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**THE SEX OFFENDER**  
**ISSUES IN ASSESSMENT, TREATMENT,**  
**AND SUPERVISION OF ADULT AND**  
**JUVENILE POPULATIONS**

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**VOLUME V**

**Barbara K. Schwartz**



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**VOLUME V**

**Edited by**  
**Barbara K. Schwartz, Ph.D.**



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# Preface

In 1990 Honey Faye Knopp gave a moving plenary address to the ATSA (Association for the Treatment of Sexual Abusers) conference in San Francisco when she praised the audience as being “bio-phils”—lovers of life, dedicated to helping the most despised among us. Few people in that auditorium had a vested, much less a financial, interest in discrediting sex offender therapy in general, specific treatment programs, or their fellow professionals. Unfortunately, civil commitment has changed that. The model of the profession has moved in many places from one of restorative justice, of which Honey was an early advocate, to one of adversarial criminal justice. While the Center for Sex Offender Treatment continues to advocate for a collaborative model in which all involved parties cooperate, those jurisdictions with involuntary commitment have seen professions and programs pitted against each other as lawyers on both sides of commitment hearings seek to impeach each others’ witnesses or discredit the programs referenced by each side.

Poor Honey would weep to see the field she so gently nurtured as undergoing, at best, a conflict-ridden adolescence. Ideally, it will regain its healing vision as it matures. This volume, like its series predecessors, seeks to offer the current and innovative approaches to dealing with the complex issues facing the field of sex offender management. Although many of the chapters present hard-core, empirical evidence to substantiate their approaches, others do not even quote references. These latter chapters address practical issues of little interest to researchers but of great relevance to the front-line clinician (e.g., how to select and train inmate peer counselors, or how to conduct experiential treatment sessions).

Were the field to wait for empirical validation of its every move, there would be no new programs to study. Therefore, *The Sex Offender* series will continue to seek out and present innovative theories and approaches. Some will fall by the wayside. Others will set the standard for the future.

In preparing this volume, as in the past, I wish to thank my very patient publisher, Deborah Launer, with able assistance from editorial assistant Leslie Gwyn and copy editor Lori Jacobs. They have demonstrated inordinate patience, as my professional life has gone in numerous demanding directions. Again, I wish to thank my colleagues at Justice Resource Institute for their support, including Greg Canfield, M.S.W., Susan Wayne, M.S.W., and Robert Prinke, Ph.D. I wish to thank my colleagues at New England Forensic Associates, especially Dr. Carol Ball. Of course, I am only able to do this work with the support of my ever-patient husband Ed, the moral support of my children, Betsy and Ben, and the emotional support of the four-legged members of my family, including especially my ever-present professional and personal companion, Thomas, my service dog trained by Canine Companions for Independence.

*Barbara Schwartz*  
March 31, 2005

# Introduction

Our world has experienced many significant changes since the preparation of *The Sex Offender: Current Treatment Modalities and Systems Issues* (Volume 4). The public's pervasive fear of sex offenders has been compounded by fears of terrorism. When people operate out of fear and anger, they risk making poor decisions. Certainly clinicians see this operating in the deviant cycles of their sexually abusive patients, and it is equally true for the average citizen. Fear-driven decisions have had a direct impact on the world of sex offender treatment by draining resources and creating a harsher social climate. Programs have experienced staff cuts, as well as decreases in training budgets. National funding for research has been diverted from critical studies on the origin and prevention of sexual violence to a focus on terrorism. Loss of jobs, particularly in manufacturing, which would have provided low-risk occupations for sex offenders in the community, have deprived offenders of the ability to support themselves; and this, along with the continuing crisis in health care, has deprived many of these individuals of the funds to pay for treatment. All these issues challenge clinicians and supervisors to make do with fewer and fewer resources.

The field is also challenged by ongoing controversies. The public notification and sexually violent predator statutes passed in the 1990s continue to present numerous problems, with little evidence that they are accomplishing their intended goals. How many citizens are really safer because they can access information on sex offenders in their neighborhoods? Contrast this with the number of high-risk offenders who are now more dangerous because they cannot find employment or are repeatedly evicted from their residences. One state recently passed a law requiring high-risk sex offenders to wear bulky tracking devices to facilitate Global Position Monitoring, ensuring that these individuals will be immediately identifiable, and thus probably rendered unemployable and subsequently unable to pay for their treatment or offense-related fees. The number of individuals in sexually violent predator (SVP) programs continues to grow. Because few of these individuals are ever released (e.g., California has released one individual of the several hundreds on that state's rolls), the populations of these programs continue to swell, and while the cost of maintaining and treating these individuals is significant (ranging from \$75,000 to \$125,000 a year per person for care and treatment), the legal expenses of committing, recommitting, and defending related lawsuits can be staggering. These programs have spurred the development of actuarials which, although better than unaided clinical estimates of risk, leave much to be desired given the seriousness of the decisions they impact. Controversy continues to swirl around their statistical stability, with different cross validations producing radically different risk estimates. Furthermore, although the heterogeneity of sex offenders is one of the most salient characteristics of the group, the actuarials lump all types of sex offenders together, ignoring the dynamic differences between the violent, criminally oriented rapist and the pedophile priest.

However, rather than pooling their scientific expertise to improve risk assessment tools, we now witness the war of the experts (of which I admit I am one) over ROC (receiver operating curve analysis) and AUC (area under the curve) values, base rates, and survival curves.

In addition, the efficacy of treatment is widely debated in these arenas. In some states this amounts to public officials undermining the proven effectiveness of their own treatment programs in order to support state attorneys and SVP hearings of individuals who have completed those programs.

Other related controversies involve diagnoses related to involuntarily committed sex offenders under the SVP status. Is rape a paraphilia or is it criminal behavior. Do “psychopaths” actually exist, and if so, is this actually a condition reflecting some type of underlying pathology—such as attachment disorder, a neurologically based impairment of executive cognitive functioning, or a combination of the two.

The controversy over the diagnosis of psychopathy has largely revolved around challenges of the most popular assessment tool, the Psychopathy Checklist—Revised (PCL-R; Hare, 1991). Another diagnosis related to SVP commitments involves a diagnosis of paraphilia nonconsent. During the past two revisions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994; DSM-IV-TR; 2000), the proposal was brought forward to include arousal to resistance on the part of the person with whom one is having sex and whether this represents a paraphilia. The advocates argued that, just as in pedophilia or exhibitionism, some individuals have preferential arousal to sex with nonconsenting individuals. They may prefer this to mutually consenting sexuality and may experience intrusive fantasies associated with this behavior. These fantasies and this conduct may even be distressing to the individual but he is unable to control these urges.

The opposition argued that, given the prevalence of this behavior in the male population as derived from self-reports of college males, forced sex cannot be considered an unusual behavior. Individuals representing feminist perspectives argued before the American Psychiatric Association that this conduct reflects the way our society socializes males, not a mental illness afflicting a few unfortunate individuals. It was also felt that labeling rape as the by-product of an illness would alleviate the offender’s responsibility for his behavior.

It can certainly be argued that there are some people who show preferential deviant arousal directed specifically toward resistance and nonconsent. This would not include just any rapist capable of sustaining an erection despite his victim’s distress. This can be attributed to many motives, including being oblivious to the suffering of others. Whatever the arguments on either side, the authors of DSM-III (American Psychiatric Association, 1980), DSM-IV, and the DSM-IV-TR have specifically rejected labeling any kind of rape behavior, other than sadism, as a paraphilia. Ironically, this is now an argument against the commitment of some individuals as SVPs, a result probably not intended by the parties in this debate.

In discussing the controversy swirling around psychopathy, it is recognized that anyone exposed to a large number of antisocial individuals recognizes that there exists a subset of individuals who present as glib, entitled, arrogant, and insensitive and whose behavior reflects a total indifference to the welfare of others.

The problem is in a specific evaluator using a particular instrument to diagnose a specific individual. Someone may appear to be “glib” to one evaluator but not to another. Indeed they may deliberately present as “glib” to one evaluator but not to another. In addition, there are a number of reasons for people to present with the Factor 1 personality dynamics. Victims of posttraumatic stress disorder may present as emotionally flat and lacking in empathy or remorse because they have completely repressed all their emotions.

Another problem with the PCL-R is the context in which a certain symptom is judged. If an offender, for example, violated another human being and at that time showed little or no empathy toward that person but now does express sincere remorse and understanding of her pain and, moreover, has shown empathy for scores of other people in his life, must he then get at least some points in the PCL-R for not being empathetic? The answer is not clear.

In making a diagnosis of psychopathy, we need research on the neurological and neuropsychological characteristics that clearly meet the criteria. Studies are now being conducted that will eventually lead us to an understanding of the actual nature of this condition, which can then lead to ways to measure these underlying processes. Until we have a better understanding of this condition, we as professionals should be cautious in applying what has become a damning label, suggesting that this person is highly dangerous and his condition is intractable.

Controversy continues to swirl around the efficacy of treatment. Despite the mounting evidence that treatment of sex offenders does reduce the offense rate (A. Aylworth, 2004, personal communication), some experts continue to argue that until strictly controlled studies are conducted with either matched samples or random assignment, the efficacy of treatment will remain unknown. Certainly from a purely empirical view, this cannot be disputed. However, as with all research on psychotherapy, the practical problems are immense. The subjects of this experiment would not be laboratory rats but real individuals who have actually sexually assaulted other people. The sponsoring institution would not be a university or research institute but a criminal justice agency or treatment program.

Even more alarming, the result would not be a test score or a self-report index but a real human victim. What the advocates of highly controlled studies are suggesting is that certain sex offenders who are highly motivated for treatment be denied that opportunity by agencies designed to protect the public. Furthermore, the measure of the success of this experiment would be the number of new victims of sexual assault. In addition, in sixteen states, this offender who is denied treatment and now has recidivated would probably be a candidate for civil commitment. Moreover, must any treatment guarantee long-term abstinence from certain conditions in order to be considered effective? If a substance abuser undergoes treatment followed by five years of abstinence before relapsing, was the treatment ineffective? If a medication alleviates depression for a substantial period of time but the depression recurs, was the drug ineffective? If an individual stops practicing the techniques he has learned in any kind of treatment, does this condemn the therapy or the therapist? Perhaps this is only true in the field of sex offender treatment where there is zero tolerance for reoffense. This places an unprecedented burden on the profession. Assuming that long-term abstinence is a goal of effective treatment, then how long should the follow-up period be—three years? five years? ten years?

The problems with extended follow-ups are multiple. The longer the period of time elapsed, the more difficult the follow-up. One may choose to rely on national crime data base such as National Crime Information Center (NCIC). However, if a name does not show up as a recidivist, should this person be considered a treatment success? Or might he be dead or physically incapacitated?

Another very significant issue is the changing field of sex offender treatment itself. This is a problem endemic to evaluating any long-term intervention. By the time the follow-up program is completed, will the treatment be obsolete? Hanson faces this

difficulty in his recent twelve-year follow-up of an outpatient treatment program in Canada (Hanson et al., 2002). By the time his study was completed, the treatment standards had changed substantially.

In this Volume 5, the authors have attempted to wrestle with a number of issues that are current in the field today. For example, the new phenomenon of interstate pornography is addressed in Chapter 4, by David Delmonico, on cyber sex offenders. It has become a growing problem, and it is basically unknown whether these people are actually pedophiles or whether their behavior is more the by-product of aspects of the media.

The field of sex offender treatment continues to be involved in the vagaries of politics more than other forms of treatment. Politicians are quick to establish themselves as “tough on crime” by jumping on any bandwagon that claims to “get sex offenders.” Unfortunately these policies are rarely based on reason, much less research. In addition, and unfortunately, sex offender treatment programs have often been the victim of intra-agency feuds and controversies over privatization. If public officials are serious about eliminating the tragedy of sexual abuse, they will quit making this issue the object of their personal ambitions and unite with all legitimate stakeholders seeking to reduce this problem.

Barbara Schwartz  
March 31, 2005

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