Sex Offender Treatment and Legislation

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The current issue of the Journal contains three articles related to sex offenders. The first, by Scott and Holmberg, discusses legislation that mandates either "chemical or surgical castration." The second, by Saleh and Guidry, reviews diagnostic and treatment considerations. The third, by Scott and Gerbasi, discusses sex offender registration and community notification. Much of the relevant sex offender legislation, including that pertaining to testosterone-lowering treatments, has been enacted in response to intense public passion. When it comes to the issue of sex offenders, there is a pressing need to develop a coherent body of evidence-based forensic concepts and knowledge that can rationally inform both clinical practice and future public policy. That may require a closer collaboration between both the criminal justice and legislative sectors, and the scientific-medical communities. The three papers published in this issue provide useful information that may assist toward such a goal.

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The current issue of this journal contains three important articles related to the matter of how sex offenders are presently being dealt with nationally, either from a civil and criminal justice point of view, or from a public health perspective. Collectively, the issues raised by those articles highlight the importance of establishing an effective dialogue, and ongoing working relationship, between the criminal justice sector (as represented nationally by the Office of the Attorney General), and the scientific-medical communities (as represented by the Office of the Surgeon General). Most of the recent statutory decisions regarding sex offenders have been enacted in response to understandable public emotion surrounding a small number of violent sexual murders that have been more the exception than the rule with respect to sexual offenses in general. It would be preferable that future legislative decisions be informed by evidence-based input from the relevant scientific-medical communities.

The article by Scott and Holmberg[1] entitled, "Castration of Sex Offenders: Prisoners' Rights versus Public Safety," provides a thoughtful and thorough review of the history and nature of castration statutes that have recently been enacted in nine states. As they point out, one of the more vexing concerns raised by such statutes is whether an individual can give meaningful informed consent under circumstances in which his refusal to undergo such an intervention could negatively impact on his parole or probationary status. The situation is made even more complicated by the fact that some of the relevant statutes fail to require a psychiatric assessment to determine whether such mandated treatment is even medically appropriate. Such treatment is ordinarily appropriate only for a select subset of sex offenders whose actions have been driven by intense, recurrent, eroticized, pathological urges and fantasies of a paraphilic nature.[2]

In those instances in which such treatment has been deemed to be medically appropriate (and it is difficult to see how surgical castration would be, given the availability of less intrusive medications), the matter then becomes somewhat less problematic. That is especially so in those instances in which the individual in question clearly himself desires access to testosterone-lowering treatment (so-called chemical castration).

The article by Scott and Holmberg touches on the issue of competency to make an informed choice. Ordinarily, a paraphilic disorder does not impair an individual's capacity to make an informed decision about taking a medication. Therefore, assuming that there is solid evidence that the individual will be much safer if he takes it (as was the case historically

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when the smallpox vaccination was mandated), then, if hesitant to do so, he may indeed have to make a difficult decision. That is, he has to decide whether to take such medication or instead be quarantined from society.[3] Many cancer patients often have to make similarly difficult decisions—for example, whether to take a powerful medication whose side-effects may kill them, or whether, instead, to refuse, in which case the cancer may kill them. The fact that a decision may be difficult does not necessarily mean that a person is mentally incompetent to make it. Would it somehow be more just, to deny a fully informed adjudicated patient the opportunity to decide for himself whether he wants to take a testosterone-lowering medication, an opportunity that may enable him to live safely and freely in the community? At the same time, the rights of such an individual to be treated fairly must be carefully preserved.

Many of the so-called castration statutes discussed by Scott and Holmberg stipulate that its use, whether pharmacological or surgical, should be based primarily on the nature of an individual's prior offense history. Clearly, that is psychiatrically inappropriate, given that persons can engage in analogous behavior for a variety of reasons. Only those whose psychiatric conditions may warrant such treatment should receive it, and that can be determined only after a proper psychiatric assessment.[4] Sex-drive-lowering medications (antiandrogens) of the sort discussed by Scott and Holmberg are prescribed under U.S. Food and Drug Administration (FDA) guidelines regarding the use of an approved drug for a nonlabeled indication, and thus their use should not be considered experimental.[5]

Finally, as pointed out by Scott and Holmberg,[1] some may try to argue from a First Amendment standpoint, that antiandrogens can somehow inappropriately control a man's mind, and that therefore their use may, in effect, violate his right to both freedom of thought and speech. There are only three legitimate uses for psychotropic medications: (1) to restore function, as with antipsychotics; (2) to reduce suffering, as with antidepressants; and (3) to increase the volitional capacity to be in full self-control, as with antiandrogens. No psychotropic medication has ever turned a Democrat into a Republican, or vise-versa. Sex-drive-lowering medications can be used to free a person's mind from intrusive, recurrent, pathological eroticized urges and fantasies that are often obsessional in nature. They can also be used to increase a person's capacity to be in full control of his sexual drive, rather than allowing it, in effect, to be in control of him. Ideally, such medications are likely to be most effective when the person taking them can be convinced that it is in his best interest to do so.

Another article related to sex offenders in this issue of the Journal, by Saleh and Guidry,[6] is entitled "Psychosocial and Biological Treatment Considerations for the Paraphilic and Nonparaphilic Sex Offender." That article stresses the importance of appreciating the heterogeneity that exists within any group of sex offenders. Thus, both from a research and clinical perspective, making a proper differential diagnosis is particularly important. That process should begin by distinguishing between nonparaphilic offenders (who in some instances at least, may simply lack a sense of conscience and moral responsibility), and paraphilic offenders (whose behavior may be driven by the ongoing presence, through no fault of their own, of intense, recurrent, pathological, eroticized fantasies and urges).

Medications that can lower the intensity of pathological sexual cravings may assist some paraphilic individuals in maintaining proper self-control. That is so, because if left unabated, intense cravings can sometimes wear down personal resolve. Such medications can do nothing to instill a conscience and sense of moral responsibility in those sex offenders who are lacking in such virtues. Unfortunately, much of the professional literature uses terms such as sex offenders, sexual aggressors, rapists, child molesters, and so on, none of which have any diagnostic specificity.[7]

Both forensic and clinical problems can develop as a consequence of failing to make a proper differential diagnoses. In developing an individualized treatment plan, it is critical to appreciate, fully and correctly, the implications of a specific diagnosis—for example, pedophilia. As pointed out by Saleh and Guidry,[6] not all persons who sexually abuse children have pedophilia. If a person with pedophilia fantasizes about the sort of partner that causes him to experience an erection, he is probably fantasizing about a prepubescent child. That is so, neither because he lacks social skills, nor because he yearns to exert power over those who are most vulnerable. Rather, it is so because there is something fundamentally different about his sexual makeup.[8] As suggested by Saleh and Guidry, some programs treat all sex offenders against children as if they were some-

how all the same. Teaching a "child molester" with pedophilia, as is sometimes done, how to develop better social skills may only result in that individual's developing an enhanced capacity to interact more effectively with prepubescent youngsters. Similarly, teaching empathy for the victim to those who are already feeling both guilty and remorseful may only serve to heighten their sense of estrangement and despair unnecessarily. Saleh and Guidry have effectively made the simple, but important point, that sex offenders are not all the same.

The third article related to sex offenders in the current issue was authored by Scott and Gerbasi[9] and is entitled, "Sex Offender Registration and Community Notification Challenges: The Supreme Court Continues its Trend." In recent years, besides the new castration laws, three other sorts of legislation have been enacted that are unique to sex offenders. Those enacted statutes have been related to: (1) a requirement that sex offenders register locally with appropriate criminal justice authorities; (2) the stipulation that certain aspects of the registered information should be shared with the community at large (so-called community notification); and (3) the civil commitment of some sex offenders for treatment immediately following the conclusion of their terms of incarceration. The article by Scott and Gerbasi provides a good review of the history and nature of the various registration and community notification statutes, followed by a discussion of two recent United States Supreme Court decisions regarding legal challenges to certain aspects of them.

Although historically records of prior convictions have traditionally been maintained within the criminal justice system both locally and federally, as pointed out by Scott and Gerbasi,[9] current registration statues may now mandate the maintenance of a great deal of additional information. For example, in New York State, registered information must include a record of both an individual's Internet accounts and screen names. Most registration statutes also require information about current residence and current place of employment. If maintained in confidence for law enforcement purposes, the collation of such information may have little impact on the daily lives of those who have registered. However, when such information is released via community notification, it can become a very different matter.

The ability to conduct a criminal background check has traditionally been available to those with a valid reason for doing so. However, as pointed out by Scott and Gerbasi,[9] posting the names, addresses, and other personal information about previously convicted sex offenders on the Internet as is now the practice in many states, represents a marked departure from that more established traditional process. Even though there may be a disclaimer stating that the persons listed are not necessarily currently believed to be dangerous, those reviewing such a list would probably have reason to wonder why those names would be posted there, if such a risk was not present. After all, others who have previously committed crimes ranging from housebreaking, to drunk driving, to kidnapping and murder do not ordinarily have their names posted in such a fashion.

Prior to the enactment of community notification statutes, this writer had published data documenting a low rate of sexual recidivism among more than 600 men treated in a community-based program, more than 400 of whom had qualified for a diagnosis of pedophilia.[10] Many of those men may have found it easier to succeed because they were able to get a fresh start. Generally, they had not felt disenfranchised or socially stigmatized, they had been accepted by their neighbors, and they had been able to obtain meaningful employment. Whether they would have been able to succeed as well in treatment, had all of the above not been true, is uncertain.

Community notification statutes, though potentially helpful, may at the same time embitter and harm individuals who are trying hard not to reoffend. Conversely, those who may want to offend may simply congregate in neighborhoods in which they are less well known. Citizens receiving notification, which in some jurisdictions may be in the form of a mandated postcard from a former offender, may be uncertain what to do with it. In the case of incest offenders, community notification may also inadvertently disclose the identity of a former child victim, and the children of registered offenders may be subjected to ridicule.

Registration and community notification statutes have not been enacted based on a body of empirical evidence showing that they can enhance community safety. Instead, as detailed by Scott and Gerbasi,[9] the impetus for their enactment had been as a response to understandable community concerns and distress. Although such emotion is certainly quite human, it may not necessarily serve as a sound basis for effective public policy. It is often very difficult to predict, even

with the use of group-based actuarial data, specifically which former sex offenders are likely to pose a future risk. Physicians usually do a much better job with risk management than they do at predicting it in a vacuum. Indeed, a basis for enacting the various community notification statutes had been the assumption that they would help to reduce risk. Little consideration had been given either to the possibility of more effective options or to the possibility that such statutes might even inadvertently heighten the community's risk. A study in Washington state found no reduction in recidivism after the introduction of community notification, even though some offenders had, indeed, possibly been apprehended more quickly following an offense.[11,12]

As documented by Scott and Gerbasi,[9] when new laws, such as those pertaining to sex offender registration and community notification, have been enacted in response to intense public emotions, the United States Supreme Court is likely to become involved eventually. From a historical perspective, the history of Supreme Court decisions on minority rights has only sometimes been both timely and exemplary. For example, many decades had passed before the court eventually overturned the legacy of legislatively sanctioned slavery. It took a constitutional amendment to accord women the right to vote.

A primary role of the Supreme Court, within the context of ensuring each state the ability to protect the safety of its citizens, is simultaneously to protect an unpopular minority from possible maltreatment, albeit inadvertent, from the majority. Absent clear information about psychiatric treatments such as those that lower testosterone, and, absent clear information about the risk posed to the community by various types of sex offenders, both clinicians and society in general may be forced to operate in the dark. Clearly, much of the relevant legislation regarding registration and community notification had been based on the contention that, as a group, sex offenders pose an exceptionally high risk of recidivism. Yet, a recent publication by the Office of Justice Programs suggests that as a group, sex offenders actually have a lower recidivism rate than many comparison groups who have committed other serious crimes.[13]

Collectively, the three articles contained in the current issue of the Journal are illustrative of the need to establish a comprehensive and coherent forensic approach to issues surrounding sexual misconduct, which can range from the need for society to be safe to the need to hold individuals morally accountable for their own actions. They can also relate to the need to appreciate that some persons, particularly those afflicted with obsessional, volition-impairing paraphilic disorders, may, metaphorically speaking, manifest broken minds in need of repair, rather moral flaws. Absent greater coherence, much of which may need to emerge from the field of forensic psychiatry, future court decisions in this area may begin to look much like the product of a projective Rorschach ink blot test. That is, they may come to reflect, in large part, preexisting internalized judicial biases, more so than being guided and informed by a rationally based body of knowledge. The three articles presented herein, by design and content, have effectively documented both why, and just how desperately, such coherence is needed.

References

1. Scott CL, Holmberg T: Castration of sex offenders: prisoner's rights versus public safety. J Am Acad Psychiatry Law 31:502–9, 2003
2. Berlin FS, Malin HM, Lehne GK, *et al*: The eroticized violent crime: a psychiatric perspective with six clinical examples. J Sex Addict Compulsivity, 4:10–32, 1997
3. Berlin FS, Meinecke CF: Treatment of sex offenders with antiandrogenic medication: conceptualization, review of treatment modalities and preliminary findings. Am J Psychiatry 138:601–7, 1981
4. Berlin FS: "Chemical castration" for sex offenders. N Engl J Med 14:1030, 1997
5. Archer JD: The FDA does not approve uses of drugs. JAMA 252:1054–5, 1984
6. Saleh FM, Guidry LL: Psychosocial and biological treatment considerations for the paraphilic and nonparaphilic sex offender. J Am Acad Psychiatry Law 31:486–93, 2003
7. Berlin FS: Issues in the exploration of biological factors contributing to the etiology of the sex offender plus some ethical considerations. Ann NY Acad Sci 528:183–92, 1988
8. Berlin FS: Pedophilia: when is a difference a disorder?—peer commentaries on Green and Schmidt. Arch Sex Behav 31:1–2, 2002
9. Scott CL, Gerbasi JB: Sex offender registration and community notification challenges: the Supreme Court continues its trend. J Am Acad Psychiatry Law 31:494–501, 2003
10. Berlin FS, Hunt WP, Malin HM, *et al*: A five-year plus follow-up survey of criminal recidivism within a treated cohort of 406 pedophiles, 111 exhibitionists, and 109 sexual aggressives: issues and outcome. Am J Forensic Psychiatry 12:5–28, 1991
11. Petrunik MG: Managing unacceptable risk: sex offenders, community response, and social policy in the United States and Canada. Int J Offend Ther Comp Criminol 46:483–511, 2002
12. Menteer T. "A House Built on Stone Will Not Last:" learning from the errors of Washington state's failing sex predator statue (available at htpp://www.whitestonefoundation.net/2000_07_nl.html/. Accessed October 21, 2002)
13. Greenfeld LA. Sex offenses and offenders: an analysis of data on rape and sexual assault. Washington, DC: U. S. Department of Justice, Bureau of Justice Statistics, 1997, NCJ163392