June 2011

The Insider

THE INSIDER ONLINE

VOICES OF CALIFORNIA'S CIVIL DETAINEES AT COALINGA STATE HOSPITAL

Inside this issue:

DSM-5 Rejects Coercive Paraphilia: Once Again Confirming That Rape Is Not A Mental Disorder

By Allen Frances, MD

Psychiatric Times, May 12, 2011

The proposal to include "coercive paraphilia" as an official diagnosis in the main body of t DSM-5 has been rejected. This sends a important message to everyone involved in approving psychiatric commitment under Sexually Violent Predator (SVP) statutes. The evaluators, prosecutors, Public defenders, judges and juries must all recognize that the act of being a rapist almost always is an indication of criminality, not of mental disorder. This now makes four DSM's (DSM-III, DSM-IIIR, DSM-IV, DSM-5) that has unanimously rejected the concept that rape is a mental illness. Rapists need to receive longer prison sentences, not psychiatric hospitalizations that are constitutionally quite questionable.

This DSM-5 rejection has huge consequences for forensic psychiatry and for the legal system. If "coercive paraphilia" had been included as a mental disorder in DSM-5, rapists would be routinely subjected to involuntary psychiatric commitment once their prison sentences had been completed. While such continued psychiatric incarceration makes sense from a public safety standpoint, misusing psychiatric diagnosis has given risk that greatly outweigh the gain. Mislabeling rape as mental disorder in SVP cases allows a form of double jeopardy, constitutes a civil rights violation, and is an unconstitutional deprivation of due process. Preventive psychiatric detention is a slope with possibly disastrous future consequences for both psychiatry and the law. If we ignore the civil rights of rapists today, we risk someday following the lead in other countries in abusing psychiatric commitment to punish political dissent and suppress individual difference.

This DSM-5 rejection of rape as mental disorder will hopefully call attention to, and further undercut, the widespread misuse in SVP hearings of the fake diagnosis "Paraphilia Not Otherwise Specified, nonconsent." Mental health evaluators working for the state have badly misread the DSM definition of paraphilia and have misapplied it to rapists excluded as an example of paraphilia NOS in order to avoid such backdoor misuse. Not Otherwise Specified diagnoses are included in DSM only for clinical convenience and inherently too idiosyncratic and un reliable to be used in consequential forensic proceedings.

Which brings us to one continuing problem raised by the DSM-5 posting. The sexual disorders work group proposes placing "coercive paraphilia" in an appendix for disorders requiring further research. We created such an appendix for DSM-IV. It was meant as a replacement for proposed new mental disorders that were clearly not suitable for inclusion in the official body of the manual, but might nonetheless be of some interest to clinicians and researchers. In preparing DSM-IV, we had very strict rules and high hurdles for adding any new diagnosis – only a few suggestions made the cut, while close to 100 were rejected. Because it wass no more than an unofficial tag along, we had no similar qualms about the appendix and felt comfortable including numerous rejected diagnose in what seemed like a benignly obscure way that could do no harm.

If "coercive paraphilia" were like the average rejected DSM suggestion, it would simply make sense to park it in the appendix – as has been suggested by the DSM-5 sexual disorder work group. This might facilitate the work of researching and also provide some guidance to clinicians in assessing the vanishingly rare

Continues on Page 2

THE VIEW FROM THE EDITOR'S SEAT:

The good news is that as long as this issue is I am going to keep this short.

All hell is breaking loose around here, the state, and the country. No money. You can't run anything with no money.

This issue has a continuation of "The Fiefdoms of Coalinga" as well as multiple entries by our newly appointed staff writer Derek Luers. Welcome aboard Derek and good luck.

There are a couple of really long articles in this issue as well as a new name on the Forever in Our Thoughts page.

I am not going to add anything else. Go ahead, read and enjoy. Maybe you'll learn something. Maybe you'll be inspired to get out and help. Maybe you'll just sit there and complain about how unfair life is. Whatever you decide to do, do it because it is what you want to do.

Live your life. You're never going to get another chance.

William Hester, Editor

DSM-5 Rejects Coercive Paraphilia: Once Again Confirming That Rape Is Not A Mental Disorder—continues from Front Page

"black swan" rapist who does have a paraphilia pattern of sexual arousal.

But "coercive paraphilia" is not the average rejected DSM diagnosis. It has been, and is continuing to be, badly misused to facilitate what amounts to an unconstitutional abuse of psychiatry. Whether naively or purposefully, many SVP evaluators continue to widely misapply the concept that rap signifies mental disorder and to inappropriately use NOS categories where they do not belong in forensic hearings.

Including "Coercive Paraphilia" in the DSM-5 appendix might confer some unintended and undeserved back-door legal legitimacy on a disavowed psychiatric construct. Little would be gained by such inclusion and the risk of promoting continued sloppy psychiatric diagnosis and questionable legal proceedings are simply not worth taking.

The rejection of rape as grounds for mental disorder must be unequivocal in order to eliminate any possible ambiguity and harmful confusion. We did not include any reference to "coercive paraphilia" in DSM-IV, and it should not find its way in any form, however humble and unofficial, into the DSM-5. The inclusion of "coercive paraphilia" in the DSM-5 appendix is a bad idea because the appearance of this white

GOING HOME A SAFER YOU

Billy Redding U-13

"Going Home a Safer YOU". A group designed, planned, and initiated by one of us. It's a long, strong premise with some high-falut'n ideals and expectations….

A resident here at CSH got tired of hearing a lot of moaning and wailing about:

> *"There are not enough classes or groups offered which meet any of our barriers to discharge. There aren't enough groups to help me get out. There aren't many groups outside of Mall hour's hat I have time to attend…"*

A lot of kvetching without much action or 'Doing-Something-About-It'. One of us got off his duff and prepared a 12-week class outline. Prepared a 3-quarter long lesson plan and a class-by-class schedule.

One of us went out and dug up two decent staff to facilitate this group, Ms. Frances Hicks and Mr. Tom Kipnis. One of us submitted this entire packet for administration review and got an approval from the Curriculum Committee.

CSH took yet one more step further from their norm. The group is designed to meet the risk factors of "Dangerous Impulsivity", "Poor Problem Solving", and "Distortional Thinking". Administration decided that one of us might know a bit more about these areas from someone wearing khaki, who has been there and done that… moreover, who can work with his peers in finding individual answers for themselves.

The class curriculum is simplicity itself: all the material and topics have been used here all the time. The one major difference is that attendees HAVE to demonstrate exactly how they think! They already have been through most the issues raised in "Going Home a Safer YOU", but here they will be expected to produce methods they actually apply, using all the techniques and skills they picked up in all the other groups.

Certificates will be given to attendees in this one guys – the hope is this will be as useful as the successful "*Breaking Barriers*" group as far as being out there to learn skills against our barriers to discharge – without being forced into Phases.

RIGHTS OF THE MENTALLY ILL

(Includes patients involuntarily confined for mental health purposes
in whatever stage of process or placement they may reside)

MINIMUM CONSTITUTIONAL STANDARDS FOR ADEQUATE TREATMENT OF THE MENTALLY ILL (Wyatt Standards)

42 CFR §§ 483.70(d)(iv) (bedrooms must be designed or equipped to assure full visual privacy for each resident), 483.70(d)(v) (each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains)

The right to dignity. (**Wyatt v. Stickney** (M.D.Ala. 1972) 344 F.Supp. 373, 379 (Standard #1);); UN International Covenant on Civil and Political Rights (1966), Article 10, section 1 (all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person); Universal Declaration of Human Rights (1948), Article 1 (all human beings are born free and equal in dignity and rights); 42 CFR § 483.15 (facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality); W&IC §§ 5325.1(b), 5327; 9 CCR § 883(b)(1); 22 CCR § 73523(a)(11) (right to be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs))

PROVIDED AS A PUBLIC SERVICE ANNOUNCEMENT BY:

Civil Detainees' Advisory Council

with cooperation from

THE INSIDER

Daily Life in Treatment Unit #2

Submitted by: Thomas A. Alexander

I requested a copy of my IDN (InterDisciplinary Note) dated 4/7/2011 from staff and I received it 5/7/2011. This document stated that I was verbally assaultive towards staff on that date. I asked Jerry Foster, Senior Psychiatric Technician, who was the Shift Lead that afternoon. He checked the Communications Log ("Comm Log") and also checked my chart to find out whose signature it was, and apparently none of the staff know.

The incident revolved around my telling Jack Sellick, Psychiatric Technician, "You were told to stay away from me and not to talk to me." Jack told me in a threatening manner that he will put me in seclusion if I didn't stop interfering with medical. I responded, "Go away, go away, I am helping McDonald with his wrist brace." RN Eric Njorge asked me and Mr. Profitt to help him with it because he was confused in how to put the wrist brace on. Eric asked us to help Mr. McDonald with it so the RN could attend to another patient in the Exam Room. We pushed him a little further down the hall from the Exam Room.

Jack then shoved me out of the way, and Mr. Profitt stepped in front of Mr. McDonald to protect him. Jack told Mr. Profitt, "If you don't move out of the way, I will have to push my red light." He did after Mr. Profitt told him, "I will not let you get to Mr. McDonald because he did nothing wrong and you (Jack) threatened to put all three of us in seclusion." I got pushed away from McDonald real hard after the staff and DPS showed up.

Then Jack got into Mr. McDonald's face. Mr. McDonald socked Jack on the side of the face because Jack violated his personal space, talking loud to him at the same time putting spittle on him. Jack then grabbed Mr. McDonald out of his wheelchair, placed him in a bear hug and carried him from the Exam Room to the Seclusion Room. All this while in front of staff and DPS who knew damn well that this was unethical and unprofessional. Jack has had a reputation here for coming to work drunk or nearly drunk and his actions showed that he was nearly drunk that night. One DPS officer told me in front of Cory Hoch that DPS was going to file a formal Dependent Adult Abuse report against Mr. Sellick for his behavior toward my peers.

I have been a Seventh Day Adventist for many years and as such have never used foul language, hurt people; nothing. I don't do these kinds of negative things.

Be Advised: Jack Sellick was walked out of the Hospital around two days after the April 7th incident. It is not known at this time whether a Dependent Adult Abuse report was actually filed against Mr. Sellick. The three Individuals involved have requested that charges be filed against Mr. Sellick on the grounds of Dependent Adult Abuse.

THE TROUBLING ROLE OF PSYCHOLOGISTS IN SEXUAL PREDATOR LAWS

Paul Good, Ph.D. and Jules Burstein, Ph.D.

Sexually violent predator (SVP) laws have compromised the scientific and professional integrity of psychologists and failed to serve the public interests. Psychologists on state SVP panels have become witch-finders, despite noble intentions of protecting public safety. Their testimony supporting the civil commitment of a small (but growing) group of so-called "predators" relies upon fictitious mental disorders and problematic actuarial formulae. Psychologists have become essential components of SVP laws that expend huge sums on new prisons, create impossible treatment situations for those who are civilly committed, indiscriminately demonize all sex offenders, and diminish the quality of American justice by sanctioning preventive detention. Psychologists should withhold their support for these laws and their civil commitment policies, not only because they promote a paradigm of detention based on risk status, but because they siphon away resources from programs and policies that address the more insidious and pervasive ways that society promotes sexual violence. Recommendations by some critics to improve the quality of civil commitment evaluations, the validity of diagnostic and prediction models, and the usefulness of court testimony cannot fix a broken system. In recognition of the ethical duty to do no harm and the failure of SVP laws to protect the public, we call on psychologists to resign from state SVP panels and to work toward more sensible solutions in adjudicating sex offenders.

During the Salem witchcraft trials, 19 women and men were tried and executed in a community gripped by hysteria and by a legal system with too few checks and balances. Jurors were allowed to listen to panicky gossip and judges used vague standards of proof. Most egregious was the admission of invisible "spectral evidence," the extra-sensory experience of victims who had a vision of the accused as a witch. Ministers like Samuel Parris and Cotton Mather, instead of serving as a buffer against people's anxieties by critically examining the false claims of witchcraft, acted as "witch finders" (1).

Unlike the Salem "witches" who were innocent, sex offenders are guilty of having committed terrible crimes and rightfully serve lengthy sentences. In an attempt to block a small subset of the most serious offenders from being released, county prosecutors in the 20 states with SVP civil commitment laws use psychologists to determine if the offender meets statutory requirements of a loosely defined "mental disorder" that "predisposes" them to the commission of criminal sexual acts in the future. These individuals are then qualified as "sexual predators." At civil commitment trials, juries commit "predators" to state mental hospitals for involuntary and indeterminate treatment.

In this article, we argue that psychologists testifying for the state in SVP civil commitment trials are using contrived mental disorders and the scientific veneer of actuarial formulae in a manner that is more prejudicial than probative. We further propose that psychologists undermine the public interest by supporting SVP laws that are structured around a "predator" paradigm. This model gives the public a false sense of security by concentrating vast sums of money on incarcerating a small group of sexually violent offenders, in place of a more useful public health approach to the problem of sexual violence. The consequences of this misguided effort include emphasizing incarceration over treatment, draining scare resources from multi-pronged approach to preventing sex crimes, demonizing sex offenders, and promoting the "slippery slope" of preventive detention. Psychologists should stand in opposition to these regressive laws.

THE CONSTRUCTION OF FICTITIOUS MENTAL DISORDERS

The "mental disorder" underlying SVP civil commitment is typically defined as a congenital or acquired condition affecting the individual's emotional or volitional capacity, and predisposing the person to commit sexually violent offenses in a degree constituting a menace to the health and safety of others. This definition is broad and wide-ranging, incorporating conditions which are genetic or based on environmental factors, and that affect virtually any psychological facet of the individual.

Unfortunately, the diagnosed mental disorder required for SVP civil commitment "has no parallel or precedent in 'clinical' psychiatric or psychological practice or literature" (2). State legislatures invented a legal definition that does not correspond to anything in the Diagnostic and Statistical Manual of Mental Disorders (DSM) (3).

Clinicians working for the state most often rely on the diagnostic category of paraphilia as the predicate mental disorder necessary for civil commitment, even though the incidence of paraphilias among sex offenders is quite low (4). The DSM-IV-TR (3, p. 522-523) defines paraphilia as follows:

A. Recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving non-human objects; the suffering or humiliation of oneself or one's partner; or children or other non-consenting persons, that occur over a period of at least 6 months; and

B. The person's behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

The two most frequent paraphilias that are used to justify commitment are "Paraphilia, Not Otherwise Specified (NOS)," which is invoked for some men who rape women, and Pedophilia, which predisposes men to sexually abuse prepubescent children generally under the age of 13.

Paraphilia NOS

Included under this diagnostic rubric are such varied and uncommon behaviors as telephone scatologia (obscene phone calls), necrophilia (sex with corpses), partialism (exclusive focus on part of the body), zoophilia (sex with animals), coprophilia (sexual arousal to feces), klismaphila (love of enemas), and urophilia (sexual pleasure associated with urine).

Grave problems exist when this "wastebasket" diagnosis is used for rape by SVP evaluators for the state. First, this diagnosis, like all NOS diagnoses in DSM-TR, is particularly lacking in empirical research, and especially absent are reliability and validity data. This is because the A criterion is so ambiguous and poorly crafted as to make clinical studies and differential diagnosis nearly impossible. The DSM-IV sexual deviation disorders category was not subjected to field trials, and DSM-III field trials were based on only seven cases (5).

SVP panel psychologists typically diagnose Paraphilia NOS simply on the basis that the individual has committed two or more sexual offenses. Frances and colleagues (6) point out that in the paraphilia criteria, the phrase "or behaviors" was inadvertent and not meant to signify that a paraphilia could be diagnosed on acts alone. Behaviors that were the culmination of urges or fantasies distinguished a paraphilia form opportunistic criminality. They concluded that the use of Paraphilia NOS to describe repetitive rape could not be justified solely on the basis of the term "or behaviors." To be absolutely clear, the two psychiatrists in charge of the sexual disorders sub-group for DSM-IV-TR clarified in an editorial that "Defining paraphilia based on acts alone blurs the distinction between mental disorder and ordinary criminality" (7, p. 1240).

Second, the B criterion of the diagnosis makes little sense. In our many years of working with sex offenders, we cannot remember one rapist ever telling us that his urges, fantasies, or illegal sexual behavior caused clinically significant distress (anxiety, depression, sleep disorder, guilt, shame), or affected his social life or job, unless he was in fear of impending criminal charges and the concomitant fear of being sent to prison. Our experience is echoed by Michael First, M.D., one of the editors of the DSM-IV-TR Paraphilias disorder section, who said, "In fact, most people with paraphilias are not bothered by it, insofar as they feel fine having them. They feel that the problem is it gets them into trouble, but they feel it's okay to have them…" (8, p. 70). Thus, it is sophistry of the highest order when SVP panel psychologists argue that an individual meets criteria for Paraphilia NOS because he has lost his freedom by way of incarceration and therefore has "impairment" in "other important areas of functioning."

Third, and perhaps most importantly, we believe Paraphilia NOS is a clinical Trojan horse for panel psychologists to civilly commit rapists as "mad." The psychologists ignore DSM-IV-TR and the American Psychiatric Association (APA), which has made it clear over the years that rape was not a mental disorder. The complete history is detailed in Zander (9) and Abel (10). Briefly, in 1983 there was a proposal by the DSM-III Task Force on Paraphilias to include in the manual a new diagnosis called "paraphilic coercive disorder." This was a way of designating a type of rapist who was specifically excited by the coercion and act of forcing

Continues on Page 5

THE TROUBLING ROLE OF PSYCHOLOGISTS IN SEXUAL PREDATOR LAWS—Continues from Page 4

sexual contact on a non-consenting person. After reviewing the literature and debating the issues, the Board of Directors of the APA in 1986 voted against inclusion in part due to its potential misuse as an insanity defense, concerns about reliability, problems with differential diagnosis, and lack of general acceptance in the psychiatric community.

Zander (9) argues that psychologists who shoehorn rape into the diagnosis Paraphilia NOS are explicitly violating the intent of the drafters of the DSM. Organized psychiatry had rejected the inclusion of rape as a paraphilic disorder and specified in the DSM-IV Manual a clear alternative category for individuals who raped. The V codes describe a series of psychological or relationship problems which do not constitute a "mental disorder," but which may be a "focus of clinical attention" (3, p. 731). The codes for rape, V61.12 or V62.83 called "Sexual Abuse of an Adult," make "sexual coercion" or "rape" a problematic behavior in need of treatment (3, p. 738). This diagnosis, which clearly specifies rape, would not, however, qualify a sex offender for civil commitment. Further, the use of the diagnosis Paraphilia NOS could not be a valid and reliable entity, nor could a forensic psychologist testify with "reasonable medical certainty" that it was the cause of sexually deviant behavior since the NOS status is the "antithesis" of "reasonable certainty" (11).

The most ardent proponent of using the paraphilia category for rapists is Dennis Doren, the director of psychological evaluations for Wisconsin's SVP civil commitment program. He is credited with coining the term "Paraphilia NOS, non-consent." While he concedes that this diagnosis is not included in DSM-IV-TR, he clearly thinks that it should be and has been omitted because of extra-scientific "legal, political and fiscal concerns" (12, p. 64).

Doren (12) believes such a diagnosis is justifiable when "the offender has repetitively and knowingly enacted sexual contact with non-consenting persons over a period of at least 6 months (specifically for sexual arousal to the non-consensual interaction), and the behavior has caused him significant impairment in social, occupational, or other areas of functioning" (p. 67). Although multiple acts of rape would qualify a person for this diagnosis, Doren (12) states that there are other actions besides repetitive rapes that can be used to make the determination and he enumerates thirteen criteria (pp. 68-76). He is not clear on whether one, two, three or all thirteen are necessary to make the diagnosis. He offers no empirical research or studies validating these criteria—only his clinical experience.

In sum, Doren's construct of "Paraphilia NOS, non-consent," is one clinician's attempt to create de novo a new diagnostic category of mentally ill sex offenders on the basis of his creative imagination, rather than on the basis of research and field trials. For Doren, the Field of Dreams admonition, "If you build it, they will come," has been transformed into "If you create a diagnosis, they will use it." As Zander (9) points out, Paraphilia NOS is a "proxy" for the rejected diagnosis of paraphilic coercive disorder, and has offered legislators and mental health professionals carte blanche to invent criteria by which to deprive sex offenders of their freedom after they have completed their sentences.

Pedophilia

There are a number of problems with this diagnosis. First, one would think that the term "pedophile" means an exclusive and certainly primary form of sexual arousal to children. But the DSM-IV-TR includes modifier terms "Exclusive Type" and "Non-exclusive Type" which suggest that a pedophile may not exclusively prefer children. We believe that the "non-exclusive" type should be thought of as a regressed child molester (the classic example being incest cases), and the "exclusive" type be considered the fixated pedophile. Now, regardless of the offender's history or the situational context of the instant offense, all individuals who sexually abuse children are labeled as pedophiles. This does not do justice to the reality that only a small minority of men who sexually abuse children are true pedophiles.

Second, the terms "recurrent," "intense," and "behaviors" involving sexual activity with a prepubescent child are imprecise and undefined, and can easily result in both false positive and false negative diagnoses (13). For example, there is great subjectivity in determining whether the sexually arousing fantasies to prepubescent children have been "recurrent" and/or "intense." The criterion that the behavior has lasted for at least six months also seems subjective and arbitrary. Only the perpetrator knows the answers to these questions. In the context of an adversarial evaluation, it is understandable that an individual would engage in denial, and a psychologist consequently has little basis on which to make this diagnosis.

Third, the notion that one could meet the diagnostic criteria for pedophilia with only fantasies, or only urges, or in their absence simply "behavior" alone, is nothing sort of startling. It makes no sense to consider as conceptually equivalent "mental illnesses" that are based on thoughts and feelings on the one hand, with mental disorders based on actual behavioral harm to children on the other hand. In fact, the authors of the Paraphilia section in DSM-IV have now clarified that the disjunctive "or" ("fantasies, sexual urges or behaviors") was inserted by mistake and that the definition was never meant to include individuals who just engaged in repeat behavior (14).

A fourth problem with this definition has to do with the second or B criterion, which states that the urges or fantasies cause marked distress or interpersonal difficulty. For many pedophiles, the behavior itself is not a cause of distress but only becomes so in response to social sanction. Thus, DSM-IV-TR acknowledges that many individuals with paraphilias "…assert that the behavior causes them no distress and that their only problem is social dysfunction as a result of the reaction of others to their behavior," (3, p. 567). To meet criteria for a mental disorder, the distress must be "present distress" (3, p. xxxi) which implies that if the distress is mitigated, or in remission, the individual no longer meets the criteria for the diagnosis.

Moser and Klienplatz (15), while clearly condemning sexual contact between adults and children, argue for removing pedophilia (and indeed all paraphilias) from the DSM, not wishing to see child molesters make potential use of such a diagnosis to diminish their criminal responsibility for harming children by claiming to suffer from a "mental disorder" needing treatment. We agree.

ACTUARIAL RISK ASSESSMENT IS NOT READY FOR PRIME TIME

Problems with clinical judgment and the prediction of violence spurred an interest in the 1980s and 1990s in actuarial risk assessment (ARA), an effort at utilizing the empirical factors correlated with violence as a basis for making predictions. With respect to the prediction of sexual violence, commonly used actuarial instruments include the Sex Offender Risk Appraisal Guide (SORAG) (16), the Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR) (17), Minnesota Sex Offender Screening Tool-Revised (MnSOST-R) (18) and the Static-99 and Static-2002R (19). These tools have achieved a "moderate" degree of accuracy and are believed to be better than clinical predictions. In addition, actuarial instruments are assumed to provide an improvement over clinical predictions because they are "transparent" in allowing the trier of fact to understand the key variables that underlie the risk assessment process

Continues on Page 6

HERE'S WISHING EVERY FATHER OUT THERE…

HAPPY FATHER'S DAY!

THE TROUBLING ROLE OF PSYCHOLOGISTS IN SEXUAL PREDATOR LAWS—Continues from Page 5

and its limitations.

There are a number of problems with ARA, however, that undermine its utility in SVP civil commitment hearings. First, predicting future behavior will always be imperfect because individuals have the capacity to choose. The existential reality of human behavior is that people can and do change. In spite of the many determinants and habitual forces that drive us to repeat the behaviors of the past, choosing a new path is a defining feature of being human. This is as true for rapists and child molesters as it is for politicians, schoolteachers, clergy and children.

Second, most ARA relies solely on static factors, variables that are stable over times and do not change. Actuarial or mechanical prediction schemes incorporate such factors as number of prior charges or convictions for sex offenses, whether the victim was a stranger or male, and whether the offender has ever lived for two years with an intimate partner, to name a few. Because of one's score on these variables cannot change (i.e., because they are "static"), an individual's actuarial risk will remain constant no matter what changes occur in the person or the environment. Thus, a man of 85, deemed to have been high risk at age 35 on the basis of actuarial test results, will be seen as remaining equally dangerous 50 years later!

Dynamic factors are variables that can change over time. These include such things as age, physical incapacity, attitudes tolerant of sex offending, substance abuse, the effect of treatment, and characteristics of the release environment. For example, there is an age related decline in sexual recidivism which initially was not taken seriously enough (20). Although dynamic factors are extremely important in determining risk, much less is known about them. Moreover, actuarial research has thus far not shown how dynamic variables should be integrated into a risk assessment (21).

Third, ARA instruments have been criticized by Campbell (22) who notes: "…risk assessments of sex offenders are systematically biased…in the direction of ruling-in recidivism risk" (p. 67). Rogers (23) chastises ARA for failing to incorporate protective factors, variables that reduce the likelihood of sexual recidivism. These include a former offender's advancing age, change in attitude, abstinence from drugs or alcohol and a community environment of support.

Hanson (24) admits that actuarial scales are not comprehensive and do not include all the relevant variables. Thus, based on meta-analyses by Hanson and Bussiere (25), Hanson and Thornton (19) and Hanson and Morton-Bourgon (26), a list of additional or "extraneous" risk predictors are reviewed by evaluators to supplement actuarial measures. Each one is considered in terms of whether it increases or decreases the risk to reoffend. But for evaluators who are trying to take into account the risk and protective factors left out of the actuarial equation, the obvious problem is this: how much should the actuarial estimate be increased or decreased by the extraneous variable? There is no decision rule to rely upon and so it is left to the subjectivity of each evaluator whether to add or subtract a little or a lot to the actuarial probability. Doren (12) admits that "evaluators seem to be left with adding clinical judgments where the actuarial instruments leave off" (p. 161). Furthermore, confounding occurs when additional risk factors related to recidivism are cited by evaluators as offering incremental risk to the actuarial estimate without knowing the degree to which they overlap with variables already included in the formula. This phenomenon of inter-correlation or duplication of variance amounts to double counting (27) and has been found to lower the predictive accuracy of the Static-99 and MnSOST-R (28).

Fourth, it is critical for such ARA instruments to demonstrate that two or more evaluators reliably obtain the same result. Some have argued that ARA instruments have demonstrated adequate inter-rate reliability (12), while others have pointed out how inter-rater reliability estimates are adversely affected by data collection procedures, by changes in scoring rules, and are inflated when studies examine agreement between expert "research" investigators which may be better than agreement between "field" clinicians (22). One study by Murrie et al. (29) found that opposing forensic evaluators (i.e., field clinicians rather than research investigators) produced greater than expected inter-rater disagreement on the Psychopathy Checklist Revised, calling into question the reliability of that instrument and the corrupting effect of partisan allegiance.

Fifth, some ARA instruments like the MnSOST-R (18) have been marginally validated and the literature is equivocal on its validity as a predictor of sexual re-offense (30).

Sixth, ARA instruments are good at sorting individuals into risk categories from low to high. Within a particular sample, an instrument like the Static-99, with an "Area Under the Curve" (AUC) of 72%, is considered "moderately accurate." That means 72% of the time a randomly selected on-recidivist will have a higher score than a randomly selected non-recidivist. The accuracy refers to the sorting process, which may be useful in comparing instruments or ranking subjects, but is not meant to refer to the instrument's accuracy for any specific prediction (32). Vrieze and Grove (30) also note that the AUC in one study cannot be assumed to be the accuracy rate when applying the instrument to a sex offender from another population.

Although actuarial instruments provide information about the relative raking of recidivists and non-recidivists, Amenta and colleagues (32) argue they provide little assistance to triers of act who must make decisions about whether to commit or release a particular offender. For example, the fact that an offender obtains a score of 6 on the Static-99 and falls in a bin from which 52% of the validation sample re-offend within 15 years, does not mean that the offender himself has a 52% probability of re-offending. As Berlin et al. (33) points out, "Actuarials can potentially be very misleading if one incorrectly attributes the overall risk of a previously screened group to a specific individual within it" (p. 381). There is no way of knowing whether an offender with a score of 6 on the Static-99 is among the 52% of the validation sample that re-offended, or among the 48% that did not re-offend. If everyone with a score of 6 were committed, then the false positive rate would be 48%. Thus, Sjosdedt and Grann (34) state: "In our opinion, the AUCs are oftentimes reported as more encouraging than they actually are, considering the rate of false positives and false negatives and the human and monetary costs associated with these errors" (pp. 181-182).

Recidivism predictions come from base rates obtained by researchers in construction samples. The vexing issue here is that overall base rates of recidivism across multiple reference samples can vary considerably from 0.10 to 0.40 (35). Furthermore, base rates for individuals within a specific high risk bin score such as 6+ on the Static-99 also range widely across different samples (36, 37). the field continues to struggle with "how to define and identify the base rate" (38, p.5). This is because in the real world, base rates are typically "ambiguous, unreliable and unstable" (39, p. 1). For example, Helmus and colleagues (36) have recently had to issue new Static-99 experience tables based on a larger sample, forcing clinicians to use new risk information and decision

Continues on Page 7

WHAT DO YOU THINK?

"True guilt is guilt at the obligation one owes to oneself to be oneself.

False guilt is guilt felt at not being what other people feel we ought to be or assume that one is."

'Self and Others' (1961) ch. 10 / 12.8 R. D. Laing 1927-89

THE TROUBLING ROLE OF PSYCHOLOGISTS IN SEXUAL PREDATOR LAWS—Continues from Page 6

rules which have yet to be peer reviewed or psychometrically validated (40).

Prentky et al. (41) argue that two important problems in the SVP context are ignoring population heterogeneity and basing conclusions on selective and erroneous base rates. For example, ARA instruments have been developed on mixed samples of rapists and child molesters. As Harris and Morton-Bourgon's (26) data showed, recidivism rates differed significantly for rapists, incest child molesters, "girl victim" child molesters, and "boy victim" child molesters. Each of these groups could be further differentiated into subgroups based on type (e.g., sadistic versus opportunistic rapists; situational versus fixated child molesters) or personality characteristics (e.g., lifestyle impulsivity).

Age of the offender is another key variable, as older offenders are notably less likely to reoffend than young ones. Decreasing levels of testosterone across the life span correspond to less sexual arousal and mitigate the risk of sexual re-offense. Yet, the Static-99 developmental sample was over-represented by younger offenders whose average age at release was in the mid-30s. By not accounting for negative relationship between age and recidivism, ARA instruments inflated the risk estimate for an offender released in his 50s or 60s (42). Waggoner et al. (43) actually re-specified the original Static-99 actuarial tables to correctly account for age.

Abbott (44) illustrated the confounding effect of region or nationality on base rates. He compared five-year recidivism rates from Hanson and Thorton's (19) Static-99 developmental samples in Canada with rates from Minnesota, Tennessee, Arizona and California. The five-year recidivism rate in the U.S. offender samples was 58-82% lower than the Static-99 rate, and the ten-year rates were 44-81% lower. At the highest risk level (Static-99 score of 6+), the recidivism rates were 17-77% lower than the Static-99 rates. This suggests that the Static-99 over-predicts risk for local U.S. populations.

Optimizing predictive validity requires choosing a sample that most closely reflects the characteristics of the offender whose recidivism is being predicted. The more heterogeneous the composition of the sample from which the base rate comes, the more likely it is that the individual in question will not share all of the critical characteristics and the prediction will mis-estimate the risk. As Prentky et al. (41) warn, the "accuracy of the estimate is a function of the similarity of the assessed individual to the members of the reference group that were used to derive the estimate" (p. 17). ARA scales developed for adult male sex offenders should not be used with young, old, female, and cognitively or developmentally impaired offenders, say these authors.

When actuarial are used in jurisdictions with low base rates, Vrieze and Grove (30) have found that "they offer negligible to negative incremental validity over what is already known about the likelihood of re-offense [i.e., from the base rate]; they possess at most paltry probative value…" (p. 276). Mossman (45) disagrees, arguing that ARAs of moderate accuracy are relevant to legal decision making and better than simply relying on the base rate.

At this point, there is no consensus on what constitutes an adequate level of predictive validity in forensic risk assessment (34). The selection of such a level is never just a statistical decision but an ethical and moral value judgment that weighs the human and economic costs associated with false positive and false negative errors (46).

We agree with Janus and Prentky (47) that neither actuarial methods nor clinical judgment are good enough to justify SVP laws' long-term deprivation of liberty. but they are willing to endorse the use of actuarial methods as the lesser evil: "Our point is simply that if courts deprive people of liberty based on assessed risk, the ARA should be part of the assessment" (p. 1447). Our position is that methodological limitations and unstable recidivism estimates compromise the usefulness of ARA for juries and are more prejudicial than probative (48-51, 81).

TREATMENT OR THERAPEUTIC INJUSTICE?

In states with SVP laws, men who are civilly committed are sent either to a secure facility, which may include an outpatient treatment program, or to a prison disguised and labeled as a "state hospital." They must remain in these programs until certified that their mental disorders are in remission and no longer make them sexually dangerous. This generally requires at least two years of treatment, but in most cases those committed endure many more years of therapy and little ever "complete" treatment. Despite their right to petition for release every year or two, the commitment is tantamount to an indeterminate sentence.

Those who undergo treatment face the formidable fear that being honest about past sexual behaviors, as program therapists implore them to be, may result in local prosecutors initiating new charges against them, should staff in these facilities communicate such admissions to the District Attorney's office. Despite the fact that inmates are told such accounts will not be communicated, the understandable anxiety such disclosures might generate remains a difficult treatment issue.

The quality of treatment is also an issue. Many "patients" have told us that therapists in SVP programs transfer in and out so frequently that continuity of care is sacrificed. Oftentimes therapists are young trainees who lack the experience to deal with longstanding emotional problems.

In California, as many as 75% of the men certified as SVPs since January 1996, when the law went into effect, opt not to participate in treatment (52). They have learned that clinicians who decide their fate may never certify them for discharge to the community. Those who are civilly committed have discovered that they stand a better chance of gaining their freedom by petitioning the court for a jury trial than by successfully completing the prison treatment program.

Is it any wonder that the men mandated to participate in these programs should view them as a duplicitous and obviously successful ploy by the state to deprive sex offenders of their freedom indeterminately? Consider, for example, the fact that of the approximately 600 men in California who have been certified as SVPs since 1996, less than 10 have been released to the community by treatment staff at Atascadero or Coalinga State Hospitals. One of the few sexual predators who won his freedom at trial after six years in the SVP program told us, "I've seen more people die at Atascadero than get released" (53).

What could be the state's motive for passing a law that ensnares men at the end of long prison sentences, has them civilly committed as SVPs, and then mandates that they participate in open-ended treatment? If the legislative intent was genuinely aimed at rehabilitation, it should have and would have offered treatment concurrent with the time a convicted sex offender spent in state prison. For example, if a man is sentenced to 15 years for raping a woman, or sexually abusing a child, would it not be sensible to begin treatment immediately, often when a man is in his thirties or forties, rather than after he completes a lengthy sentence and is often in his fifties or sixties? We conclude that the legislation was a politically expedient way of authorizing preventive detention.

If state governments were serious about providing treatment to sex offenders with the genuine intent of helping them develop reliable relapse prevention strategies, they should do the following: First, initiate treatment as soon as a man enters prison, not after he has completed his sentence. Although we would expect some resistance to treatment no matter when it was offered, resistance to address sexual psychopathology is most likely at the end of a man's sentence and on the eve of his release.

Second, clinicians working with sex offenders need to be more conscious that the relationship with the therapist is the key ingredient of change (54). This factor of a supportive and caring "working alliance" between therapist and patient is sorely missing in most SVP treatment programs, where inmates often see their therapists as authoritarian and as possessing the power to determine if and when they will be released. It is difficult to imagine real progress in treatment without a truly collaborative professional relationship.

Finally, the cognitive-behavioral approach used extensively in SVP programs insists that offenders internalize an identity in which they are consumed entirely by sex (82). This approach does not give adequate attention to attachment deficits, difficulties with regulation of emotions, and fears of intimacy. Research on attachment suggests that sex offenders need help in reducing feelings of shame associated with their crimes, by conveying to them that they have value as human beings in spite of their terrible deeds. Offenders need skills to deal effectively with the intense emotional arousal that is likely when they are asked to take a close and detailed look at their often neglectful and abusive childhoods. With regard to intimacy deficits, one can see just how critical the relationship with the therapists will be for this cohort inasmuch as such clinicians may provide the only example and experience with a securely attached person. That dyad can then provide a

Continues on Page 8

THE TROUBLING ROLE OF PSYCHOLOGISTS IN SEXUAL PREDATOR LAWS—Continues from Page 7

model for how to select partners in the world outside of therapy, partners less likely to have a damaged, abusive, or neglectful life history.

SVP PROGRAMS ARE NOT COST-EFFECTIVE

The real expense of SVP laws is only beginning to impact states, already mired in debt and on the verge of bankruptcy. States with SVP civil commitment laws have spent nearly $450 million annually to administer their programs (52). If estimates for the future are correct, the national expense for SVP commitment programs is estimated to be close to $1 billion annually within the next decade (55).

In 2007, California had the largest state budget for SVP civil commitment at $147.3 million (52). This budget includes the cost of screening sex offenders referred by the Department of Corrections to determine if they require a full psychological evaluation, performing the evaluation to see if they meet criteria, and then providing expert testimony at civil commitment hearings. In 2007, about 2200 offenders were evaluated at a cost of $24 million. Of the 79 psychological contractors hired by the state, two earned over $1 million per year and 14 made over a half million dollars (56).

The annual SVP budget covers operating costs for assessment, treatment and housing, but it does not include expenditures for constructing the special state hospitals/prisons that incarcerate exclusively SVP offenders, such as Coalinga State Hospital, built at a cost of $388 million.

The passage of California's Proposition 83 in 2006 stands to make it even more expensive to house sexual predators by reducing from two to one the number of prior victims of sexually violent offenses necessary for SVP evaluation, and lengthening prison sentences for some sex offenders. This will increase the state prison population, thus significantly increasing prison operating costs to the tune of tens of millions of dollars annually (57).

Nationally, the annual price of housing a regular prisoner is about $26,000 per year, in contrast to an average of greater than $100,000 for a committed sex offender (52). The extra costs are for programming, treatment and supervision. Although we are outraged like everyone else by the crimes of sex offenders, we think it is irrational to spend four times as much to imprison an offender who has committed sexual abuse than one who has committed physical abuse. We are not aware of any research to show that sex offenders are more likely to be driven by mental disorders than other types of criminals.

The absurdity of the current system is glaring when one considers that the cost of imprisoning a sexual predator is cheaper than releasing one who has graduated from the program. According to research by Hennessy (58), James Lamb spent ten years in California's SVP program at a cost to the taxpayers of about $15,000 per month or $180,000 per year for housing and treatment. After completing the program and being released to Monterey County on July 4, 2007, the State has paid about $35,000 per month or $420,000 per year to maintain him on conditional release.

In the coming years, registered sex offenders in the community are going to be monitored by a Global Positioning System (GPS) device. This high tech solution will be very expensive, as Proposition 83 requires these offenders to be tracked while on parole and for the remainder of their lives. The provision would result in the costs of purchasing GPS equipment as well as for supervision staff to track offenders in the community. In 2009, GPS tracking of 6300 parolees cost about $60 million. Says Alfred Martinez, a state parole official in Los Angeles: "We're probably using 60 to 70 percent of our resources managing 10 percent of our population" (59).

As costs and future projection indicate, society is spending astounding amounts of money fighting a very small segment of the sex offender population. The predator paradigm is dominating efforts to prevent sexual violence and limiting the impact of other public health approaches. For example, for the hundreds of millions of dollars we now spend annually, how much sexual violence could we stop by funding sex offender specific treatment for inmates already serving prison sentences? Or funding substance abuse and mental health treatment in the state prison system, since individuals with alcohol, drug addictions and mental illness are more likely to act out impulsively, either physically or sexually? Since we know attitudes toward women and children may predispose individuals to engage in sex crimes, we could provide grants to high schools to educate young people regarding the traumatic consequences of sexual assault and molestation. Programs for spousal abuse, anger management and self-awareness could also contribute to reducing sexual violence. Establishing regulations for media that prohibit advertisers from sexualizing children at younger and younger ages is another preventive measure. Finally, policies that reduce poverty may also be a part of the solution. The point is that our efforts to thwart sex crimes need to address not only predators, but sexual violence woven into the fabric of society.

THE DEMONIZATION OF SEX OFFENDERS

America is in the midst of a full scale "war on sex offenders" (60) who are now the most "vilified group in society" (61) and the new "enemy" of the state. Making war requires the enemy to be dehumanized (62). Sex offenders are first marginalized and considered outside the boundaries of mainstream society. They become outcasts because of their deviant sexual interests, and because they have violated the laws and mores proscribing normal sexual conduct. Then, sex offenders are dehumanized by negative labels, subhuman imagery and stereotyping that prevents any identification with them. We consider rapists, child molesters and other sex offenders to be "monsters in our midst" (63). Finally, sex offenders are demonized, by virtue of being regarded as totally evil or sinful, thus providing the rationale for totalistic solutions – imprisonment or banishment.

Tracing the history of the monster in Western culture, public defender John Douard (64) argues that the sex offender as monster is at the heart of civil commitment statutory schemes. The monster of antiquity was a real creature, a freak of nature, a violation of the natural order that was met with violence or pity. Today's sexual offender is a metaphorical monster that provokes feelings of terror and disgust. Modern society has responded with imprisonment or civil commitment in a treatment facility.

All societies need a monster for people to loathe and fear. Over the years the criminal, the communist, the homosexual, the terrorist and now the sex offender have served in the role of monster. These social and sexual deviants are popularly considered a threat to the values of society. Typically, the underlying complexity of the problems they pose is not dealt with adequately. Falsehoods and stereotypes about them take hold, and measured responses are foregone. Instead, vigilantism, draconian laws and curtailment of civil liberties are the consequences. Just as the "witches" of Salem inspired a collective hysteria in the towns of New England, sex offenders have now provoked across the plains of America a "moral panic" (65). Americans are now more frightened by child molesters than terrorists (66).

The mass media sensationalize the problem and stoke the public's fears. For example, in MSNBC's reality television program, To Catch a Predator, police set up a sting operation in which men solicit a young teenage girl (most often a decoy cop posing as an adolescent girl) and meet her at a residential location where NBC cameras and host await them for a humiliating interrogation. Viewers look on which disgust.

Fueled by high profile sex crimes, commentators exaggerate the danger of all sex offenders and spread misconceptions about them. In the recent case of Phillip Garrido, the sex offender who allegedly molested a young California girl for 18 years in his backyard, highly educated commentators misinform viewers about sex offenders. One of them, Chris Matthews, is grossly wrong when he remarks to his guest on Hardball, a former prosecutor, that sexual predators are "100 percent" likely to reoffend. Instead of correcting him, she agrees (67). Similarly misguided, Judge Judy Sheindlin (68) appeared on Larry King Live to comment on the Garrido case and told viewers that sexual recidivism is "well over half and probably closer to 75 percent." These assertions are demonstrably false.

Society's misunderstanding is documented in surveys by Fortney et al. (69) who found that: the public overestimates the frequency of sexual recidivism (in fact, most sex offenders do not re-offend sexually, and are among the least likely of all criminals to recidivate); the public overestimates the rate at which strangers victimize children (most child abuse is perpetrated by someone in the victim's family or a person known to the victim); and finally, the public underestimates the efficacy of treatment (therapies focusing on relapse prevention strategies have been shown to benefit sex offenders).

One important consequence of our hysteria about sex offenders is that the public's consciousness is dominated by a single source of danger and other, perhaps more significant dangers, receive less attention. For example, poverty and

Continues on Page 9

THE TROUBLING ROLE OF PSYCHOLOGISTS IN SEXUAL PREDATOR LAWS—Continues from Page 8

physical abuse affect far more children in a devastating way than child molesters do. Demonization of sex offenders is bad for public policy and laws being passed in the moral panic of today will haunt us tomorrow.

SVP LAWS AND THE SLIPPERY SLOPE

At least since September 11, preventing terrorist attacks before they occur has been the driving force behind government policy. The "preventative state" as implemented by the Bush Administration included pre-emptive war to keep threats from materializing, and torture, rendition and warrantless surveillance for the purpose of gathering information and preventing future harm. President Obama has rejected some, but not all, of these practices.

SVP laws that use civil commitment to incarcerate sexual predators before they strike represent a similar thrust in social policy. Predator laws make risk, rather than guilt, the basis for liberty deprivation (55). Preventing future sex offenses means that potential offenders have to be identified based on an expert's judgment of their dangerousness and the presence of a mental disorder. This determination gives rise to a new status, that of sexually dangerous mentally disordered person, and it provides the state with grounds for preventive detention, lifetime registration, residency requirements and community notification. Psychologists now confer the most feared status – "high risk" – on that cohort of sex offenders judged to be "violent predators."

In a culture of fear, risk assessment and preventive detention may become an ever widening obsession: "There is immense political pressure to translate risk knowledge into risk control….The safest course for politicians is to promote the notion of zero tolerance for risk, to expand preventive control to cover all degrees of risk, broadening the population being assessed and lowering the risk threshold for intervention" (55). Gradually, more individuals and types of behavior are monitored, so that the civil liberties of all citizens end up in jeopardy.

After identifying the potentially dangerous, SVP civil commitment laws allow the state to subject these individuals to a lesser standard of justice. American has a long and inglorious history of applying "outsider jurisprudence" to those who may be threatening because of their ideas, ethnicity, religion or gender, e.g., the anarchist, the communist, the Black, the Jew, the homosexual, and the terrorist. These out-groups have been violently attacked by vigilantes or law enforcement, given separate and unequal treatment, or unfairly prosecuted.

Most recently, "enemy combatants" are being subjected to an alternate but diminished system of justice in military tribunals, which the federal government created to circumvent the criminal courts. The predator laws also place the preventive detention of sex offenders outside the criminal justice system in the civil commitment arena, where the adjudicative process offers less constitutional protection to the accused (55).

For example, in many states the civil commitment of a sexual predator does not require guilt beyond a reasonable doubt, but less rigorous standards such as clear and convincing evidence or a preponderance of the evidence. One state allows into evidence in the civil commitment trial, testimony from the "victim" in a prior criminal trial, despite the fact that the defendant was found not guilty of the alleged sex offenses in the prior trial (70). Another state has ruled that sex offenders against whom petitions for civil commitment have been filed are not entitled to competency to stand trial evaluations (71).

American society has already become too Orwellian and the power of the state too monumental. Whether it be government or corporate inspired, surveillance is increasing as individual freedom is eroding. More and more areas of human conduct are being considered out of bounds and worthy of treatment or suppression. Predator laws, which make "risk" the new status to be monitored, reflect and reinforce a dangerous zeitgeist in society. The slope is slippery, and who is to say what group will be the next to be civilly committed?

CONCLUSIONS

Professional, scientific and ethical interests compel psychologists to oppose sexual predator laws. The mental disorders relied upon for civil commitment are pretexts (9, 11) and the actuarial formulae that predict risk status have problems that make them more prejudicial than probative. At this point, civil commitment of predators is the modern day equivalent of witch hunting.

With firsthand knowledge of the intractable assessment and treatment issues of civil commitment programs and the exorbitant costs of the SVP infrastructure, psychologists can argue for society to take a sweeping look at SVP programs and shift direction to more sensible strategies for protecting the public welfare. Psychologists should put the public interest ahead of their guild interest and expose this mistake in social policy. One dramatic step would be to resign from state SVP panels.

Professional opposition to SVP laws started with the APA's Task Force on Dangerous Sex Offenders, which warned that "…sexual predator commitment laws represent a serious assault on the integrity of psychiatry…" (72, p. 173). The most brazen assault was exposed by Zander's (9, 11) original research which revealed how a cadre of professionals surreptitiously brought back the damning diagnosis of paraphilia rape after the APA had formally rejected it.

Other leading researchers and clinicians such as Ewing (73, 74), Grisso and Tomkins (75), Grisso (38), and Campbell (22) argue that predicting dangerousness through actuarial instruments like those utilized in SVP evaluations has not achieved a level of scientific accuracy sufficient for making liberty determinations in a courtroom. Janus and Prentky (47) make the sensible point that preventive detention is legally and ethically problematic even with perfect knowledge about the future, but "…the imperfection of risk assessment exacerbates constitutional and ethical concerns because it raises the likelihood that non-recidivists and low risk individuals will be among the group suffering long term loss of liberty."

Yale psychiatrist Howard Zonana (76) expresses doubt that sex offender testimony is scientifically good enough, and cautions professionals about proffering "junk science" or "unethical testimony." Ward et al. (77) criticize forensic psychologists for focusing almost exclusively on issues pertaining to risk assessment and risk management rather than finding ways to support and rehabilitate sex offenders. Glaser (78) points out that psychologists in prison-based and outpatient parole treatment programs are required to systematically sabotage traditional ethics by protecting the welfare of the community ahead of the welfare of the offender.

Some of our colleagues believe that while the field pursues efforts to improve the quality of SVP assessment, they cannot turn away from the opportunities that SVP evaluations afford, "as long as society wants it done." For example, despite their concerns about diagnostic reliability, Montaldi (79), Wollert (80) and First and Halon (14) all provide guidance for more accurately diagnosing paraphilias and describe how the diagnosis can be appropriately used in SVP commitment hearings. We fundamentally disagree. Doing a better job at what we believe is inherently a "dirty job" is not worthy of our core ethical and professional commitment as members of a profession which purports to reduce human suffering and to promote human welfare.

In sum, psychologists who lend their services to state SVP panels are not only betraying the public interest and ignoring compelling professional concerns, they are acting on questionable ethics. That all these injustices and flaws exist in SVP laws and the treatment programs inspired by them, and that so many psychologists have nevertheless signed up as agents of the state, does not speak well for psychology as a profession. In the same way that psychologists should refuse to develop and participate in "enhanced interrogation" at Guantanamo and other "black site" detention centers, we call on our fellow professionals to extricate themselves from SVP programs.

REFERENCES FOLLOW AT END OF THIS EDITION (PAGES 13-16)

"Professional, scientific and ethical interests compel psychologists to oppose sexual predator laws. The mental disorders relied upon for civil commitment are pretexts (9, 11) and the actuarial formulae that predict risk status have problems that make them more prejudicial than probative. At this point, civil commitment of predators is the modern day equivalent of witch hunting."

Good Cause and Individualized Treatment

Submitted by: Cory Hoch

The following is a compilation of law that expounds on the definition or better describes the process known as "individualized treatment" that is a crucial element for conditions of confinement for any person who is civilly confined.

Edward v. Lamkins (App. 1 Dist. 2002) 122 Cal.Rptr.2d 1, 24, 99 Cal.App.4th 516, 545 (showing of good cause is in effect an individualized showing of exigent circumstances in a particular case and a blanket statement of reasons offered as a matter of routine policy does not constitute good cause)

Norman v. Unemployment Ins. Appeals Bd. (Cal. 1983) 34 Cal.3d 1, 11-12, 192 Cal.Rptr. 134, 141 (term "good cause" is the kind of broad, open-ended language that the Legislature uses when it foregoes making specific rules in favor of individualized, case-by-case consideration)

Employment Div., Dept. of Human Resources of Oregon v. Smith (1990) 494 US 872, 110 S.Ct. 1595, 1603 ("good cause" standard created a mechanism for individualized exemptions)

W&IC § 5326 ("The professional person in charge of the facility or his or her designee may, for good cause,, deny a person any of the rights under Section 5325, except under subdivisions (g) and (h) and the rights under subdivision (f) may be denied only under the conditions specified in Section 5326.7. To ensure that these rights are denied only for good cause, the Director of Mental Health shall adopt regulations specifying the conditions under which they may be denied. Denial of a person's rights shall in all cases be entered into the person's treatment record.")

W&IC § 5327 ("Every person involuntarily detained under provisions of this part or under certification for intensive treatment or postcertification treatment in any public or private mental institution or hospital, including a conservatee placed in any medical, psychiatric or nursing facility, shall be entitled to all rights set forth in this part and shall retain all rights not specifically denied him under this part.

9 CCR § 881(w) ("'Safety' means protection of persons and property from potential danger, risk, injury, harm or damage.")

9 CCR § 881(x) ("'Security' means the measures necessary to achieve the management and accountability of patients of the facility, staff, and visitors, as well as property of the facility.")

9 CCR § 884(c) ("The rights specified in Subsection (b) of this Section shall be denied only for good cause. Good cause for denying a patient the exercise of a right exists when a facility director determines that: (1) The exercise of the specific right would be injurious to the patient; or (2) There is evidence that the specific right, if exercised, would seriously infringe on the rights of others; or (3) The facility would suffer serious damage if the specific right is not denied; or (4) The exercise of the right would compromise the safety and security of the facility and/or the safety of others; and (5) That there is no less restrictive way of protecting the interests specified in Subsections (c)(1) through (4) of this Section.")

9 CCR § 884(d) ("The reason for denial of a right under this Section must be related to the specific right denied. A right specified in this Section shall not be withheld or denied as a punitive measure, nor shall a right specified in this Section be considered a privilege to be earned. A denial of a right shall not exceed thirty days without additional staff review. Treatment plans shall not include denial of any right specified in Subsection (b) of this Section.")

22 CCR §§ 71507(b) (rights may be denied except for those specified in subsection (7) and (9), whereas subsection (9) addresses all other rights as provided by law or regulation)

22 CCR § 73523(b) (patients' rights may only be denied or limited if such denial or limitation is otherwise authorized by law)

DMH Special Order 254.01, Section V-VI ("Good cause for the denial of a right exists when the Executive Director or designee has good reason to believe that: A. The exercise of the specific right would be injurious to the patient; or B. There is evidence that the specific right, if exercised would seriously infringe on the rights of others; or C. The state hospital would suffer serious damage if the specific right is not denied; D. The exercise of the right would compromise the safety and security of the facility and/or the safety of others; **and** E. There is no less restrictive way of protecting the interests specified in (A), (B) or (C). **VI. Criteria for All Good Cause Denials (all patients)** A. The reason used to justify the denial of a patient's right must be related to the specific right denied. B. A right shall not be withheld or denied as a punitive measure, nor shall a patient's right be considered a privilege to be earned. C. A patient's right denial can only be done on an individual basis. Rights may never be denied as a part of a policy or unit practice. D. Treatment modalities shall not include the denial of any rights specified in this policy. Waivers signed by the patient or by the conservator shall not be used as a basis for denying these rights in any treatment modality. E. Waivers signed by the patient or by the responsible person, guardian or conservator are not legal and shall not be used as a basis for denying any "non-deniable" right or any "deniable" right unless specifically granted by court order. F. Denial of a patient's right shall be done in the least restrictive manner. G. The patient must be informed of the reason why the right was denied, how long the right will be denied, and what action/behavior is necessary to have the right restored. H. If a patient is in seclusion and/or restraint, a denial of right(s) only occurs when the patient requests to exercise one or more rights and good cause exists for the denial.")

CSH Administrative Directive No. 604, Patient's Rights Advocacy Program, Sections IV.A-B and E ("The Executive Director or designee (Program Director or Program Officer of the Day (POD)) may for "good cause" deny an Individual any of the statutory rights listed in

Continues on Page 11

Good Cause and Individualized Treatment—Continues from Page 10

Section V, upon recommendations from the Individual's Interdisciplinary Team. The team must include the psychiatrist responsible for the Individual's treatment program…In emergencies, a right may be denied immediately by treatment staff; however, approval for continuation of the denial of a right shall be obtained as soon as possible or no longer than twenty-four (24) hours after the emergency action. A copy of all completed Denial of Rights forms shall be submitted to the Standards Compliance Department. **A.** Definition of "Good Cause" for Denial of Rights: "Good cause" for denying an Individual the exercise of a right exists when the Executive Director or designee has good reason to believe that: (1) The exercise of the specific right would be injurious to the Individual. (2) There is evidence that the specific right, if exercised, would seriously infringe on the rights of others. (3) The institution would suffer serious damage if the specific right isn't denied. (4) There is no less restrictive way of protecting the interests specified above. **B. Limitations on "Good Cause" Denial of Rights:** (1) The reason used to justify denying a right must be directly related to the specific right denied. A right shall not be withheld or denied as a punitive measure. A right shall not be considered as a privilege that is to be earned. A right cannot be denied as part of a treatment plan. (2) When a denial is in effect, a treatment plan must be instituted to assist the Individual in restoration of his rights…**E. Restoration of Rights:** Individuals' rights shall not continue to be denied when "good cause" for the denial no longer exists. When a right has been denied, staff shall employ the least restrictive means of managing the issues that led to the denial. Restrictions of Individuals' communication (visits, telephone calls, correspondence) shall be evaluated daily by unit staff and should be reviewed formally by the Interdisciplinary Team at least every seven (7) days. All other rights shall be formally reviewed every thirty (30) days. The Individual shall be informed of both the denial and the restoration of his right (s).

Additionally, the following should be noted:

Porter v. Superior Court (6th Dist. 2007) 56 Cal.Rptr.3d 240, 254, 148 Cal.App.4th 889, 909 (effective waiver of constitutional rights means it must not only be voluntary but also knowing, intelligent acts done with sufficient awareness of the relevant circumstances and likely consequences); **Burton v. Terrell** (5th Cir. 2009) 576 F.3d 268, 271 (same); **U.S. v. Ramirez** (9th Cir. 2003) 347 F.3d 792, 799 (same); **Sailer v. Gunn** (C.D.Cal. 1974) 387 F.Supp. 1367, 1372 (same)

In re Rosenkrantz (Cal. 2002) 128 Cal.Rptr.2d 104, 162, 29 Cal.4th 616, 59 P.3d 174, cert. den., 123 S.Ct. 1808, 538 U.S. 980, 155 L.Ed.2d 669, citing **In re Minnis**, 7 Cal.3d at p. 647, 102 Cal.Rptr. 639, 749, 498 P.2d 997 ("It is well established that a policy of rejecting parole solely on the basis of the type of offense, without individualized treatment and due consideration, deprives an inmate of due process of law."); **In re Lawrence** (Cal. 2008) 82 Cal.Rptr.3d 169, 44 Cal.4th 1181, 190 P.3d 535 (same)

Seling v. Young (2001) 531 U.S. 250, 121 S.Ct. 727, 729 (SVPs have a right to adequate care and individualized treatment)

Foy v. Greenblott (1st Dist. 1983) 190 Cal.Rptr. 84, 90 fn. 2, 141 Cal.App.3d 1 ("Congress has also declared that all state mental health programs should provide treatment in the least restrictive environment. (Mental Health Systems Act, 42 U.S.C. § 9501, subd. (1)(A), (F), (G), (J).) Numerous courts have found a federal constitutional right to the least restrictive conditions of institutional treatment. (See **Wyatt v. Stickney** (M.D.Ala. 1972) 344 F.Supp. 373, aff'd sub. Nom., **Wyatt v. Aderholt** (5th Cir. 1974) 503 F.2d 1305; **Davis v. Balson** (N.D.Ohio 1978) 461 F.Supp. 842; **Gary W. v. State of La.** (E.D.La. 1976) 437 F.Supp. 1209.) The Supreme Court has stated that "reasonably non-restrictive confinement conditions" are constitutionally mandated. (**Youngberg v. Romeo**, supra, --US--, --, 102 S.Ct. 2452, 2463, 73 L.Ed.2d 28.)

Implementing the Right to Treatment

Submitted by: Larry Lowe

The following is an interesting excerpt out of **People v. Feagley** (Cal. 1975) 14 Cal.3d 338, 121 Cal.Rptr. 509, 525 fn. 19:

The uncertainty in the typical statutory definition and finding of dangerousness sufficient to warrant 'involuntary civil commitment' is tolerated on the rationalization that the person is not being imprisoned, but rather hospitalized for treatment. Of course when no treatment is forthcoming, we cluck sympathetically, but reluctantly refuse to release the individual because he is dangerous. This chicanery is intolerable. Courts cannot force legislators to provide adequate resources for treatment. But neither should they play handmaiden to the social hypocrisy which rationalizes confinement by a false premise of treatment. Quite the contrary, courts should, and must, reveal to society the reality that often festers behind the euphemism of hospitalization.

10 BEST JOBS of the future:

Human/Robot Interaction Specialist

JOB: Help robots and people get a long. HIRING: 2030

TREND: Robot nurses won't help Grandpa much if they don't understand his sarcasm. We'll need savvy workers making-and-remaking 'bots to ensure that they operate seamlessly in our world. And we'll require help coping in theirs. As droids lure people away from real human contact, expect a demand for specialized therapists to boost people's social and robotic-al skill.

EDUCATION: Schools strong in artificial intelligence, such as MIT, Carnegie Mellon University and Stanford University.

Written By: Ben Paynter / Popular Science

GUIDELINES FOR PUBLICATION IN *THE INSIDER ONLINE*

All submissions to The Insider Online are subject to editing for proper grammar, punctuation, length, language, and clarity. They may not include hate-speech, inciting or inflammatory language, or unnecessary profanity. Submissions may be returned to the individual author for revision or rejected outright.

The Insider Online is produced at Coalinga State Hospital, in Coalinga, California. Material published in this electronic paper is written, edited, and published entirely by hospital residents without input or editing by staff.

The ideas and opinions expressed herein do not reflect the opinions of the hospital's staff or its administration, unless otherwise noted.

The Insider, in all its forms, is dedicated to fair, unbiased and impartial reporting of information, current events and news that is of interest to civil detainees and others who are interested in finding out about the real people here. Any questions and correspondence can be submitted by mail to:

THE INSIDER

VOICES OF CALIFORNIA'S CIVIL DETAINEES, COALINGA STATE HOSPITAL

THE INSIDER ONLINE

The Insider Outreach

Voices of California's Civil Detainees, Coalinga State Hospital

THE INSIDER

P.O. Box 5003
Coalinga, CA 93210
c/o William Hester / Unit 4

Phone: (559) 934-0137
(559) 934-1837

The Insider Online

Let us remember all those who have fallen since the beginning of this law and pray that they now know the freedom that was denied them in life...

Robert Cloverdance; Carl Coleman; Jim Davis; Don Lockett; David Stansberry; Charles Rogers; Larry Goddard; Ed Samradi; Dean Danforth; Craig Rauwens; Wayne Graybeal; Donald Hughes; Lloyd Johnson; Robert Alperin; Tim McClanahan; Patrick Brim; Wayne Porter; Cash O'Doyd; Elmer Bock; Dave Gonick; Jose Vlahoitis; Corwin Weltey; Ross Washington; Richard Bishop; Alton Robinson; Robert Canfield; Jerry Sanchez; Gerald Brooks; James Aceves; Frank Valadao; Donovan Myrick; Paul Real; Paul Pedersen; Kenneth Edmonton; Jimmy Guthrie; James Rosenberg; Charles Grecien; David Harney; James Wallace; Jare Stevens; John Martinez; Delbert Smith; Dennis Boyer; Ruben Garcia; Wilbur Perryman; David Montgomery; William Laughlin; Richard Garcia; Francs Hansen; Steve Mendoza; Robert Berry; Ramon Malbrough; Vernon Madden; Victor "Weasel" Segovia; and John "Colonel" Norman (May 22, 2011)

THE TROUBLING ROLE OF PSYCHOLOGISTS IN SEXUAL PREDATOR LAWS—Continues from Page 9

REFERENCES

1. Hoffer P: The Devil's Disciples: Makers of the Salem Witchcraft Trials. Baltimore, MD, The Johns Hopkins University Press, 1996

2. Halon, R: The demise of psychology in SVP commitment trials: smoke and mirrors. Presentation at 22nd Annual Symposium of the American College of Forensic Psychology, San Francisco, CA, 2006

3. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (4th Ed., Text Revision). Washington, DC, Author, 2000

4. Prentky R, Coward A, Gabriel A: Muddy diagnostic waters in the SVP courtroom. Journal of the American Academy of Psychiatry and Law 2008; 36: 4:455-458

5. O'Donohue W, Gree J (eds.): Handbook of the Assessment and Treatment of the Sexual Dysfunctions. New York, Allyn and Bacon, 1993

6. Frances A. Sreenivason S, Weinberger L: Defining mental disorder when it really counts: DSM-IV-TR and SVP/SDP statutes. Journal of the American Academy of Psychiatry and Law 2008; 36: 3:375-384

7. First M, Frances A: Issues for DSM-V: unintended consequences of small changes: the case of paraphilias. American Journal of Psychiatry 2008; 165:10

8. In re Davenport, No. 99-2-50349-2 (December 11, 2006) Deposition of M. First

9. Zander T: Civil commitment without psychosis: the law's release on the weakest links in psychodiagnosis. Journal of Sexual Offender Civil Commitment. Science and the Law 2005; I:17-82

10. Abel G: Paraphilias, in Comprehensive Textbook of Psychiatry. Edited by Kaplan H, Sadock B. Baltimore, MD, Williams and Wilkins, 1989

11. Zander T: Commentary: inventing diagnosis for civil commitment of rapists. Journal of the American Academy of Psychiatry and the Law 2008; 36:4:459-469

12. Doren DM: Evaluating Sex Offenders: A Manual for Civil Commitments and Beyond. Thousand Oaks, CA, Sage, 2002

13. O'Donohue W, Regev LG, Hagstrom A: Problems with the DSM-IV diagnosis of pedophilia. Sexual Abuse: A Journal of Research and Treatment 2000; 12:95-105

14. First M, Halon R: Use of DSM paraphilia diagnoses in sexually violent predator commitment cases. Journal of the American Academy of Psychiatry and the Law 2008; 36:443-454

15. Moser C, Kleinplatz PJ: DSM-IV-TR and the paraphilia: an argument for removal. Journal of Psychology and Human Sexuality 2005; 17:3/4:91-109

16. Quinsey V, Harris G, Rice M, Cormier C: Violent Offenders: Appraising and Managing Risk. Washington, DC, American Psychological Association, 1998

17. Hanson K: The Development of a Brief Actuarial Risk Scale for Sexual Offense Recidivism. (User report 97-04) Ottawa, Department of the Solicitor General of Canada, 1997

18. Epperson D, Kaul J, Huot S, Goldman R, Alexander W: Minnesota sex offender screening tool-revised (MnSOST-R): development, validation, and recommended risk level cut scores, 2003,http://www.psychology.iastate.edu/faculty/Epperson/TechUpdatePaper12-03.pdf

19. Hanson R, Thornton D: Static 99: Improving Actuarial Risk Assessment for Sex Offenders (User Report No.99-02) Ottawa, Department of the Solicitor General Canada, 1999; Notes on development of Static 2002 (Use Report No. 2003-01) Ottawa, Department of the Solicitor General Canada, 2003

20. Prentky R, Lee A: Effect of age-at-release on longer term sexual re-offense rates in civilly committed sexual offenders. Sexual Abuse: A Journal of Research and Treatment 2007; 19:1:43-59

21. Miller H, Amenta A, Conroy M: Sexually violent predator evaluations: empirical evidence, strategies for professional, and research directions. Law and Human Behavior 2005; 29:29-54

22. Campbell T: Assessing Sex Offenders: Problems and Pitfalls. Springfield, IL, Charles Thomas, 2004

23. Rogers R: The uncritical acceptance of risk acceptance in forensic practice. Law and Human Behavior 2000; 24:595-605

24. Hanson K: What do we know about sex offender risk assessment? Psychology, Public Policy and Law 1998; 4:1/2:50-72

25. Hanson K, Bussiere M: Predicting relapse: a meta-analysis of sex offender recidivism studies. Journal of Consulting & Clinical Psychology 1998; 66:348-362

26. Hanson K, Morton-Bourgon K: Prediction of Sexual Recidivism: An Updated Meta-analysis (Report No. 2004-02). Ottawa, Ministry of Public Safety and Emergency Preparedness of Canada, 2004

27. Donaldson T: Accuracy of predictive instruments. Presentation at the SVP Defense Practice Seminar, April 21, 2001

28. Hanson K, Morton-Bourgon K: The accuracy of recidivism risk assessments for sexual offenders: a meta-analysis of 118 prediction studies. Psychological Assessment 2009; 21:1:1-21

29. Murrie D, Boccaccini M, Johnson J, Janke C: Does interrater (dis)agreement on Psychopathy Checklist scores in sexually violent predator trials suggest partisan allegiance in forensic evaluations? Law and Human Behavior 2008; 32:352-362

30. Vrieze S, Grove W: Predicting sex offender recidivism. I. Correcting for item-overselection and accuracy overestimation in scale development. II. Sampling error-induced attenuation of predictive validity over base rate information. Law and Human Behavior 2008; 32:3:266-278

31. Donaldson T: Prediction instrument accuracy: or everything you wanted to know about ROC curves. Unpublished manuscript, 2003

32. Amenta A, Guy L, Edens J: Sex offender risk assessment: a cautionary note regarding measures attempting to quantify violence risk. Journal of Forensic Psychology 2003; 3:39-50

33. Berlin F, Galbreath N, Geary B, McGlone G: The use of actuarials at civil commitment hearings to predict the likelihood of future sexual violence. Sexual Abuse: A Journal of Research and Treatment 2003; 15:377-382

34. Sjostedt G, Grann M: Risk assessment: what is being predicted by actuarial instruments? International Journal of Forensic Mental Health 2002; 1:179-183

35. Barbaree H: Evaluating treatment of efficacy with sexual offenders: the insensitivity of recidivism studies to treatment effects. Sexual Abuse: A Journal of Research and Treatment, 1997; 9:11-128

36. Helmus L, Hanson K, Thornton D: Reporting Static-99 in light of new research on recidivism norms. ATSA Forum 2009; 21:1: Winter

37. Abracen J, Loorman J: Evaluation of civil commitment criteria in a high risk sample of sexual offenders. Journal of Sexual Offender Civil Commitment Science and the Law 2006; 1:124-140

38. Grisso T: Ethical issues in evaluations for sex offender re-offending. Paper presented at the Symposium on Sex Offender Re-Offense Risk Prediction, Sinclair Seminars, Madison, WI, 2000

39. Koehler J: The base rate fallacy reconsidered: descriptive, normative and methodological challenges. Behavioral and Brain Science 1996; 19:1-53

40. Abbot B: Applicability of the new Static-99 experience tables in sexually violent predator risk assessments. Sex Offender Treatment 2009; 4:1

41. Prentky R, Janus E, Barbaree H, Schwartz B, Kafka M: Sexually violent predators in the courtroom: science on trial. William Mitchell College of Law: Legal Studies Research Paper Series No. 50, 2006 http://ssrn.com/abstract=937010

42. Woolert r: Low base rates limit expert certainty when current actuarials are used to identify sexually violent predators: an application of Baye's theorem. Psychology, Public Policy, and Law 2006; 12:1:56-85

43. Waggoner R, Wollert R, Cramer E: A respecification of Hanson's updated Static-99 experience table that controls for the effects of age on sexual recidivism among young offenders. Law, Probability and Risk 2008; 7:305-312

44. Abbott B: The role of local base rate information in determining accuracy of sexual recidivism actuarial instruments. Perspectives 2008; Fall:1,11,12

45. Mossman D: Analyzing the performance of risk assessment instruments: a response to Vrieze and Grove (2007). Law & Human Behavior 2008; 32:279-291

46. Bengston S, Langstrom N: Unguided clinical and actuarial assessment of reoffending risk: a direct comparison with sex offenders in Denmark. Sexual Abuse: A Journal of Research and Treatment 2007; 19:135-153

47. Janus E, Prentky R: Forensic use of actuarial risk assessment with sex offenders: accuracy, admissibility and accountability. American Criminal Law and Review 2003; 40:1443-1499

48. Heilbrun K, Douglas K, Yasuhara K: Violence risk assessment: core controversies, in Psychological Science in the Courtroom: Consensus and Controversy. Edited by Skeem J, Douglas K, Lilienfeld S. New York, Guilford Press, 2009

49. Hart S, Michie C, Ciijem D: The precision of actuarial risk assessment instruments: evaluating the "margins of error" of group versus individual predictions of violence. British Journal of Psychiatry 2007; 190:S60-S65

50. Litwack T: Actuarial versus clinical assessments of dangerousness. Psychology, Public Policy, and the Law 2001; 7:409-443

51. Sjostedt G, Langstrom N: Actuarial assessment of sex offender recidivism risk: a cross validation of the RRASOR and the Static-99 in Sweden. Law and Human Behavior 2001; 25:629-645

52. Davey M, Goodnough A: Doubts rise as states hold sex offenders after prison: costly efforts keep ex-convicts off streets, but mandated treatment often fails. New York Times, March 4, 2007; I,18,19

53. Sterling R: Personal communication, December 13, 2008

54. Linehan M: Cognitive-Behavioral Treatment of Borderline Personality Disorder. New York, Guilford Press, 1993

55. Janus E: Failure to Protect: America's Sexual Predator Laws and the Rise of the Preventive State. Ithaca, NY, Cornell University Press, 2006

56. Piller C, Romney L: State pays millions for contract psychologists to keep up with Jessica's Law. Los Angeles Times, August 10, 2008, www.latimes.com

57. Analysis by the Legislative Analyst: Proposition 83: Sex Offenders. Sexually violent persons. Punishment, residence restrictions and monitoring. Initiative statute, 2006, www.lao.ca.gov/ballot/2006/83_11_2006.htm

58. Hennessy V: Big bucks to house sex offender. Monterey Herald, May 25, 2008

59. Vick K: Laws to track sex offenders encouraging homelessness. December 27, 2008; A03, www.washingtonpost.com

60. Yung C: The emerging criminal war on sex offenders, 2009, http://ssrn.com/abstract=1456042

61. Wakefield H: The vilification of sex offenders: does it increase recidivism? Presentation at the 22nd Annual symposium of the American College of Forensic Psychology, San Francisco, CA, 2006

62. Keen S: Faces of the Enemy: Reflections of the Hostile Imagination. New York, HarperCollins, 1986

63. Strong M: Monsters in our midst. San Francisco Focus 1996; 63-74

64. Douard J: Loathing the sinner, medicalizing the sin: why sexually violent predator statutes are unjust. Intnl Journal of Law & Psychiatry 2007; 30:36-48

65. Cohen S: Folk Devils and Moral Panics (3rd Ed.). New York, Routledge, 1972

66. Gallup Poll, June 9, 2005. www.gallup.com/video/16708/sex-offender.aspx

67. Matthews C: Hardball, September 2, 2009

68. Sheindlin Judge Judy: Appearing on Larry King Live, September 8, 2009

69. Fortney T, Levenson J, Brannon Y, Baker J: Myths and facts about sexual offenders: implications for treatment and public policy. Sexual Offender Treatment 2007; 2:1:1-15

70. Ellison v. Commonwealth of Virginia, 639 S.E. 2d 209 2007

71. Wisconsin v. Luttrell, Court of Appeals, District 1, No. 2007AP1840, May 20, 2008

72. American Psychiatric Association: Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association, Washington, DC, Author, 1999

73. Ewing C: Dr. Death and the case for an ethical ban on psychology and psychological prediction of dangerousness in capital sentencing proceedings. American Journal of Law & Medicine 1983; 8:407-428

74. Ewing C: Preventive detention and execution: the constitutionality of punishing future crimes. Law and Human Behavior 1991; 15:139-163

75. Grisso T, Tomkins A: Communicating violence risk assessments. American Psychologist 1996; 51:928-930

76. Zonana H: Sex offender testimony: junk science or unethical testimony. Journal of American Academy of Psychiatry and Law 2000; 28:386-388

77. Ward T, Gannon T, Birgden A: Human rights and the treatment of sex offenders. Sexual Abuse: A Journal of Research and Treatment 2007; 19:195-216

78. Glaser B: Therapeutic jurisprudence: an ethical paradigm for sex offender treatment programs. Western Criminal Review 2003; 4:2:143-154

79. Montaldi D: The logic of sexually violent predator status in the United States of America. Sexual Offender Treatment 2007; 2:1-28

80. Wollert R: Poor diagnostic reliability, the Null-Bayes Logic Model and their implications for sexually violent predator evaluations. Psychology, Public Policy and the Law 2007; 13:3:167-203

81. Cooke D: More prejudicial than probative? The Journal Online, January 18, 2010, http://www.journalonline.co.uk/legals

82. Lacombe D: Consumed by sex: the treatment of sex offenders in risk society. The British Journal of Criminology 2008; 48:55-74

ABOUT THE AUTHORS

Paul Good, Ph.D.

Clinical and Forensic Psychologist in private practice, San Francisco, CA
Adjunct Professor of Psychiatry, University of California at San Francisco

Jules Burstein, Ph.D.

Clinical and Forensic Psychologist in private practice, Berkeley, CA
Adjunct faculty member, Wright Institute, Berkeley, CA
Member: Superior Court Panel of Psychologists