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Testimony
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House Bill 1717 and House Bill 1718
Evaluation of Sexual Offenders for Hormonal Treatment

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House Bills 1717 and 1718, Court ordered evaluation of sex offenders for chemical treatment, represent the contemporary attempts by lawmakers, treatment agents, and researchers to address the ongoing social, behavioral and criminal problems associated with predatory sexual assault. Because sexual predators are family members, clergy, physicians, dentists, teachers, judges, police officers, community leaders as well as those disenfranchised individuals whose transient lifestyle facilitate escape from apprehension, the problem of recidivism appear intractable.

Sexual psychopath laws can be formally traced to the 1930s in the United States and well before that in Europe. The frustrating consequences of numerous and varied attempts are reflected in these hearings. The goal of these hearings is the enactment of proactive legislation which prevents offenders from committing new crimes. Sexual predatory behavior induces panic in our families, our schools and our workplace. For purposes of the testimony, I will limit myself to a discussion of paraphilia, sexual predatory behaviors requiring obsessive-compulsive dependence on unusual stimuli, physical or fantasy in order to achieve and maintain sexual arousal and/or orgasm. The object of this predatory behavior is a non-consenting person, animal, or non-human object.

Exhibitionists, stalkers, pedophiles, rapists, voyeurs and sadistic lust serial killers are paraphiliacs. Because of the secrecy required of sexual predators, the apprehension,

prosecution and sentencing of these offenders must reflect an educated and comprehensive realization of the causes of the behavior, the repetitiveness of the behavior, and the resistance of the behavior to change. When faced with incarceration, the promise to radically change behavior is easily uttered and almost impossible to assess.

If this legislation passes, the important issues from my perspective rests with the following:

1. How is this classification determined?
2. What determines eligibility for this treatment?
3. What will the protocol be for those individuals offered a plea by the prosecutor's office to a non-sexual offense?

Plea bargains might exempt a predatory sexual offender from appropriate and necessary evaluation and treatment. Further, because of the opportunity offered by drugs that suppress aberrant sexual behavior, sexual offenders can readily offer to plead guilty to a sexual offense because/as long as treatment and community supervision are the sentence. I will answer these questions based upon my experience investigating, supervising, and facilitating treatment of these offenders. This experience has been coupled with research, teaching and publishing in the area of predatory behaviors.

<u>Eligibility for Treatment</u>

Those eligible for treatment according to these bills require a conviction under 18 PA.C.S. Ch. 31 (relating to sexual offenses).

While these two scenarios reflect the mechanics of plea bargaining, they do not reflect the offender's amenability to treatment or critical analysis for potential recidivism.

Eligibility for treatment needs to be based upon the motivation of the offender, a variety of treatment modalities, availability of effective supervision, results of personality and psychiatric evaluations, a medical evaluation, and prior criminal behavior. If the offender has exhibited violence, torture or anomie coupled with substance abuse and a transient lifestyle, the offender remains a serious risk to the community.

Thus, the sex offender who is intelligent, verbal and is willing to learn how to control his behavior may be most amenable to treatment. Often this willingness extends to the use of hormonal treatment coupled with behavioral-cognitive treatment. Behavioral-cognitive treatment includes group therapy, individual therapy, courses on sex education, human sexuality, social skills development, conflict management, stress management and anger management.

The incestual father or step-parent is often considered a good risk for hormonal treatment. However, caution must be used to investigate extensively the background of a step-parent or significant other as single-headed households offer pedophiles ready-made victims. These offenders are not incestual in nature but are coldly calculating how to engage in satisfying their obsession and compulsion to engage in sexual activity with children. Further, these predatory offenders may be violent and

enjoy the pain they cause their victims.

Amenability to Treatment

An appropriate designation as "amenable to treatment" benefits the community as it saves money and is far more reasonable than imprisonment with or without treatment. Further, it decreases the risk posed by predatory sexual offenders.

Analogous to the jail house conversions, most sex offenders agree to treatment if faced with imprisonment. Sex offenders agree to treatment if they are imprisoned in an therapeutic environment where potential for their physical and sexual abuse is not just deserts for their criminality. This is important as the environment surrounding the staff, the gender of the staff, the training, and the expectations of the treatment plan are enacted in a therapeutic environment. I fully believe that a dedicated location for these individuals maximizes the effectiveness of the treatment and the on-going evaluation process necessary to make a parole determination. Further, I believe that a dedicated location can also be used to evaluate and assimilate those ultimately released on probation or parole into a prescribed course of treatment.

Hormonal treatment does not "cure" the offender unless coupled with an introductory course of behavioral-cognitive treatments that address and answer associated questions. This treatment milieu offers the highest statistical success according to the literature and what I experienced with my caseload.

Allowing for a period of institutional assessment, appropriate sexual behaviors can be introduced and initiated, and aberrant sexual behaviors can be renounced. Dr. Berlin and Dr. Able are two individuals who offered me direction when I was responsible for these predators.

The use of hormonal treatment facilitates a period of decreased testosterone for the offender that facilitates the awareness of the deviant obsession, its repercussions, and the need to control it. Other side effects include fatigue, gallstones, cold sweats, nightmares, migraine headaches, weight gain, muscle weakness, hypertension, and diabetes for those who are prone to diabetes. While hormonal treatment allows for consensual sex with an appropriate partner, some offenders have difficulty with spontaneous erections or ejaculations. Sexual dysfunction poses a risk to the success of the treatment if on-going treatment supervision is not maintained. Depression, frustration and anger may result if ample opportunity is not provided to talk out the emotional turmoil and adjust hormonal dosage if necessary.

If anger was commensurate with the previous predatory behavior, then it is very possible that the steps involved in hormonal treatment, the therapeutic results of the hormonal treatment, and accompanying group or individual therapy may not deter the offender from recidivating.

Two issues must be considered for the protection of the community. If anger accompanied the predatory sexual behavior,

if the offender exhibited antisocial personality traits, and if the offender trawled for the opportunity to violently assault another victim, then an intramuscular injection of hormones is not going to stop him. Further, if the anger is associated with a past of displacing the blame for the assault on the victim or circumstances, the inability to maintain a spontaneous erection or experience an ejaculation may result in resorting to instrumental rape. If the fantasy is about sexually torturing or abusing a victim as a means of overcoming the anger, there is a high risk that this person may resort to this type of rape.

Other forms of treatment include the use of anti-depressants to control the compulsiveness of some sexual behaviors. In the years I supervised a caseload, I found this to be less than effective.

Beyond behavioral-cognitive therapy and hormonal treatment, some behavioral treatments and education were effective when incorporated into a complex and thorough treatment regime. Masturbation to inappropriate stimuli, measurement of arousal to inappropriate stimuli couple with aversion therapy offered one avenue of treatment. The aversion therapy routinely now used is the shooting of ammonia spray into the nostrils and immediate deconstruction of what was occurring with the offender's fantasies and why the ammonia was needed. By itself, such behavioral treatments are shown to be ineffective statically.

While research touts group therapy as one of the most effective treatments, the long-term results are less than

satisfying. In the groups that I watched versus the groups that I facilitated, those run solely by offenders appeared to be an arena where the one who "says the right thing and is feeling the most" is the best rather than the offender internalizing the issues. Groups that have a facilitator and guest facilitators challenge the offenders and allow their comfort level to be challenged. I believe that this is very important because, once an offender is comfortable with their control of sexually predatory behavior, they are going to recidivate. It is a consistent struggle to be aware and in control.

Educational training in human sexuality and relationship development should be offered along with dating techniques and life skill management. Included in this educational training is the realization that in order to prevent relapse, the offender will have to be released into the community in a slow and deliberate manner that reduces the risk of recidivism. A commitment to the process of transition must be sustained. (It should be noted that general recidivism for parole is often associated with minimal or no transition.) Further, the offender returns to the physical areas where the sexual fantasies were developed, rehearsed, and enacted upon. I recall one multiple rapist who remained incident free as long as he remained in Tennessee under the supervision of Dr. Able's program. Once he returned to the city where he had committed several rapes, he returned to trawling outside of hospitals looking for nurses and in parking lots looking for young high schoolers.

This is my last concern. Eligibility for treatment and amenability to treatment should not be dependent on the socio-economic status of the individual, their race, their gender or their ability to pay for private counsel. If offenders can pay, then they should be expected to pay but if not, the same opportunity for treatment should be afforded those with minimal financial means.

Conclusion

I do not believe that hormonal treatment violates any constitutional rights as long as the offender is fully informed and is receiving the full span of treatment. Less than 3 percent of our cases engaged in treatment with what we determined to be issues of self-interest. Hormonal treatment of sexual predators is not a panacea. Initially, most of the offenders sought out the treatment because they thought it might help, they thought they could successfully engage in it, or they thought it was a better alternative than incarceration. When they elected to withdraw from treatment and the courts allowed them to remain in community supervision, our expertise in understanding and evaluating these types of offenders was tested.

I believe in specialized training of correctional personnel who are appropriate for this type of offender. I also implore you to include a strong statement that, if a sexual offender is in treatment within an institution or as a condition of community release, confidentiality does not apply. All too often the therapeutic agents would withhold poor progress in treatment,

hoping to regain the attention and commitment of the offender. This cannot be tolerated.

I also believe that there must be a community, therapeutic and academic commitment to providing expertise and services to address this issue. This cannot be accomplished without mandating training of appropriate personnel and requiring already trained personnel to share their expertise.

Considering the number of academic institutions, the milieu of treatment specialties required to address the sexual predator, the therapeutic professionals within the Commonwealth, and the risk and amelioration of some of that risk to the community, Bills 1717 and 1718 should be strongly considered.