Washington State's Unscientific Approach to the Problem of Repeat Sex Offenders

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In 1990, Washington State enacted the Sexual Predator Act, allowing the civil commitment of sex offenders to a mental health facility for life if they are deemed to be sexual predators (repeat, hardcore offenders). They are released only upon proof that they are no longer a threat to others. This paper reviews the debate about this law and the recent literature on the treatment of sex offenders. We conclude that the Washington State law is unscientific, because the available treatments are not adequate to ensure future safety and because the law selects poor candidates for treatment. Finally, a comment is made about preventive detention effected by psychiatry, and an analogy made to the habitual drunk driver.

Civil commitment for rapists and child molesters is not new. Since 1937, the prevalence of sexual psychopathy laws has waxed and waned, reaching a high point in the mid-1960s, at which time most states had laws permitting indefinite therapeutic commitment of sex offenders. However, as of 1990, only twelve states and the District of Columbia retained such laws and only five of these states actually enforced them in more than a few isolated cases.[1] Further, in the early 1980s, California and New Hampshire repealed existing sex offender commitment systems. The recent trend is moving away from such laws.[1,2]

In 1990, in response to public outrage over sexual offenses committed by individuals having a history of sexual deviance,[1,2] Washington State enacted the "sexual predator act." The purpose of this statute was to commit "sexually violent predators" with antisocial personality features to treatment that is "very long term."[3] The legislature noted that these personality features are "unamenable to existing mental illness treatment modalities."[3] Washington State's existing involuntary treatment act had been intended for short-term civil commitment.

Under the new statute, anyone deemed to be a sexual predator can be committed to a psychiatric facility indefinitely. It defines a sexual predator as

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"any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence."[3] The law defines mental abnormality as "a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts." It is acknowledged that the prognosis for these offenders is poor.[3] Convicted sexual predators are treated at a psychiatric component of the state prison in Monroe, Washington under high-security conditions.[2]

Under this act, the secretary of social and health services may authorize a committed sexual predator to petition the court for release. The prosecutor then has the burden of proof before a judge or jury (depending on agreement between the opposing sides) to show that the offender is still "likely to commit predatory acts of sexual violence." An offender may also petition the court over the objections of the secretary and is given annual notice of the right to do so. If the initial petition is denied, each subsequent petition may be denied without a hearing if the court holds that the petition is frivolous because there is not sufficient new evidence to warrant a hearing.[3]

Debate over the Sexual Predator Act

From the time the law was proposed in early 1990, it met with considerable debate in both the legal and psychiatric communities as to its usefulness and constitutionality. Proponents included the Attorney General's office of Washington state and local District Attorney's offices throughout the state. Opponents included the American Civil Liberties Union (ACLU) and the Washington State Psychiatric Association (WSPA).

Proponents cited the need to protect the public as the primary motivation for this law, noting that it is aimed at hard core, repeat sex offenders with multiple convictions, who have not shown evidence of remorse or change of behavior while in prison. Consistent with this rationale, all but one of the people tried under this law have been tried while still in prison, and the one exception had recently been released from prison.

Prosecutors argued that the stringent requirements of proving someone to be a sexual predator beyond a reasonable doubt protect the rights of that individual. Specifically, a qualified mental health professional must find that the person is a sexually violent predator and this fact must be proved to the court or jury beyond a reasonable doubt. Further, provision is made for release from civil commitment at "such time as the person's mental abnormality or personality disorder has so changed that the person is safe to be at large."[3]

Opposition to the law was based on three main points. First, the ACLU and WSPA saw the law as "pure preventive detention masquerading as indeterminate psychiatric treatment."[1, 4] They cited the fact that sexual predation in and of itself does not define a mental illness. They argued that sex offenders

are a heterogenous group of individuals, some of whom have mental disorders that influence them to commit sexually violent behavior and some of whom act without such influence.[4]

When California repealed its Mentally Disordered Sex Offender commitment statute in 1982, it stated that sexual offenses are not in and of themselves the product of a mental disease.[5] The California Department of Mental Health has stated that 96 percent of the Mentally Disordered Sex Offender population lack a major mental disorder.[6] The law was changed after increased public scrutiny following heinous crimes committed by former detainees who were released from state hospital treatment and supposedly cured.[7] In reviewing the California law, Oliver[7] concludes that "laws promulgated on the basis of faulty scientific premise are likely to be discredited in the course of their implementation." Therefore, it is important to review the current scientific data regarding treatment of sex offenders.

Sexual psychopathy laws tend to stigmatize the mentally ill by linking psychiatric illness and criminal behavior.[7] The Diagnostic and Statistical Manual of the American Psychiatric Association is emphatic that criminal behavior and mental disorders do not necessarily go hand in hand.[8] For example, a paraphilia is defined as sexual arousal from unconventional sexual objects, situations, or imagery. However, while convicted pedophiles may fit this category, some find lawful outlets, such as fantasy, for their sexual attraction to children.[7] Thus, they are not criminals but do have a mental disorder.

Antisocial personality disorder is another DSM-III-R diagnosis potentially applicable to this law. Its definition includes "[failure] to conform to social norms with respect to lawful behavior, as indicated by repeatedly performing annisocial acts that are grounds for arrest."[6] However, not all courts recognize DSM-III-R diagnoses as defining a mental illness. For example, in the Supreme Court case, *Foucha v. Louisiana*,[10] the Court ruled that a hospital could make a distinction between mental illness and antisocial personality when a defendant is an insanity acquittee. With this ruling, the hospital released Foucha, stating that he had no mental illness, even though he was diagnosed as having an antisocial personality.

Another argument of the ACLU and WSPA is that because sex offenders do not necessarily have a mental illness, no curative treatment is yet available for their behavior, and, consequently, lifetime preventive detention is likely.[5, 8] They also note that because these individuals are involuntarily committed to a treatment facility they are less likely to respond to conventional treatments,[5] in that forced treatment has been shown to be less effective than voluntary treatment.

Opponents of the law also argue that mental health professionals cannot predict future behavior accurately, so that some individuals will be committed who would not commit future crimes and others will be set free who will.[1, 2, 5, 9] They note that the best predictor of fu-

ture behavior is recent past behavior, and because those being held under this law have recently been incarcerated, there is no way of determining their recent behavior outside of prison.[5,9]

Opponents argue that sex offenders would be better dealt with by the criminal justice system.[5,9] In legal terms, they contend that the goals of criminal law: deterrence (to inhibit similar behavior), retribution (to punish), and incapacitation (to protect the public),[2] would be better achieved by criminal confinement than by placing the offender in a state mental health facility.[1] Civil commitment is justified in the law by incapacitation, as well as by the doctrine of *parens patriae*, which grants the state the ability to care for the disabled.[2] However, these offenders fall into a different category, where the goals of deterrence and retribution are also being fulfilled. The Supreme Court classifies civil confinement as unconstitutional if the state's only purpose is deterrence or retribution.[2] Opponents of the law argue that criminal sentences for repeat sex offenders in Washington should be stiffened.[1]

The Washington State Supreme Court recently upheld the Sexual Predator Act in a six-to-three decision.[10] The Court held that civil commitment did not violate the prohibition against double jeopardy, that the statute was not void for vagueness, that the state was required to prove dangerousness of unincarcerated detainees by recent overt acts, and that the prisoner was protected in that jury unanimity was required.[10] The dissent argued that the law "offends the prohibitions against *ex post facto* laws and double jeopardy by masquerading as a civil commitment law when its purpose is penal."[10]

The next section explores the scientific evidence regarding treatment of sex offenders and the ability of researchers to predict treatment outcome. This merits scrutiny because the Washington law could be destined for repeal, as was the California law, if mental health professionals cannot 'cure' the sex offender or at least predict future dangerousness.

Current Treatment of Sex Offenders

Treatment of the sex offender has involved two approaches—behavioral and medical. Within these two broad categories, variation exists in the treatments used, types of patients treated, treatment settings, and measurements used to assess success. However, certain generalizations may be made within each category from studies and case reports.

Behavioral Therapy

The goals of behavioral treatment are to normalize sexual preferences and enhance social functioning. To accomplish these ends, most treatment programs employ several or all of the following techniques: aversion therapy, orgasmic reconditioning, cognitive restructuring, and social skills training.[12–19] In the following studies, the definition of a sex offender included only child molesters and rapists.

In aversion therapy, the patient is conditioned to associate negative stimuli with deviant sexual feelings. One is through painful electrical shocks.[12,19]

Patients are shown slides of deviant sexual stimuli and then penile circumference is measured. If the circumference of the penis increases beyond a preset level, the patient receives an electrical shock in the arm. Another strategy is to give patients smelling salts to carry with them and instruct them to inhale the salts when they have deviant sexual thoughts.[13, 16]

Orgasmic or masturbatory reconditioning consists of two phases. First, the patient masturbates to orgasm while using socially acceptable fantasies (consenting men for homosexuals; consenting women for heterosexuals). Then, the patients are instructed to masturbate for 30 to 60 minutes while verbalizing variations of their deviant sexual fantasies.[13, 16, 20] In this way, patients begin to associate sexual satisfaction with appropriate sexual themes and minimal pleasure with deviant themes.

Cognitive restructuring helps the patient recognize decisions and precursors leading to his deviant sexual behavior.[13, 16, 17] Men often blame intoxication, stress, sexual deprivation, and their own abuse as children for their inappropriate acts.[13] The sex offender also frequently blames his victim for acting in a seductive way. Through the technique of cognitive restructuring, the therapist helps the sex offender recognize the antecedents to deviant sexual behavior and attempts to restructure the offender's interpretation of these antecedents. The therapist evaluates the offender's coping skills and helps him gain control over urges that were previously triggered by dangerous thoughts and situations.[13, 16, 17]

The fourth behavioral technique is social skills training. This teaches the sex offender normative assertiveness, conversational skills, and reduction in social anxiety.[13, 14, 20] The behavior of sex offenders is modified through role-playing, group discussion, and training in relaxation as a self-control strategy.[13] All of these behavioral techniques have been in use for more than a decade.

Recidivism with Behavioral Therapy

Assessing the success of behavioral therapy is problematic for two reasons. First, recidivism is difficult to measure. Several studies have used subsequent conviction for a sexual offense as evidence for treatment failure.[12, 13, 18] Erectile response to deviant stimuli[21] and information from family and friends[13] have also been used. Use of ancillary sources is important because sex offenders undoubtedly commit crimes for which they are not convicted. However, even with all these sources, there is under-reporting of recidivism. Since rape and child molestation are reportable offenses, sex offenders are unlikely to reveal their offenses to researchers or to family and friends.[20] They are also capable of suppressing their erectile response to deviant stimuli when tested.[19]

Second, none of the above studies has had an optimal control group, namely a placebo-treated one, to compare with treated groups.[19] For ethical reasons, such a control group would not be practical.[19] Some studies have used offenders

who have declined treatment as a substitute.

In studies that use repeat conviction as evidence for treatment failure, a recidivism rate of 32 percent[13] has been reported for untreated offenders. With treatment, the recidivism rate in one to five years ranges from 12 to 31 percent.[12, 13, 18, 20] In two studies that measured the statistical significance of behavioral treatment over no treatment, one found a significant decline in recidivism[13] and one did not.[12]

One study of outpatient treatment of child molesters attempted to determine which factors were reliable predictors of recidivism.[20] The following characteristics correlated with low recidivism rates: endorsing the goals of treatment, being married or separated, and not having multiple pedophilic targets or behaviors (such as more than one child). Other characteristics with no predictive value included age, race, social class, education, employment status, religious preference, frequency of pedophilic acts before entering treatment, lifetime number of molestations or sexual victims, and reported self-control over pedophilic behavior before entering treatment. By using a combination of the above variables, the investigators could classify recidivists and nonrecidivists with 85.7 percent accuracy.

Treatment of child molesters rather than incarceration has been found to be cost effective.[18] Because of the large expense of repeat incarceration, a decrease in recidivism by even three percent makes treatment, rather than incarceration, cost-saving.

Medical Treatment of Sex Offenders

The literature concerning medical treatment consists mainly of case reports and crossover studies in which the same patients are treated with drug and placebo. A problem in evaluating these reports is that the definition of a sex offender varies greatly. In contrast to the definition of a sexual predator as someone who commits repeated rape and/or child molestation, over the past 25 years, men with many sexual deviancies have been included in drug studies. Researchers have studied exhibitionists,[22, 29] hypersexual men (men with a libido that was considered abnormally high by themselves or their wives),[24, 26, 30] voyeurs,[26-28] transvestites[24, 28] men with other fetishes,[22, 27] men with distressing vivid sexual fantasies,[23] and homosexuals.[26, 30] The use of so many types of subjects prevents firm conclusions regarding the treatment of sexual predators.

The principal drugs used to treat sex offenders are the antiandrogens—cyproterone acetate (CPA) and medroxyprogesterone acetate (MPA), although fluoxetine has been suggested[31] because of its side effect of reducing sexual drive.

Cyproterone Acetate

CPA's mechanism of action is not known precisely. However, it lowers serum testosterone[32] by decreasing its production in the testes and adrenal glands.[25] It also blocks the androgen receptor response,[33, 34] both centrally and peripherally.[26, 35] In particular, it blocks the intracellular testosterone up-

take, the intracellular metabolism of androgens, as well as receptor binding.[33] Thus CPA works by reducing the effect of androgens, but other unknown biological factors may play a role.[25]

The net effect of CPA is to reduce libido and ability for erection, increase latency to orgasm,[32] and cause oligospermia.[32, 34] CPA's suppression of physiological sexual response and libido occurs within 2 to 4 weeks after the onset of treatment,[32] and is approximately as effective as surgical castration.[25] However, while CPA does lessen the intensity and frequency of sexual behavior, it does not change sexual orientation or direction.[25]

Side effects of CPA include easy fatigability and an increased sleep requirement in early treatment (two to six weeks).[34] During this time, patients also may experience depressed mood, inability to concentrate, and nervousness. These early side effects tend to normalize as therapy progresses.[34] In 20 percent a later side effect that occurs at about the sixth to eighth month is gynecomastia. Less commonly, a decrease in body hair, an increase and softening of the scalp hair, and a decrease in sebum excretion was observed. The following is a description of studies of CPA.

Three cases, those of a pedophile, an 'oversexed' male aged 72, and a homosexual priest, were reported by Cooper et al.[30] With the first case, a decline in serum testosterone levels to 50 percent was noted after four days of treatment with a diminished ability to have an erection and reach orgasm. These effects were maintained for the three weeks of treatment and were reversed three weeks after discontinuing treatment. No side effects were noted. In the latter two cases, both patients experienced decreased libido and a decrease in erectile ability with an absence of ejaculations. All patients noted a general tranquilizing effect presumed to be related to their diminished sexual urges.

Twelve involuntarily committed psychiatric inpatients who were being detained for exhibitionism or for rape and other violent crimes were studied by Bancroft et al.[36] The researchers attempted to avoid biased reporting from their subjects by assuring them that study participation would not change their length of stay. Each patient underwent three treatment periods: one with CPA, one with estrogen, and one with no treatment. Results were measured using patient reports of sexual interest, activity, and attitude, and their penile response and reported response to sexual stimuli. There were no significant differences between the two drugs. Both significantly lowered sexual interest and activity, but did not change the direction of sexual interest. In general, there was no significant interaction between drug and stimulus response. However, there was some reduction in response to fantasy and film when patients were receiving CPA. Neither drug produced troublesome side effects.

Fifty patients with various paraphilias and 16 rapists and child molesters were treated by Davies.[23] Many patients with chromosomal abnormalities, including a boy with XYY-syndrome and a history of sexual aggression and hypersexuality,

were also included. In all cases, there was significant improvement and no recidivism while receiving treatment or in three years of follow-up. Feelings of sexual calm were also noted. However, the method of measuring recidivism was not specified. Two patients developed slight gynecomastia.

Ten patients with a range of sexual problems, including voyeurism, transvestism, pedophilia, and rape were treated by Baron and Unger.[24] These men all reported a diminished sex drive while taking CPA; this was reversible with discontinuation of the drug. Slight gynecomastia was noted in some patients.

Six European studies conducted during the 1970s were summarized by Ortmann.[25] The number of subjects ranged from six to 33, with a follow-up of three months to four and one-half years. A relapse rate while taking CPA of 0 percent to 50 percent was reported. The reviewer went on to correct these studies for insufficient treatment, questionable registration of relapse, and lack of effect on sexuality, and concluded that the relapse rate was 0 percent to 16.7 percent.

Nine men with deviant sexuality were examined by Cooper[26] in a placebo-controlled crossover trial. CPA reduced libido and associated sexual arousal with a parallel reduction in testosterone of 30 percent. These changes were reversible with a 30-day washout period. There was a virtual absence of side effects.

A single case study was reported by Bradford and Pawlak[38] of a case of sadistic homosexual pedophilia with chronic organic brain syndrome. While this patient was receiving CPA, he had a decrease in serum testosterone. As measured by penile tumescence, he had a decrease in deviant pedophilic arousal to 120-second audiotapes of children and adults involved in various deviant sexual acts. The patient developed the ability to suppress his erection while listening to these tapes. The authors concluded that this case demonstrated the differential effects of CPA on the absolute level and direction of sexual arousal.

All of these studies are case reports except for Cooper, which included a trial of placebo and CPA in the same patients. Because they were not double-blinded and did not have placebo controls, confounding factors, such as the desire by patients and their physicians to resolve the patient's sexual deviancies, may play a role.

Medroxyprogesterone Acetate

MPA is available as Provera for oral administration and in long-acting form as Depo-Provera for intramuscular injection. The injectable form is normally used because the oral form is not well absorbed from the gut.[32, 38] Like CPA, the mechanism of MPA's action is not completely understood; and like CPA this drug reduces the intensity of sexual urges, but does not change its direction.[27, 39] MPA lowers testosterone levels by accelerating the metabolism of testosterone and by inhibiting release of luteinizing hormone from the pituitary gland,[38, 40] thereby diminishing the amount of testosterone released from the testes.[32] Also like CPA, MPA induces a feeling of sexual calm and is reversi-

ble.[38, 41] Side effects[28, 29, 32, 42, 43] are common and include weight gain, fatigue at the time of injection, hot and cold flashes, headaches, and insomnia. Thrombophlebitis, pulmonary embolism, skin sensitivity reactions, nausea, and hyperpyrexia have also been reported.

A patient with transvestism and homosexual pedophilia was described by Money.[40] MPA administration resulted in a suppression of serum testosterone along with complete impotence and decreased libido. With a reduction in MPA dosage, the patient was again able to have an erection and intercourse with his wife. After two years, the medication was discontinued, but there was a return of his deviant sexual feelings in nine months. The patient was then restarted on MPA with a remission of symptoms and a second discontinuation of medication without relapse for 10 months at the time of reporting.

A combination of MPA and milieu therapy for up to one year was used by Gagne[28] in 48 subjects. Again, the subjects ranged greatly in their sexual disorders, with many of the problems listed above included. Eighty-five percent of patients were admitted to the hospital, with an average stay of 28 days. Patients were each assigned a female psychiatric nurse who worked with them to establish a trusting relationship. Patients had frequent contact with staff, other patients, and visitors, as well as frequent psychiatric assessments. Testosterone levels were followed. Forty of the 48 subjects reported improvement. In addition to reporting a diminished sexual drive and decreased frequency of sexual fantasies, an increase in verbal communication was reported, with patients showing more concern about their wives, children, and families. Testosterone levels, which dropped to as low as one-fourth of their pretreatment levels after starting MPA, returned to normal after treatment. With a three-year follow-up, none of the 40 improved patients returned to his pretreatment sexual behavior, by self-report.

A group of sexually deviant men, including four patients with male-to-female transsexualism incompatible with their career commitments and 14 patients with 47, XYY syndrome, were followed by Money and Bennett[41] for up to five years and nine months using MPA and concurrent counseling. MPA was considered as providing a real life test of deandrogenization for the transsexuals. The authors concluded that "paraphilias, even those that expose the person to extreme and severe punishment, are chronic and tenacious to such a degree that, even though they may be in remission, follow-up or maintenance is necessary." They argued that the law adheres to a "long-outmoded" theory that paraphilia is related to moral decadence in adulthood and is a judicial, not a biomedical, responsibility. They recommended early diagnosis and treatment, but cautioned that the long-term outlook with treatment is statistically modest.

A review by Berlin and Meinecke[27] of the treatment of 20 men with sexual deviance (voyeurism, exhibitionism, erotic sadism, and pedophilia) revealed

recurrences in only three while taking medication. The length of treatment lasted from three months to five years and nine months. The recurrence rate jumped after medication was discontinued, as 10 patients relapsed.

MPA was used by Kiersch[39] in eight volunteers at Atascadero State Hospital in California, a facility that houses hardcore incarcerated individuals. Half completed the 64-week study, which consisted of alternating MPA injections and sterile saline injections in the same patients. Both patient reports of sexual fantasies and masturbation and penile tumescence to deviant stimuli were measured. The author concluded that his results were confounded by self-reporting that was probably confabulated. Patients were believed to have given responses that they felt were desirable to hasten release from confinement. Further, patients demonstrated decreased erection to deviant stimuli with both MPA and saline injections. Thus cognition, learned behavior, and other factors are involved in this complex behavior.

Thirty patients with a wide array of sexual deviancies divided into three groups of 10, and treated with MPA, imaginal desensitization (ID), or both were studied by McConaghy et al.[29] ID was described as having patients, while relaxed, visualize situations where they have carried out their deviant sexual behavior but visualize not completing the behavior. No significant differences were reported by the three treatment groups in reduction of deviant urges or reduction of general tension. Further, 25 patients reported marked reduction in or no deviant desire at one month, and all but three of these remained relapse-free at two or more years.

Forty men with various sex-offending behaviors were treated by Meyer et al.[42] with MPA, group therapy, and individual psychotherapy. They found that recidivism rate, as measured by rearrest records and reports to the therapist, was higher in a group that refused MPA treatment than in the MPA-treated group. Further, those patients who remained compliant with MPA were much less likely to reoffend than those who stopped the medication. Pretreatment testosterone concentrations also "seemed to be linked to reoffense whether on or after discontinuation of therapy."

As with behavioral therapy, recidivism with medical therapy is difficult to measure. Because offenders may be reluctant to report their illegal activity, true recidivism rates may differ from reported rates.[44]

To summarize, antiandrogens are not a "cure" for the sex offender. Although they do diminish testosterone levels and effects, most studies indicate that they do not change the direction of a patient's sexual desire. Further, compliance with these treatments is a major issue. The offender must cooperate with treatment in order to have any chance for containing the deviant sexuality. Many sex offenders are unwilling to do this.[24, 27, 38, 41] Those who are noncompliant frequently relapse.[35, 38, 41] The depot form of medroxyprogesterone acetate was initially thought to resolve the compliance issue, because it suppresses testosterone pro-

duction for two weeks. However, a sex offender may counteract the effects of MPA by taking either oral or injectable testosterone.[41]

Several researchers have raised the issue of compliance as a condition of probation or parole. Money[38] recommended this approach. However, Gagne[28] notes the complexity of the ethical issue involved, namely forcing patients to receive medical care. He refused to treat anyone on an involuntary or coerced basis, and treated only those who gave informed consent. Cooper[35] stated that the physician and patient must attempt "to balance as best they can the rights and needs of the subject against those of society." Halleck[45] questioned whether anyone under threat of criminal prosecution can give informed consent. He warned that if society starts to treat one form of deviance involuntarily, the boundaries of nonpolitical use will be difficult to define. But Halleck and others[27] note that society as well as the offender will benefit if the offender can be treated successfully rather than released from prison unchanged.

Discussion

This treatment outcome review corroborates the views of opponents of the Washington State law. Because there is currently no proven treatment of sex offenders, and because we are not yet able to predict future behavior, sexual predators confined under this law will be unable to prove that they are no longer a danger in order to be released. Thus, the sexual predator act results in preventive detention. Although behavioral and medical therapy have at times shown favorable results, overall they are mixed. Evaluation of improvement for the incarcerated offender is difficult and with medical therapy, compliance cannot be assured after discharge.

With regard to predicting future behavior, studies of behavioral treatment of child molesters noted "endorsing treatment goals" and not having multiple targets as major predictors of abstaining from future sexual offenses. However, because the sex offenders treated through this law are forced to comply, they are less likely than outpatient offenders (some of whom receive treatment voluntarily) to genuinely endorse treatment goals. Also, by definition, sexual predators have multiple targets, and therefore this factor predicts a poor outcome.

In general, it is difficult for psychiatrists to predict future behavior, especially violence.[2,46] The best predictors of violent behavior are 1) excessive alcohol intake, 2) a history of violent acts with arrests or criminal activity, and 3) a history of childhood abuse.[46] Only one of three persons that psychiatrists label as dangerous actually commits a violent act within the relevant future (generally three to five years).[2] Although by definition a sexual predator is someone likely to engage in future acts of sexual violence, the only real predictor to be inferred based on current knowledge is that patients with a history of sexually violent behavior are in a high-risk group for committing future acts of this nature. In short, anyone treated for sexual deviance is at high risk for repeating such

acts. Therefore, because the ability of psychiatrists to predict behavior is not precise, some individuals who are thought to be "cured" will commit future acts of sexual violence, and others who are detained would not have committed these acts if set free.[2] Offenders committed under this law may spend their lives in a mental health facility under preventive detention.

The question of psychiatry's place in preventive detention came to widescale debate after the California Supreme Court decision in *Tarasoff v. Regents of the University of California.*[47] This decision established the duty of therapists to protect potential victims from harm by their patients when this danger is known to the therapist.[47] In many cases, this has led to preventive detention, even for patients with no mental illness.[48] Applebaum argues that the potential benefit is probably only a minor measure of safety for society, given our "highly inaccurate" ability to predict violence. Scarce resources are diverted from patients in greater need of care. He urges psychiatrists "to disavow their availability to serve as agents of preventive detention."[48]

Attempting to avoid the problem of unreliable expert testimony, two-thirds of American jurisdictions,[49] including Washington State,[50, 51] use the *Frye* test or a variant for determining admissibility of scientific testimony.[49] The *Frye* test was originally used in a case involving the use of the polygraph as evidence, and states that a new scientific technique is admissible only if it is "generally accepted in the appropriate scientific community."[2, 49] The court verifies the technique's acceptance through expert testimony, legal and scientific writings, and other judicial opinions.[2] The remaining states use the relevancy test, which permits evidence having any tendency to make a fact more or less probable.[52]

In 1993, in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,[53] the U.S. Supreme court held that under Federal Rules of Evidence a scientific technique need not be generally accepted to be admissible. Rather, the judge has the task of ensuring that an expert's testimony rests on a reliable foundation and is relevant. Thus, to the extent that individual states follow the Federal Rules of Evidence, the *Frye* test may no longer be applicable. With this modification, psychiatric testimony might not currently be admissible in sexual predator cases, because the ability to predict dangerousness may not be reliably based. And without expert testimony, the law as written cannot be enforced. Thus, it falls of its own weight.

A Comparison with Drunk Driving Laws

An analogous situation in society to the treatment of sex offenders is the treatment of drunk drivers. Both types of offenders are scorned for their behavior. Both have the potential to cause injury (psychologic and/or physical) or death. Mental health professionals have attempted the treatment of both. An Alcoholics Anonymous model for postconfinement treatment of sex offenders has been recommended, in which "the person admits to having a

problem he cannot control and seeks assistance from others."[54]

To compare the treatment of the two under the law, consider the drunk driving equivalent of the sexual predator laws, namely habitual offender laws. In various states, drunk drivers are considered habitual offenders if they have either been caught driving drunk three or more times or if they are caught driving after their license has been suspended for drunk driving. The maximum incarceration for this crime in any state is five years. This represents a wide discrepancy between the way sexual predators and habitual drunk drivers are treated, because sexual predators may be committed for life. Is the Washington State law too harsh or are drunk driving laws too lenient?

References

1. Bodine B: Washington's new violent sexual predator commitment system: an unconstitutional law and an unwise policy choice. U Puget Sound L Rev 14:105–41, 1990
2. Gleb G: Washington's sexually violent predator law: the need to bar unreliable psychiatric predictions of dangerousness from civil commitment proceedings. UCLA L Rev 39:213–50, 1991
3. Wash Rev Code Ann §§71.09.010-.012 (West 1975 and Supp. 1991)
4. Lafond, Washington's unconstitutional response to sexual predators, L A Daily J, May 6, 1991
5. Cal Welf & Inst Code §6301 (West 1981)
6. Department of Mental Health Office of Forensic Services, The effect of the mentally disordered sex offender program upon community-based programs for mentally disordered offenders, October 1982
7. Oliver AD: The sex offender: lessons from the California experience. Int J of Law Psychiatry 5:403–11, 1982
8. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, (DSM-III-R). Washington, DC: APA, 1987
9. Reardon J: Summary of the civil commitment law for sexually violent predators. WSPA Report, special insert; Jan. 1991
10. Young v. Washington, 857 P.2d 989 (Wash. 1993)
11. Foucha v. Louisiana, 112 S. Ct. 1780, (1992)
12. Rice ME, Quinsey VL, Harris GT: Sexual recidivism among child molesters released from a maximum security psychiatric institution. J Consult Clin Psychol 59:381–6, 1991
13. Marshall WL, Barbaree HE: The long-term evaluation of a behavioral treatment program for child molesters. Behav Res Ther 26:499–511, 1988
14. Marshall WL, Barbaree HE: An outpatient treatment program for child molesters. Ann NY Acad Sci 528:205–13, 1988
15. Saphira M: Can men who abuse children change? Med Law 8:125–9, 1989
16. Marques JK: The sex offender treatment and evaluation project: California's new outcome study. Ann NY Acad Sci 528:235–43, 1988
17. Pithers WD, Kashima KM, Cumming GF, Beal LS, Buell MM: Relapse prevention of sexual aggression. Ann NY Acad Sci 528:244–60, 1988
18. Prentky R, Burgess AW: Rehabilitation of child molesters: a cost-benefit analysis. Amer J Orthopsychiatry 60:108–17, 1990
19. Marshall WL, Laws DR, Barbaree HE (eds): Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender. New York: Plenum Publishing, 1990.
20. Abel GG, Mittelman M, Becker JV, Rathner J, Rouleau JL: Predicting child molesters response to treatment. Ann NY Acad Sci 528:223–34, 1988
21. Becker JV, Kaplan MS, Kavoussi R: Measuring the effectiveness of treatment for the aggressive adolescent sexual offender. Ann NY Acad Sci 528:215–22, 1988
22. Bradford JMW, McLean D: Sexual offenders, violence and testosterone: a clinical study. Can J Psychiatry 335–43, 1984
23. Davies TS: Collaborative clinical experience with cyproterone acetate. J Int Med Res 3,supp 4:16–9, 1975
24. Baron DP, Unger HR: A clinical trial of cyproterone acetate for sexual deviancy. N Z Med J 85:366–9, 1977
25. Ortmann J: The treatment of sexual offenders. Int J Law Psychiatry 3:443–51, 1980
26. Cooper AJ: A placebo-controlled trial of the antiandrogen cyproterone acetate in deviant

hypersexuality. Comp Psychiatry 22:458–65, 1981
27. 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
28. Gagne P: Treatment of sex offenders with medroxyprogesterone acetate. Am J Psychiatry 138:644–6, 1981
29. McConaghy N, Blaszczynski A, Kidson W: Treatment of sex offenders with imaginal desensitization and/or medroxyprogesterone. Acta Psychiatr Scand 77:199–206, 1988
30. Cooper AJ, Ismail AAA, Phanjoo AL, Love DL: Antiandrogen (cyproterone acetate) therapy in deviant hypersexuality. Br J Psychiatry 120:59–63, 1972
31. Abel GG, Osborn C: Stopping sexual violence. Psychiatric Ann 22:301–6, 1992
32. Murray JB: Psychopharmacological therapy of deviant sexual behavior. J Gen Psychology 115:101–10, 1987
33. Bradford JMW: Organic treatment for the male sexual offender. Ann NY Acad Sci 528:193–202, 1988
34. Laschet U, Laschet L: Antiandrogens in the treatment of sexual deviations of men. J Ster Biochem 6:821–5, 1975
35. Cooper AJ: Progestogens in the treatment of male sex offenders: a review. Can J Psychiatry 31:73–9, 1986
36. Bancroft J, Tennent G, Loucas K, Cass J: The control of deviant sexual behaviour by drugs: behavioural changes following oestrogens and anti-androgens. Br J Psychiatry 125:310–5, 1974
37. Bradford JMW, Pawlak A: Sadistic homosexual pedophilia: treatment with cyproterone acetate: a single case study. Can J Psychiatry 32:22–30, 1987
38. Money J: Treatment guidelines: antiandrogen and counseling of paraphilic sex offenders. J Sex Marital Ther 13:219–23, 1987
39. Kiersch TA: Treatment of sex offenders with depo-provera. Bull Am Acad Psychiatry Law 18:179–87, 1990
40. Money J: Use of androgen-depleting hormone in the treatment of male sex offenders. J Sex Res 6:165–72, 1970
41. Money J, Bennet RG: Postadolescent paraphilic sex offenders: antiandrogenic and counseling therapy follow-up. Int J Ment Health 10:122–33, 1981
42. Meyer WJ, Cole C, Emory E: Depo Provera treatment for sex offending behavior: an evaluation of outcome. Bull Am Acad Psychiatry Law 20:249–59, 1992
43. Physician's Desk Reference, (ed 46) Oradell, NJ, Medical Economics Co, 2336–7, 1992
44. Torpy D, Tomison A: Sex offenders and cyproterone acetate- a review of clinical care. Med Sci Law 26:279–82, 1986
45. Halleck SL: The ethics of antiandrogen therapy. Am J Psychiatry 138:642–3, 1981
46. Kaplan HI, Sadock BJ: Comprehensive Textbook of Psychiatry, (ed 5) Baltimore, MD: Williams and Wilkins, 576, 1428, 1989
47. Tarasoff v Regents of the University of California, 17 Cal. 3d 425, 131 Cal Rptr 14, 551 P 2d 334 (Cal 1976)
48. Appelbaum PS: The new preventive detention: psychiatry's problematic responsibility for the control of violence. Am J Psychiatry 145:779–85, 1988
49. Imwinkelried EJ: The evolution of the American test for the admissibility of scientific evidence. Med Sci Law 30:60–4, 1990
50. State v. Martin, 684 P.2d 651 (Wash. 1984)
51. State v. Noltie, 809 P.2d 190 (Wash. 1991)
52. Strong JW: McCormick on Evidence, (ed 4) St. Paul, MN: West Publishing, 774, 1992
53. Daubert v. Merrell Dow Pharmaceuticals, Inc., 113 S. Ct. 2786 (1993)
54. Eisenman R: Monitoring and postconfinement treatment of sex offenders: an urgent need. Psychological Rep 69:1089–90, 1991