

JG: Yes.

01: in those groups. We had a couple situations where younger women therapists actually got involved with a group member. I’m not sure that there was any sex…

JG: Involvement.

01: …in the classic sense, I mean, there may have been…

JG: Light petting.

01: Kissing, petting, what have you. And the group members knew it was going on, but people got, you know, what -

JG: A regime of silence.

01: It came, it came, well not so much, I think, they were – well, if it was your therapist that was doing it, and the person had the power over you, would you go to the other therapist on the ward and say "Hey, by the way, so-and-so is involved with so-and-so"? Well, it came out, and…. there was letters going back and forth… in one occasion someone escaped because they had help from a nursing staff or a therapist. You know, there were those kind of funny things. And these two young women, we did find out what was going on, because we did some investigating, and… eventually the guy confessed, the guys confessed, what was happening, and, uh…. the two therapists were let go, and, uh, in different, at different spaces… but I think it really made life difficult for those two guy- two guys involved, that I can remember, and when offered the opportunity to stay, the one guy said "No, I'm not going to deal with this anymore,

JG: Yeah.

01: "I wanna go back to jail." What have you. So, would he have done that, had this not happened? But, boundaries with people, particularly – Well, I don't, I don't experience it as much, because I've been used to working with this population, but for young women I think, that don't have a lot of training, I think that, perhaps, the tendency to want to fall into that might be a greater possibility, but learning boundaries and what you should and shouldn't do is a really important thing.

JG: Alright. Yeah, in the interest of time I'll have to close it out here, but thank you so much for your time today.

01: Sure.

Appendix C: Interview with "02" and "03", conducted on July 28th, 2018. The interview has been edited to remove identifying names and a large tangent describing personal matters. JG is John Giacoppe, the author of this paper.

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02 and **03** Interview Transcript

JG: When and for how long did you live in the Washington area?

02: I have lived in the Washington area for fifty years of my life.

JG: When did you begin working for Western State Hospital?

02: March 11th of 1989.

JG: Did you work for the Department of Social and Health Services in any other capacity before that point?

02: No, that was my first job for DSHS.

JG: Okay. How long did or have you worked for Western State?

02: 29 years, in March it will be my 30th year at Western State Hospital.

JG: Mmkay. What positions did you occupy during your tenure at- there?

02: I started there as a custodian, then I worked my way up to a Mental Health Technician I, and then I went to a Mental Health Technician III, then I went to a Mental Health Technician V, and now I'm a Program Specialist IV.

JG: Program Specialist IV.

02: Yes.

JG: What was your experience in the healthcare profession before Western State, if any?

02: I had no experience in the healthcare field before I started working at Western State Hospital.

JG: Okay. Have any of your duties at any point brought you in contact with the Sexual Offender Program?

02: Yes it has.

Could you walk me through an average day during your days as a custodian, during the, during your early time at Western State Hospital?

02: My first part of the morning would be there for, uh, debriefing, for what wards we had to clean.

JG: Uhuh.

02: Once we were assigned the wards we had to go clean, we would go fill up mop buckets, prepare our mops, we would grab dust mops, they were called, ahead of times, then we would sweep the floors, then we would mop the floors, we cleaned bathrooms, we picked up trash, umm, we vacuumed offices, and we got rid of trash.

JG: And then, how long did you work as a custodian before you progressed to a Mental Health Technician I, was that it?

02: Yes. Approximately three years.

JG: Okay. Did you generally work in a particular area of the hospital, or were you effectively roving, and kind of changed your assignments from day to day -

02: I was roving, but the first experience was on a sexual predator ward.

JG: Oh, as a custodian?

02: As a custodian. Yes.

JG: How would you describe that ward when you visited it?

02: It was intimidating when I'd first got there, and within the first fifteen minutes I'd seen something that was quite disturbing to me, and, uh, thought about quitting in the first fifteen minutes.

JG: Um, would you like to describe that at all, or would you prefer to…

02: Uh, we were going to, uh, I went to go fill up my mop bucket, and at the time when you filled up your mop buckets, they were in the same area as the restrooms of the residents there, and there was a… sexual… thing going on between an older man and a younger patient, when I first walked in the first fifteen minutes there. The first fifteen minutes I'd worked on the ward ever, I'd seen something that no one should really see, right there in the first fifteen minutes.

JG: And this was, this was the first fifteen minutes of your first shift.

02: Correct.

JG: Okay. And that would have been – was that… that was within the sexual offender unit,

02: Yes.

JG: I'm trying to remember where that was at that time. Do you know where that was at that time?

02: It was on C-8… Central – Eight campus.

03: Oh.

JG: Yes, yes. And that was before the transition to the, kind of, the complex behind the hospital… umm, [unintelligible], to the forensic unit.

02: Yes. We had our forensic unit at the time, they were considered North Hall, which, that building is no longer there. They tore that building down after the

earthquake that we had [the February 28th, 2001 Nisqually earthquake]. But that was, outside of the forensic unit, they had a sexual predator unit outside of the forensic unit.

JG: Mhmm. Um, while you were working as a custodian, and through kind of your early years, were there any escapes from that program, from the sexual offender program?

02: No, no escapes.

JG: Alright.

03: [Unintelligible] Mentally, mentally –

02: Mentally ill offenders. But even then, we weren't even called that on that ward.

03: [Unintelligible].

JG: What did that ward look like?

02: It was pretty much one long hallway, with a dining room off to the side, um, with a layer of probably sixteen to seventeen bedrooms, a large bathroom at one end of the hallway, and another large bathroom at the other end of the hallway.

JG: Were those bedrooms single occupancy?

02: They were double occupancy.

JG: Double occupancy. And, um, the cafeteria, was this a reserved meal space for that ward -

02: For that ward specifically, yes.

JG: Were you ever told about the program by your supervisors. Did they ever talk to you about it in any way, besides "This is a ward, go clean there"?

02: They, they didn't give me any heads up, no. "Just go to the ward and start cleanin'."

JG: Did you go back to that ward often, or was it – did you only clean it every once in a while?

02: Um, when I was first hired on at the hospital, I was what they called an "intermittent employee". So, I intermittently worked on that ward, and on a lot of different wards in the hospital. It was wherever somebody called in sick, or they needed help, that's where I'd go work. So I'd work that ward. I go work on, in geriatric setting wards. I'd go work on all-female wards, there's several different style of ward that I worked on, but I never worked on the same ward twice, in a week, unless somebody was on vacation and I needed to cover them. So.

JG: Okay. Throughout most of the program, the program at least before, before 1986, they had the offenders clean their own ward, and work within a custodial capacity, with the intent of being, effectively, a self-contained kind of unit. Um, did you notice any um, offenders working within, whenever you visited there, was there anyone ever doing custodial tasks who was a patient, was there any kind of –

02: Yes. Actually. When I started there, we were assigned one to two patients to assist us in cleaning the ward.

JG: Okay, alright. Did you at that time think that that program was effective in any way?

02: Ummm… not, not that I saw, not that I saw. Now I did have a resident leave there and go to a regular psych ward after that, left that ward, and I never really understood why the person was in the sexual predator ward at the beginning.

JG: Yeah.

02: Um, but by the time he was on the regular ward, I did the Cardinal Rule and asked him actually what he had done, to get put into there, and after that happened it kind of upset me and I no longer had that patient helping me work on the ward anymore. Which caused a lot of problems, because part of the work that I didn't like doing, that person liked to do.

JG: Yeah.

02: And also I found that later on I found, later on, that person had kind of enjoyed working with me, and when I told him I no longer wanted to work with him, he got himself into a lot of other mischief, and, uh, started a lot of violence with other patients, and I kind of regret asking the question, what he did, and I also kind of regret knowing the answer because some other people were injured on the ward later because … idle, idle hands, devil's workshop type deal.

JG: Yeah.

02: He had nothing to keep him busy anymore.

JG: How do you think that… obviously there was the Westley Allen Dodd case in 1989, and that was the big media affair, and that set the stage for the Sexually Violent Predator Act in 1990. And then all the various changes that went on… really within corrections, but within sexual offender treatment through that decade of the 90's. What did, what was your kind of impression, of what the interest of the public and the interest of the government was in dealing with sexual offenders at that time…. [A rambling tangent embedded in the question has been omitted.] So what's your impression of where that was going and why?

02: Um… You know, I wasn't really too much involved in politics at that time, but… I really feel that… I have a preconceived notion that people that do that, do not get better. And that's kind of the way I feel. I feel that they were abused when they were younger, and it's something that's part of their life now, and the struggles they have with it, I don't feel will never go away. I feel they may be able to control it with therapy, I believe, but I feel they need constant monitoring and checking in, and once someone's had that happened to them, it's hard for them to establish what is right and what is wrong.

JG: We'll be just five more minutes, dawg [to his grandchild, in the living room.] I have just a few more questions. What was… resident dress?

02: Resident dress. They wore regular clothes. They dressed similar to how you and I are, right now. Jeans, collared shirts, some of them wore sweatpants. We didn't have a uniform, per se, for the residents. They just dressed in regular clothes. On the wards, we, the workers, wore the same style of clothes as they did. We didn't have badges at the time, nor did we have the white coats that you see on TV, and at times it was really tough to establish who was the resident and who was the patient, there at that time.

JG: I see. Um, what was the condition of the hospital, um in the, in your early years? How was it doing… you described that North Hall has been torn down and replaced…

02: It was more, more of a… more cavernous, less choppy. It consisted of big day rooms, littler bedrooms. Some of the wards were different from other ones. Some of the wards had barracks style bedrooms in it, where you have five patients at one time. A

big push now is to get rid of all ligature risks, for patients who want to hang themselves. Back when I started, there were a lot of exposed pipes. We had radiator systems with turn-on, turn-off knobs. It was a lot less… we had glass windows, we didn't have plexiglass windows. Yeah, it was a lot different then what it is now.

JG: Within the sexual offender program, at an earlier time, there was a major emphasis on having volunteers assist with kind of psychodrama sessions. Understandably, I don't know if you don't have much knowledge of this, but do you know what role volunteers had in the wider hospital at the time you started at Western State. Were volunteers around at all?

02: I do not recall, I do not recall ever having volunteers ever at the hospital. At Christmastime, we would have volunteers bring gifts for the patients, but that was just for the whole hospital. I believe that the, uh, the sexual predators were more segregated.

JG: Mhmm.

02: My, my mother-in-law, my former mother-in-law worked in the unit for five years, when it was on Central, it was on C-14. She used to tell me about how they would do the therapy with watching movies, and they would have, have different sexual things happen in the movie, and they would have different sensors hooked up to the resident to check their stimuli, and what have you, that goes on during that time. She later was, um… not fired from the hospital, but fired from that unit, because she had some really bad interactions in her six years that she worked there with some of her patients, and also felt there was not much… getting better, as they say, there. And she voiced her opinion, and was let go.

[We proceeded to discuss possibly meeting with her, which has been deleted from the interview to delete personal information.]

JG: I'll conclude the interview here, and then we'll speak about that more, but, umm. I don't any more questions to ask you… you… Were, were there volunteers at all in the hospital?

02: There's volunteers, but there weren't so much in that unit. They -

JG: Where were they in the hospital, then?

02: They would, they would be more into our volunteer services, which, I didn't really see them working with the patients so much as… ancillary staff, providing stuff for the patients.

JG: So, like, would that mean they were working, say… What do you mean by ancillary staff? I'm sorry.

02: So they were more like, you know, providing meals, they're providing the gifts around Christmas time… They were setting up programs, but I didn't never really saw one-to-one interactions with them. Also, I also worked for a company called Life Force. Life Force is still in existence today. I worked there for a year, and that was when patients were taken out of the hospital setting and put into housing settings, but under a, uh, stringent watch of what they do. We'd take them to the grocery store, go to the grocery store at nighttime, twenty-four hour grocery stores. We'd leave about nine-o-clock, so there was no children there at that time. We would get the newspaper, and magazines, and all children were removed – pictures were removed from the books and magazines that they read. Umm.. yeah, that was kind of a different type of experience working for them.

JG: I can imagine. Yeah, and you worked with them for a year.

02: I worked with them for a year. It was probably about fifteen years ago.

JG: Yes. Fifteen years ago.

02: Yes.

JG: Okay.

02: So while I worked at Western State Hospital, I had a part time job and I worked at Life Force. Which is still going now.

JG: Yeah, okay. Alright. Well, do you have any questions to ask me at all?

02: No.

[The following is not relevant to the thesis topic, but has been included in the interest of total disclosure.]

03: I did volunteer at Western, before I started working there, and I worked in the, a group setting. So, I was, just - There was another like a permanent staff there, a paid staff, and I would just help out with the group.

JG: Like a group therapy setting, you mean, or -

03: Yeah, yeah.

JG: And what did you - what ward was this on?

03: It was, central, central ward, uh, one of the central wards.

JG: And what sort of patients would that have been, then, in that group therapy?

03: Adult psych.

JG: Adult psych, okay. And so, did you just do, general – were you a part, effectively of the group therapy, or were you merely involved with, kind of… behind-the-scenes work, assisting?

03: I believe we were playing a game, and I was involved in playing with the game.

JG: Okay. When, when was this?

03: This must have been… 1990.

JG: 1990. Okay. Do you have anything, any other thoughts?

03: No! I just wanted to add the volunteer piece.

JG: Noted. Well, thank you both so much for your time.

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