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A PSYCHIATRIC PERSPECTIVE ON WASHINGTON'S SEXUALLY VIOLENT PREDATORS STATUTE

Robert M. Wettstein

Robert M. Wettstein, M.D.
Suite B103
401 Shady Avenue
Pittsburgh, PA 15206

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A Psychiatric Perspective on Washington's Sexually Violent Predators Statute

*Robert M. Wettstein, M.D.**

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* Co-Director, Law and Psychiatry Program, Western Psychiatric Institute and Clinic; Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, PA.

Robert M. Wettstein, M.D.
Suite B103
401 Shady Avenue
Pittsburgh, PA 15206

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I. INTRODUCTION

All societies attempt to define and manage deviant behavior. Social, economic, political, moral, religious, and medical elements contribute to the classification of abnormal from normal behavior.[1] Sexual behavior in particular has been difficult to categorize as normal or abnormal.[2] Sex offenders have been subject to differential or discriminatory disposition by many societies. They have been variously processed through the criminal justice system, the mental health system, or some specially designed hybrid system.[3] Society has struggled to determine whether they deserve treatment or punishment, perhaps even death, or a combination of both, or neither.[4]

These dilemmas are illustrated by the history of sexual psychopath statutes in the United States over the last half-century. [5] These statutes, and the specialized evaluation and treatment programs designed to implement them, proliferated rapidly but have now largely disappeared.[6] Massachusetts cur-

1. *See generally* Horacio Fabrega, Jr., *An Ethnomedical Perspective of Anglo-American Psychiatry*, 146 AM. J. PSYCHIATRY 588 (1989); Lewis M. King, *Social and Cultural Influences on Psychopathology*, 29 ANN. REV. PSYCHOL. 405 (1978); Sue V. Rosser, *Is There Androcentric Bias in Psychiatric Diagnosis?*, 17 J. MED. & PHIL. 215 (1992); THE DIVERSITY OF NORMAL BEHAVIOR (Daniel Offer & Melvin Sabshin eds., 1991).

2. *See generally* PAUL H. GEBHARD ET AL., SEX OFFENDERS: AN ANALYSIS OF TYPES (1965); BENJAMIN KARPMAN, THE SEXUAL OFFENDER AND HIS OFFENSES (1954); SEXUAL BEHAVIOR AND THE LAW (Ralph Slovenko ed., 1965); M. Ashley Ames & David A. Houston, *Legal, Social, and Biological Definitions of Pedophilia*, 19 ARCHIVES SEXUAL BEHAV. 333 (1990).

3. GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, PSYCHIATRY AND SEX PSYCHOPATH LEGISLATION: THE 30'S TO THE 80'S 845-52 (1977) [hereinafter PSYCHOPATH LEGISLATION].

4. A.M. McFarthing, *A Survey of the Social, Legal, Historical and "Psycho-Babble" Factors Leading to Sex Offenders Legislation in the Areas of British Common Law Heritage*, 9 MED. & L. 1278 (1990); Robert John Kosky, *Should Sex Offenders Be Treated?*, 23 AUSTL. & N.Z. J. PSYCHIATRY 176 (1989).

5. *See generally* PSYCHOPATH LEGISLATION, *supra* note 3.

6. As of 1991, 11 states and the District of Columbia had some form of sexual psychopath statute: COLO. REV. STAT. ANN. §§ 16-13-201 to -216 (West 1990 & Supp.

rently appears to be the most active in adjudicating and confining sexual psychopaths in institutional treatment programs.[7] The disuse or repeal of sexual psychopathy legislation in effect repudiates the premises of such legislation. These premises include: 1) sexual psychopaths can be reliably distinguished from other sex offenders; 2) sex offenders offend because of mental disorder or disease; 3) such mental disorders and diseases are curable; and 4) mental health clinicians can accurately predict which sex offenders will or will not offend over the long-term future.[8]

Against this retrenchment in sexual psychopathy legislation and practice, the State of Washington in 1990 enacted the Sexually Violent Predators statute, part of the larger Community Protection Act.[9] The statute defines a new legislative category of sex offenders as "sexually violent predators" and provides a scheme for their indefinite civil commitment in a secure facility.[10] However, no recent sexual offending, violence, or antisocial behavior is necessary to commit sexually violent predators. Commitment may be predicated upon distant past behavior, with or without criminal conviction for that behavior.[11] Commitment of sexually violent predators may occur before or after they are released from prison to the community.[12] Washington's Community Protection Act, however, significantly differs from the sexual psychopath statutes of the past. From a clinical perspective, perhaps the most significant

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1991); CONN. GEN. STAT. ANN. §§ 17a-566 to -567 (West Supp. 1992); D.C. CODE ANN. §§ 22-3501 to -3511 (1989 & Supp. 1991); ILL. ANN. STAT. ch. 38, para. 105-1.01 to -12 (Smith-Hurd 1980 & Supp. 1991); MASS. GEN. LAWS ANN. ch. 123A (West 1986 & Supp. 1992); MINN. STAT. ANN. §§ 526.09-.11 (West 1975 & Supp. 1992); NEB. REV. STAT. §§ 29-2911 to -2921 (1989); N.J. STAT. ANN. §§ 2C:47-1 to -7 (West 1982 & Supp. 1991); OR. REV. STAT. §§ 426.510, 426.650, 426.670, 426.675, 426.680 (Butterworth 1987 & Supp. 1990); TENN. CODE ANN. §§ 33-6-301 to -306 (1984 & Supp. 1991); UTAH CODE ANN. §§ 77-16-1 to -5 (1990); VA. CODE ANN. §§ 19.2-300 to -302 (Michie 1990).

7. S. Steven Yang, *Treatability of the Sex Offender: Considerations of Etiology, Pathology, and Treatment in Repealing Sexually Dangerous Offender Statutes*, 8 MED. & L. 319 (1989).

8. PSYCHOPATH LEGISLATION, *supra* note 3, at 861-67; *see also* Frederick J. Hacker & Marcel Frym, *The Sexual Psychopath Act in Practice: A Critical Discussion*, 43 CAL. L. REV. 766 (1955); Irving Prager, *Sexual Psychopathy and Child Molesters: The Experiment Fails*, 6 J. JUV. L. 49 (1982); David H. Guthman, *MDSO Law: The Assumptions Challenged*, 4 CRIM. JUST. J. 75 (1980); Vikke Henlie Sturgeon & John Taylor, *Report of a Five-Year Follow-Up Study of Mentally Disordered Sex Offenders Released from Atascadero State Hospital in 1973*, 4 CRIM. JUST. J. 31 (1980).

9. WASH. REV. CODE ch. 71.09 (Supp. 1990-91).

10. *Id.* §§ 71.09.020(1), 71.09.060.

11. *Id.* §§ 71.09.020-.030.

12. *Id.* § 71.09.030.

difference is that the statute provides for treatment of the sexual predator in addition and subsequent to completion of incarceration, rather than treatment as an alternative to incarceration.[13]

This Article will critique Washington's Community Protection Act from the perspective of a clinical and forensic psychiatrist.[14] Part II of the Article will address and examine problems with the statute's definitions and consider some of the problems in conducting evaluations of proposed sexual predators. Part III will then discuss some of the many difficulties inherent in providing treatment under the statute. Part IV will review the potential abuses, costs and risks to the participants presented by the statute. Finally, Part V will focus on the ethical issues in providing expert medical testimony pursuant to the statute.

II. DEFINITIONS AND EVALUATION

A further reflection of society's difficulty in understanding and conceptualizing sex offenders is presented by the various terminologies used to describe them. These terms include "sex offenders," "sexual psychopaths," "sexually dangerous persons," "mentally disordered sex offenders," "criminal sexual deviants," and under the Washington statute, "sexually violent predators."[15]

Sexual psychopathy and sexually violent predators are legal, not clinical terms.[16] As a result, difficulties arise when clinicians, administrators, policymakers, and the courts attempt to tailor clinical diagnoses or conditions into legal ones. The probable result is inconsistent overinclusiveness and underinclusiveness of the target population of sexually violent

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13. *Id.* § 71.09.060.

14. This Article will variously refer to the mental health professionals as clinicians, psychiatrists, psychologists, and to the professions as mental health, psychiatry, and psychology. Unless otherwise noted, I attach no differential significance to these terms in the present context.

15. "Sexual psychopath" is used in the District of Columbia, D.C. CODE ANN. §§ 22-3501 to -3511 (1989); "sexually dangerous persons" is used in Illinois, ILL. ANN. STAT. ch. 38, para. 105-1.01 to -12 (Smith-Hurd 1980 & Supp. 1991); "mentally disordered sex offender" was the designation in California, CAL. WELF. & INST. CODE §§ 6300-6330, *repealed by* 1981 Cal. Stat. ch. 928; "criminal sexual deviancy" was used in Indiana, IND. CODE ANN. §§ 35-11-3.1-1 to -37, *repealed by* 1978 Ind. Acts P.L. 2 § 3555, 1979 Ind. Acts P.L. 294 § 1.

16. PSYCHOPATH LEGISLATION, *supra* note 3 at 840; PAUL W. TAPPAN, THE HABITUAL SEX OFFENDER: REPORT AND RECOMMENDATIONS OF THE COMMISSION ON THE HABITUAL SEX OFFENDER 15 (1950).

predators. These problems are amply illustrated by the provisions of the Washington statute.

A. *Mental Abnormality*

The statute defines a "sexually violent predator" as a "person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence."[17] The statute further defines "mental abnormality" as a "congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to the commission of criminal sexual acts in a degree constituting such person a menace to the health and safety of others."[18] Apart from this statutory definition, I do not believe that it is possible for clinicians to operationally define "mental abnormality."

A great variety of psychiatric symptoms, cognitive deficits, social deficits, and histories have been reported to be characteristic of sex offenders.[19] These characteristics include denial and minimization of offending,[20] cognitive distortions about their victims,[21] impaired control of angry or sexual impulses, substance abuse, poor assertiveness and social skills,[22] absence of appropriate enjoyable activities, lack of sexual education, problems with intimacy,[23] previous sexual traumatization, as well as deviant sexual arousal and preferences. But most of these characteristics, which some clinicians might consider a "mental abnormality," are not unique to sex offenders and do not discriminate sex offenders from nonsex offenders. Undoubtedly, they do not discriminate sex offenders who are adjudicated to be sexual predators under the statute from

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17. WASH. REV. CODE § 71.09.020(1) (Supp. 1990-91).

18. *Id.* § 71.09.020(2).

19. *See* William L. Marshall & Anthony Eccles, *Issues in Clinical Practice with Sex Offenders*, 6 J. INTERPERSONAL VIOLENCE 68, 71-75 (1991).

20. H. G. Kennedy & D. H. Grubin, *Patterns of Denial in Sex Offenders*, 22 PSYCHOL. MED. 191 (1992); Richard I. Lanyon et al., *Detection of Deliberate Denial in Child Abusers*, 6 J. OF INTERPERSONAL VIOLENCE 301 (1991).

21. *See generally* Gene G. Abel et al., *The Measurement of the Cognitive Distortions of Child Molesters*, 2 ANNALS SEX RES. 135 (1989).

22. *See* Stanley L. Brodsky & Donald S. West, *Life-Skills Treatment of Sex Offenders*, 6 LAW & PSYCHOL. REV. 97, 103-06 (1981).

23. William L. Marshall, *Intimacy, Loneliness and Sexual Offenders*, 27 BEHAV. RES. & THERAPY 491 (1989).

those who are never petitioned or adjudicated, though this is an empirical question that remains to be verified.

Identifying certain characteristics of sex offenders does not establish the etiology of the behavior. It is typically not possible to determine the "cause" of sexual offending; most behavior, sexual or otherwise, is considered multiply determined.[24] Thus, the statutory requirement that a "condition . . . predisposes the person to the commission"[25] of an offense is scientifically difficult to fulfill. It could, therefore, be difficult for a clinician, evaluating a person alleged to be a sexually violent predator, to conclude that there is, or is not, a specific "mental abnormality."

Another danger is that "mental abnormality" will be established in a circular manner only by virtue of the sexual offending behavior itself. In that case, the abnormality is derived from the sexual behavior which in turn is used to establish the predisposition to other sexual behavior.[26]

"Mental abnormality" connotes sufficient vagueness that nearly any symptom, deficit, or historical detail might be included. "Mental abnormality" is much broader than any conceivable contemporary psychiatric diagnosis of mental disorder or mental illness. The definition is too broad and elastic to avoid improperly encompassing a wide variety of individuals, resulting in indeterminate incarceration. Given the vagueness of the definition, there cannot be adequate interrater reliability or diagnostic agreement between examiners in its use. As a result, much subjective interpretation and inconsistency will occur among evaluators, attorneys, jurors, and courts. This problem is compounded by the absence of a provision in the statute for a centralized site to evaluate all proposed sexually violent predators. George Dix described some of the "confusion" that examiners faced in trying to identify the requisite mental state in California's mentally disordered sex offender

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24. SEE Gordon C. Nagayama Hall & Richard Hirschman, *Toward a Theory of Sexual Aggression: A Quadripartite Model*, 59 J. CONSULTING & CLINICAL PSYCHOL. 662 (1991) (discussing possible etiological factors in sexual aggression); Howard E. Barbaree & William L. Marshall, *The Role of Male Sexual Arousal in Rape: Six Models*, 59 J. CONSULTING & CLINICAL PSYCHOL. 621 (1991); William L. Marshall et al., *Exhibitionists: Sexual Preferences for Exposing*, 29 BEHAV. RES. & THERAPY 37, 39 (1991) (only 14% of exhibitionists showed deviate sexual arousal to exhibition stimulus tapes).

25. WASH. REV. CODE § 71.09.020(2) (Supp. 1990-91).

26. PSYCHOPATH LEGISLATION, *supra* note 3, at 866-67.

program.[27]

B. Personality Disorder

The statute uses but does not define "personality disorder."[28] Personality disorder is defined by the current *Diagnostic and Statistical Manual of Mental Disorders* ("*DSM-III-R*")[29] but whether the current, or any future psychiatric definition corresponds to that intended by the statute is uncertain.[30] Again, the personality disorder must "predispose" the person to the commission of criminal sexual acts. A causative relationship must be shown between the disorder and the criminal sexual behavior,[31] an issue that is often a matter of speculation or meaningless circularity.[32]

While the interrater reliability for psychiatric diagnosis is one achievement of the *DSM-III*[33] and its successor *DSM-III-R*, reliability of personality disorder diagnoses has been less than optimal. In the field trials of *DSM-III*, the levels of agreement for pairs of raters for personality disorders was 0.56 (kappa coefficient).[34] In a later study, agreements varied greatly depending upon the particular personality disorder diagnosis.[35] In this study, the best agreement was obtained for antisocial

27. George E. Dix, *Differential Processing of Abnormal Sex Offenders: Utilization of California's Mentally Disordered Sex Offender Program*, 67 J. CRIM. L. & CRIMINOLOGY 233, 236-37 (1976).

28. WASH. REV. CODE § 71.09.020(1) (Supp. 1990-91).

29. AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS DSM-III-R (3d ed. rev. 1987) [hereinafter DSM-III-R].

30. See Jules B. Gerard, *The Usefulness of the Medical Model to the Legal System*, 39 RUTGERS L. REV. 377, 393 (1987) (discussing the differing purposes of the legal system and the medical profession in recognizing mental illness); Daniel W. Shuman, *The Diagnostic and Statistical Manual of Mental Disorders in the Courts*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 25, 26 (1989) (discussing the problems of using DSM-III and DSM-III-R to determine legally relevant behavior).

31. WASH. REV. CODE § 71.09.020(1) (Supp. 1990-91).

32. See *supra* note 26 and accompanying text.

33. AMERICAN PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS DSM-III (3d ed. 1987) [hereinafter DSM-III].

34. DSM-III, *supra* note 33, at 470. The kappa statistic expresses concordance between different examiners while correcting for any agreement between them that may have occurred through chance alone. A kappa of 0 indicates only chance agreement, a value of 1.0 reflects perfect agreement, and a negative value indicates less than chance agreement. John E. Helzer et al., *Reliability of Psychiatric Diagnosis: A Methodological Review*, 34 ARCHIVES GEN. PSYCHIATRY 129 (1977); John E. Helzer et al., *Reliability of Psychiatric Diagnosis: The Test/Retest Reliability of Diagnostic Classification*, 34 ARCHIVES GEN. PSYCHIATRY 136 (1977).

35. Graham Mellsop et al., *The Reliability of Axis II of DSM-III*, 139 AM. J. PSYCHIATRY 1360, 1360-61 (1982).

personality disorder, but it occurred less than half the time.[36] Given the limited diagnostic agreement among clinicians for a personality disorder diagnosis, evaluators will frequently disagree about whether the proposed sexually violent predator in fact has a personality disorder and therefore is or is not a sexually violent predator.

Psychiatric diagnosis is an evolutionary process rather than a static event, whether for personality disorders or otherwise.[37] Different diagnostic systems are used throughout the world.[38] *DSM-IV* is under development and is scheduled for publication in 1993;[39] future revisions undoubtedly will occur. Such category and criterion variability are a necessary correlate of the legal definition of sexually violent predator; however, when those categories and criteria vary over time, the target population of sexual predators will shift accordingly,[40] a potentially undesirable result.[41]

C. *Assessment of Future Sexual Violence*

Under the statute, a sexually violent predator must be "likely to engage in predatory acts of sexual violence."[42] This requirement is future-oriented, requiring an evaluator, as well

36. *Id.* at 1361.

37. *See generally* Leslie C. Morey, *Personality Disorders in DSM-III and DSM-III-R: Convergence, Coverage, and Internal Consistency*, 145 AM. J. PSYCHIATRY 573 (1988) (examining the impact of *DSM-III-R* revisions on personality disorder diagnosis).

38. *See, e.g.*, WORLD HEALTH ORGANIZATION, MANUAL OF INTERNATIONAL CLASSIFICATION OF DISEASES, ICD-10.

39. *See generally* Harold Alan Pincus et al., *DSM-IV and New Diagnostic Categories: Holding the Line on Proliferation*, 149 AM. J. PSYCHIATRY 112 (1992) (discussing the new diagnostic categories of DSM-IV).

40. *See generally* A. Kenneth Fuller et al., *Paraphilic Coercive Disorder*, 16 J. SEX EDUC. & THERAPY 164 (1990) (evaluating the usefulness of a controversial, proposed new diagnosis for compulsive rapists).

41. *See* Irwin N. Perr, *Medical and Legal Problems in Psychiatric Coding Under the DSM and ICD Systems*, 141 AM. J. PSYCHIATRY 418, 419 (1984).

The various conceptions, terminology, and criteria for antisocial personality disorder are an interesting example of change in diagnosis relevant to the sexual psychopath statutes. Many statutes referred either directly or indirectly to psychopathic personalities. *See* PSYCHOPATH LEGISLATION, *supra* note 3, at 856-66. The Washington statute does not specifically refer to antisocial personality disorders but it is likely to be the most prevalent personality disorder among adjudicated sexual predators. Some authorities have considered the DSM-III definition of antisocial personality disorder to unnecessarily focus on antisocial behavior rather than antisocial attitudes and personality traits. *See* Robert D. Hare et al., *Psychopathy and the DSM-IV Criteria for Antisocial Personality Disorder*, 100 J. ABNORMAL PSYCHOL. 391, 395-96 (1991); Thomas A. Widiger, *Antisocial Personality Disorder*, 43 HOSP. & COMMUNITY PSYCHIATRY 6, 7 (1992).

42. WASH. REV. CODE § 71.09.020(1) (Supp. 1990-91).

as the trier of fact, to conduct a quantitative risk assessment or to make a dichotomous (i.e., yes or no) prediction of the individual's future sexual behavior. Such a risk assessment occurs at the initial evaluation of the proposed sexually violent predator, as well as at the annual evaluation of the detained, adjudicated predator.[43] The statute is concerned only with sexually violent behavior, rather than nonsexual violence.[44] This component of the statute is clearly distinguishable from the "dangerousness" elements of the Washington statute used to civilly commit mentally ill persons to psychiatric hospitals based upon prior (and predicted future) interpersonal violence.[45]

A voluminous literature in law and mental health in the last quarter-century attests to the difficulties, if not impossibilities, of predicting future violent behavior,[46] despite the regularity with which such predictions are made in many mental health and legal contexts. A predominant finding has been that false positive predictions of violence (i.e., overpredictions) exceed true positive predictions of violence (i.e., correct predictions).[47] False negative predictions of violence (i.e., underpredictions) also occur.[48]

Several errors in predictions of violent behavior are relevant to the implementation of the sexual predator statute. Such errors are likely to result in substantial numbers of false positive predictions of sexual violence, especially if the statute is implemented in a large number of cases.

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43. *Id.* § 71.09.070.

44. *Id.* § 71.09.020(4).

45. "Substantial risk that physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm." WASH. REV. CODE § 71.05.020(3)(b) (1989).

46. *See generally* JOHN MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981) [hereinafter MONAHAN]; Edward P. Mulvey & Charles W. Lidz, *Clinical Considerations in the Prediction of Dangerousness in Mental Patients*, 4 CLINICAL PSYCHOL. REV. 379 (1984); Edward P. Mulvey & Charles W. Lidz, Note/Discussion, *Back to Basics: A Critical Analysis of Dangerousness Research in a New Legal Environment*, 9 LAW & HUM. BEHAV. 209 (1985); Christopher D. Webster & Robert J. Menzies, *The Clinical Prediction of Dangerousness* in LAW & MENTAL HEALTH: INTERNATIONAL PERSPECTIVES 158-208 (David N. Weisstub ed., 1987); Robert M. Wettstein, *The Prediction of Violent Behavior and the Duty to Protect Third Parties*, 2 BEHAV. SCI. & L. 291 (1984).

47. MONAHAN, *supra* note 46, at 41-50.

48. *Id.*

1. Lack of Specificity in Defining the Criterion

The vagueness of statutory terminology such as "mental abnormality" as a predicate for sexually violent behavior ensures that there can be little interrater reliability or predictive validity of risk assessments under the sexual predator statute.[49]

2. Ignoring Statistical Base Rates

Predictive validity is a function of the frequency or base rate of a behavior in a population. John Monahan has asserted that "knowledge of the appropriate base rate is the most important piece of information necessary to make an accurate prediction."[50] If a behavior is absent in a population, for example, then an accurate prediction would be that it would never occur in that population, and no particular skill would be required to make that correct prediction.

Sex offender recidivism rates provide information about the base rates of sexual offending in this population. A large range of recidivism of sexual offending has been reported, both for treated as well as untreated groups.[51] Meaningful specific recidivism data are not available for the different subcategories (i.e., rapists, pedophiles, incest offenders) of sex offenders, controlling for age, sex, race, and socio-economic status. The absence of these data is a serious handicap for those attempting to accurately predict sexually violent behavior.

3. Failing to Incorporate Environmental Information

It is erroneous to view any behavior as entirely a product of an individual in isolation from the rest of the world. Violent behavior is a result of an interaction between an individual and his environment. It is therefore necessary to assess the contextual elements of an individual's violent behavior, both in the past and in the future. This assessment can include factors such as marital discord, unemployment, alcohol and drug use, and noncompliance with psychotropic medication. The failure to use contextual data in predicting violence accounts in part

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49. *See generally* Saleem A. Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology*, 33 AM. PSYCHOL. 224 (1978).

50. MONAHAN, *supra* note 46, at 34.

51. *See generally* Lita Furby et al., *Sex Offender Recidivism: A Review*, 105 PSYCHOL. BULL. 3 (1989) (reviewing the wide variation of methodologies and results in sex offender recidivism studies).

for much of the difficulty in attempting to predict behavior in the community on the basis of an individual's institutional behavior (and vice versa).

4. Short Versus Long-Term Predictions

Risk assessments or predictions of future violence will probably be more accurate when the time period being predicted is shorter and sooner than if longer or later. While earlier studies of clinical predictions of violence were concerned with long-term (i.e., years) predictions, more recent studies have focused on shorter term predictions particularly in the context of civil commitment of mentally ill persons.[52] The sexual predator statute, however, clearly requires predictions for the indefinite future, not ones for the short term.[53]

5. Type of Behavior Being Predicted

The vast majority of the research literature on predicting future violence is concerned with nonsexually violent behavior, often in identifiably mentally ill persons. This behavior, however, is not relevant to the sexual predator statute. Little research has been conducted on the validity of predictions of future sexual violence. In one Massachusetts study of committed and then released sexual psychopaths, false positive predic-

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52. *See generally* Jeffrey W. Swanson et al., *Violence and Psychiatric Disorder in the Community: Evidence from the Epidemiologic Catchment Area Surveys*, 41 HOSP. & COMMUNITY PSYCHIATRY 761 (1990); Antonio Convit et al., *Predicting Assaultiveness in Psychiatric Inpatients: A Pilot Study*, 39 HOSP. & COMMUNITY PSYCHIATRY 429 (1988); Jeffrey S. Janofsky et al., *Psychiatrists' Accuracy in Predicting Violent Behavior on an Inpatient Unit*, 39 HOSP. & COMMUNITY PSYCHIATRY 1090 (1988); Deidre Klassen & William A. O'Connor, *Predicting Violence in Schizophrenic and Non-Schizophrenic Patients: A Prospective Study*, 16 J. COMMUNITY PSYCHOLOGY 217 (1988); Deidre Klassen & William A. O'Connor, *A Prospective Study of Predictors of Violence in Adult Male Mental Health Admissions*, 12 LAW & HUMAN BEHAV. 143 (1988); Dale P. McNiel & Renée L. Binder, *Predictive Validity of Judgments of Dangerousness in Emergency Civil Commitment*, 144 AM. J. PSYCHIATRY 197 (1987); Dale E. McNiel et al., *Predictors of Violence in Civilly Committed Acute Psychiatric Patients*, 145 AM. J. PSYCHIATRY 965 (1988); Dale E. McNiel & Renée L. Binder, *Relationship Between Preadmission Threats and Later Violent Behavior by Acute Psychiatric Inpatients*, 40 HOSP. & COMMUNITY PSYCHIATRY 605 (1989); Svein Blomhoff et al., *Can Prediction of Violence Among Psychiatric Inpatients Be Improved?*, 41 HOSP. & COMMUNITY PSYCHIATRY 771 (1990); Steven P. Segal et al., *Civil Commitment in the Psychiatric Emergency Room: 1. The Assessment of Dangerousness by Emergency Room Clinicians*, 45 ARCHIVES GEN. PSYCHIATRY 748 (1988).

53. WASH. REV. CODE § 71.09.060(1) (Supp. 1990-91).

tions outnumbered true positive predictions two to one.[54] In a California sample of released mentally disordered sex offenders, still thought to be a danger to the community, only twenty-four percent were reconvicted for a sex crime within the follow-up period of five years,[55] and eleven percent were convicted of nonsexual crimes against persons.

In summary, little evidence supports the claim that clinicians and triers of fact, in implementing the sexual predator statute, are able to predict future sexual violence in the long term.[56] At best, one can conclude only in a general way that past sexual behavior tends to predict future sexual behavior. Thus, only in the extremes—either very large number of past sexually deviate acts or none at all—can predictions of future sexual violence be reliably made. While sexually deviant behavior and sexual violence are often recidivistic, attempts to predict sexual violence will typically result in substantial numbers of false positive predictions, with severe consequences to the false positive individual.

D. *Treatability*

The statute does not require that an individual be considered treatable before adjudication as a sexual predator. This

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54. Harry L. Kozol et al., *The Diagnosis and Treatment of Dangerousness*, 19 CRIME & DELINQ. 371, 390-91 (1972). Although this study is widely cited for the failure of predictions of long-term sexual dangerousness, several methodological problems with the study limit its usefulness. First, most of the sample of male convicted offenders, who had been referred to a center for diagnostic evaluation pursuant to the Massachusetts "sexually dangerous persons" statute, had previous convictions for sexual offenses as the predicate offense. *Id.* at 378. Second, the postrelease recidivism crimes included nonsexual as well as sexual crimes ("serious assaultive crimes"). *Id.* at 390. Third, George Dix contended that predictive decisions are least likely to be accurate in samples in which the courts have disagreed with the clinical determination, as compared to cases in which the court would agree. George E. Dix, *Determining the Continued Dangerousness of Psychologically Abnormal Sex Offenders*, 3 J. PSYCHIATRY & L. 327, 329 (1975).

55. Vikki Henlie Sturgeon & John Taylor, *Report of a Five-Year Follow-up Study of Mentally Disordered Sex Offenders Released from Atascadero State Hospital in 1973*, 4 CRIM. JUST. J. 31, 58 (1980). This compared with a reconviction rate of 25% for a prison control group who had been convicted of sexual crimes but were not found to be mentally disordered sex offenders. The same study found a false negative rate of 12% for convictions for sexual crimes in the followup interval. The use of reconviction rates as an outcome measure likely maximizes the false positive prediction rates because many sexual offenses are never reported or prosecuted. A. Nicholas Groth et al., *Undetected Recidivism Among Rapists and Child Molesters*, 28 CRIME & DELINQ. 450 (1982).

56. GOVERNOR'S TASK FORCE ON COMMUNITY PROTECTION, DEP'T OF SOCIAL AND HEALTH SERVICES, FINAL REPORT IV-4 (1989) [hereinafter TASK FORCE REPORT].

failure to require amenability to treatment distinguishes the statute from some of the earlier sexual psychopath statutes[57] as well as from many civil commitment statutes that require the individual to need treatment or to be treatable.[58] The absence of a treatability requirement implicitly concedes the nontreatable nature of many sex offenders[59] and antisocial personality disordered individuals;[60] it also reemphasizes that the statute prioritizes incapacitation over treatment and rehabilitation. It is clear from the statute that obviously untreatable individuals could still be adjudicated as sexual predators. While some of the sexual psychopath statutes have been criticized as a product of the unrealizable therapeutic zeal of earlier times,[61] this would not appear to be the case with the Washington statute.

E. *Least Restrictive Alternative*

The statute does not require that adjudication of a sexual predator and the subsequent indefinite detention be the "least restrictive alternative" consistent with the treatment needs of the individual. The absence of this feature, characteristic of many civil commitment statutes,[62] again reveals the nonthera-

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57. California's sexual psychopath statute, repealed in 1982, required a person adjudicated as a mentally disordered sex offender to be committed to a state hospital only if he is "amenable to treatment." CAL. WELF. & INST. CODE § 6316, *repealed by* 1981 Cal. Stat. ch. 928.

58. SAMUEL JAN BRAKEL ET AL., THE MENTALLY DISABLED AND THE LAW (3d ed. 1985).

59. *See also* Furby, *supra* note 51, at 22-25 (reviewing conflicting results of studies examining treatment effectiveness and recidivism); William L. Marshall et al., *Treatment Outcome With Sex Offenders*, 11 CLINICAL PSYCHOL. REV. 465 (1991) (concluding that some treatments were effective for child molesters and exhibitionists, but not for rapists).

60. *See generally* Glen O. Gabbard & Lolafaye Coyne, *Predictors of Response of Antisocial Patients to Hospital Treatment*, 38 HOSP. & COMMUNITY PSYCHIATRY 1181 (1987) (examining failure of antisocial patients to respond to treatment, with many discharging themselves prematurely); James R. P. Ogloff et al., *Treating Criminal Psychopaths in a Therapeutic Community Program*, 8 BEHAV. SCI. & L. 181 (1990) (finding that psychopaths were less motivated for treatment, improved less, and were discharged from treatment earlier than nonpsychopaths); Eleanor Stein & Jennifer D. Brown, *Group Therapy in a Forensic Setting*, 36 CAN. J. PSYCHIATRY 718, 720-21 (1991) (finding that forensic patients were unable to benefit from group therapy in contrast to other patients).

61. PSYCHOPATH LEGISLATION, *supra* note 3, at 853-54.

62. The California sexual psychopath statute provided for carefully monitored outpatient treatment in the community as an alternative to hospitalization for individuals adjudicated as sexual psychopaths. CAL. WELF. & INST. CODE § 6316, *repealed by* 1981 Cal. Stat. ch. 928. However, this outpatient treatment was not available in every county. Donald T. Lee, *Implications of the Atascadero Study With*

peutic intent of the legislative scheme.

F. Nature and Extent of the Evaluation

The Washington statute is silent as to the nature and extent of the evaluation of a proposed sexually violent predator or the qualifications of the evaluator. Given the severe consequences to the detained individual after adjudication, these issues deserve serious consideration. The evaluation of a proposed sexually violent predator should be extensive and as thorough as possible.[63] This evaluation is especially important given the magnitude of the harm to the alleged predator should wrongful confinement occur under the statute. Ideally, an evaluation should include the following: (1) a review of all relevant records, such as previous mental health evaluations, treatment records, previous presentencing evaluations, school and work records; (2) psychiatric interview and mental status examination, including family, social, work, and medical histories; (3) psychological testing;[64] (4) medical and neurological testing, such as neuropsychological and neuroradiological testing; (5) comprehensive psychosexual history and (6) plethysmography.[65] If at the outset it appears that ade-

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Regard to Community Outpatient Treatment, 4 CRIM. JUST. J. 65, 66-67 (1980); *see also* Ingo Keilitz et al., *Least Restrictive Treatment of Involuntary Patients: Translating Concepts Into Practice*, 29 ST. LOUIS U. L.J. 691, 693 (1985) (noting that 19 states clearly provide this right, while 47 states arguably provide for it). The American Psychiatric Association's model commitment law also provides that every patient has the right to treatment that is least restrictive of the individual's physical and social liberties. *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*, 140 AM. J. PSYCHIATRY 672, 676 (1983).

63. *See* AMERICAN PSYCHIATRIC ASS'N, PSYCHIATRY IN THE SENTENCING PROCESS: A REPORT OF THE TASK FORCE ON THE ROLE OF PSYCHIATRY IN THE SENTENCING PROCESS 17-19 (1984) [hereinafter PSYCHIATRY TASK FORCE REPORT] (discussing the need for and extent of completeness in the presentencing psychiatric evaluation).

64. *See generally* Ron Langevin et al., *Use of the MMPI and its Derived Scales with Sex Offenders (parts 1 & 2)*, 3 ANNALS SEX RES. 245, 453 (1990). It has often been noted that psychologists rely more on psychological testing for data in forensic contexts than psychiatrists. *See* Mary Ann Deitchman et al., *Self-Selection Factors in the Participation of Mental Health Professionals in Competency for Execution Evaluations*, 15 LAW & HUM. BEHAV. 287, 300 (1991).

65. The penile plethysmograph measures blood flow to the penis. The ability to detect changes in penile circumference permits an objective measure of male sexual arousal. Audio or visual sexual stimuli are then administered to the subject while recording his arousal. James G. Barker & Robert J. Howell, *The Plethysmograph: A Review of Recent Literature*, 20 BULL. AM. ACAD. PSYCHIATRY & L. 13 (1992); *see generally* Kurt Freund & Ray Blanchard, *Phallometric Diagnosis of Pedophilia*, 57 J. CONSULTING & CLINICAL PSYCHOL. 100 (1989); Joseph C. Blader & William L. Marshall, *Is Assessment of Sexual Arousal in Rapists Worthwhile? A Critique of Current Methods and the Development of a Response Compatibility Approach*, 9

quate information would be unavailable to complete the assessment, then the evaluator may be justified in refusing to participate in it.[66]

G. *Qualifications of the Evaluator*

General clinical experience, outside the forensic or correctional mental health settings, is clearly inadequate to prepare one for clinical work with sex offenders.[67] There is as yet no nationally practiced credentialing or licensing process for those individuals who assert expertise in evaluating and treating sex offenders.[68] Given that sex offenders are a heterogeneous population,[69] an evaluator would need to have training or supervised experience with the variety of ages (juvenile, adult, geriatric) and psychopathologies common to sex offenders (psychosis, affective disorders, mental retardation, personality disorders, substance abuse disorders,[70] and organic mental disorders).[71] The clinician need also be skilled in differential diagnosis of these disorders. Furthermore, specialized training

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CLINICAL PSYCHOL. REV. 569 (1989); William L. Marshall et al., *Exhibitionists: Sexual Preferences for Exposing*, 29 BEHAV. RES. & THERAPY 37 (1991) (arguing against the usefulness of assessing deviate sexual arousal for exhibitionists). *See also* Eli Coleman & Margretta Dwyer, *Proposed Standards of Care for the Treatment of Adult Sex Offenders*, 16 J. OFFENDER REHABILITATION 93, app. (1990) (describing standards for use of the penile plethysmograph).

66. "Evaluators should accept for assessment only those cases in which there is a reasonable expectation that the referral questions can be answered." Robert J. McGrath, *Assessment of Sexual Aggressors*, 5 J. INTERPERSONAL VIOLENCE 507, 508 (1990).

67. In some states, any physician can be an examiner for the civil commitment of a mentally ill person. BRAKEL ET AL., *supra* note 58, at 52.

68. I am unaware of any formal, fulltime postgraduate fellowship programs in psychology or psychiatry that are exclusively devoted to training a clinician to be an evaluator or therapist for sex offenders, although continuing education courses and seminars in this area exist.

69. William S. Packard & Richard Rosner, *Psychiatric Evaluations of Sexual Offenders*, 30 J. FORENSIC SCI. 715 (1985); Gordon C. Nagayama Hall et al., *MMPI Taxonomies of Child Sexual and Nonsexual Offenders: A Cross-Validation and Extension*, 58 J. PERSONALITY ASSESSMENT 127, 135 (1992).

70. Training in the area of substance abuse disorders should include familiarity with research examining the relationship between alcohol use and violence. For an example of such research, see Richard T. Rada et al., *Drinking, Alcoholism, and the Mentally Disordered Sex Offender*, 6 BULL. AM. ACAD. PSYCHIATRY & L. 296 (1978) (surveying hospitalized mentally disordered sex offenders in California with regard to their use of alcohol at the time of their predicate offense and the presence of alcoholism).

71. See Benjamin Graber et al., *Brain Damage Among Mentally Disordered Sex Offenders*, 27 J. FORENSIC SCI. 125, 128 (1982) (stating that 50% of sex offenders who were tested demonstrated "brain dysfunction").

and formal supervised experience in evaluating and treating sex offenders of all types in several settings is necessary to become a competent practitioner in this area. It is preferable to have active rather than previous involvement in the area of practice.[72] Finally, training and experience in malingering and dissimulation are necessary in evaluating sex offenders.[73]

Coleman and Dwyer proposed that clinicians should meet four minimum standards to be considered competent professionals in "sexology": (1) a minimum of a master's degree or its equivalent in a clinical field granted by an accredited institution; (2) a license or certification to practice in an area of mental health; (3) "demonstrated specialized competence in sex therapy as indicated by documentable training and supervised clinical experience and continuing education in sex therapy"; and (4) "demonstrated specialized competence in counseling and diagnosis of paraphilias and sex offending behaviors as documentable by training or supervised clinical experience, along with continuing education."[74]

H. *Therapists as Evaluators*

By consensus, a patient's therapist should not serve as an evaluator in any administrative or legal proceeding.[75] The

72. *See* American College of Physicians, *Guidelines for the Physician Expert Witness*, 113 ANNALS INTERNAL MED. 789, 789 (1990) ("The physician expert witness [in a medical malpractice case] should be familiar with the clinical practice of the specialty or the subject matter of the case at the time of the alleged occurrence giving rise to the claim, and should be actively involved in the clinical practice of the specialty or the subject matter of the case for three of the previous five years at the time of the testimony.").

73. "Malingering" is defined as the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives such as avoiding military conscription or duty, avoiding work, obtaining financial compensation, evading criminal prosecution, obtaining drugs, or securing better living conditions." DSM-III-R, *supra* note 29, at 360. Dissimulation is a more "general term to describe an individual who is deliberately distorting or misrepresenting his or her psychological symptoms." CLINICAL ASSESSMENT OF MALINGERING & DECEPTION 5 (R. Rogers ed., 1988); *see generally* Linda S. Grossman & James L. Cavanaugh, Jr., *Psychopathology and Denial in Alleged Sex Offenders*, 178 J. NERVOUS & MENTAL DISEASE 739, 742-43 (1990) (noting that alleged sex offenders may deny psychopathology as well as their sex offense).

74. Coleman & Dwyer, *supra* note 65 at 97-98.

75. See Robert D. Miller, *The Treating Psychiatrist as Forensic Evaluator*, 29 J. FORENSIC SCI. 825 (1984) (stating that although legal and clinical literature emphasizes the importance of impartial expert testimony, there may be advantages to having clinicians more involved in forensic science); Robert D. Miller, *The Treating Psychiatrist as Forensic Evaluator in Release Decisions*, 32 J. FORENSIC SCI. 481 (1987); Robert D. Miller, *Ethical Issues Involved in the Dual Role of Treater and Evaluator*,

therapeutic relationship can be significantly distorted once the therapist has even agreed to prepare a report or testify on behalf of the patient. Such evaluations obscure the therapist's obligations to the patient, risk motivating the therapy by an external tangible benefit ("secondary gain"),[76] and engender the patient's animosity should the therapist fail to support the patient's legal claim. Similarly, the quality of the forensic evaluation when conducted by the therapist is lower compared to that conducted by an independent evaluator who has no preexisting relationship with the patient. It is difficult for the therapist to be objective about a person with whom he has been intimately involved over an extended period of time.

Formal evaluations for entry or release as a predator should be conducted by independent staff, not the patient's therapist; preferably it will be conducted by those who are independent contractors rather than employees of the state. There is evidence to suggest that agency can bias forensic evaluations: Employees can, even unintentionally, assume the values and orientation of the state agency that employs them, thus compromising their objectivity.[77] Failure to distinguish and separate the evaluative and therapeutic functions compromises both the court evaluations as well as the treatment program for sexual predators.[78]

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in ETHICAL PRACTICE IN PSYCHIATRY AND THE LAW 129-50 (Richard Rosner & Robert Weinstock eds., 1990).

76. "Secondary gain" is the "external gain derived from any illness, such as personal attention and service, monetary gains, disability benefits, and release from unpleasant responsibility." AMERICAN PSYCHIATRIC ASS'N, THE AMERICAN PSYCHIATRIC ASSOCIATION'S PSYCHIATRIC GLOSSARY 122 (1984). Secondary gain is distinguished from "primary gain," which represents an emotional benefit obtained from a psychological defense mechanism. *Id.* at 109.

77. There is no reason to believe that loyalty to one's employer, (here a state agency) even if it is an institution, is any less likely to bias an evaluator than pretrial forensic evaluations conducted at the request of the defense or prosecution. *See* Richard Rogers, *Ethical Dilemmas in Forensic Evaluations*, 5 BEHAV. SCI. & L. 149 (1987). Rogers notes that "the forensic clinician may see him/herself as the agent of the defendant, defense attorney, prosecuting attorney, or the court itself." *Id.* at 150. He also asks: "Are clinicians unduly biased by agency? Do forensic experts engage in either self-deception and/or conscious misrepresentation regarding whom they see as the client? Does agency necessarily compromise objectivity?" *Id.*

78. *See, e.g.*, Han Blankstein, *Organizational Approaches to Improving Institutional Estimations of Dangerousness in Forensic Psychiatric Hospitals: A Dutch Perspective*, 11 INT'L J. L. & PSYCHIATRY 341 (1988). Blankenstein suggests the following:

> Those who are actively engaged in treatment contacts with the patients have first-hand information concerning these patients and are, therefore, best informed about their psychological condition; nevertheless, therapists

III. TREATMENT ISSUES

The Washington legislature acknowledged that "the prognosis for curing sexually violent offenders is poor, the treatment needs of this population are very long term, and the treatment modalities for this population are very different than the traditional treatment modalities for people appropriate for commitment under the involuntary treatment act."[79] Several potential problems arise in implementing a treatment program for the adjudicated predator, which render the program essentially one of indeterminate, preventive detention rather a therapeutic one.

A. *Can Meaningful Treatment Be Offered?*

Every governmental agency has finite resources which can be devoted to any particular problem or group. Funds for health care in the public as well as private sectors are increasingly in demand, as growth of health care expenditures rapidly continues. Securing funding for mental health care in the public sector has traditionally been difficult, even more so in the 1990's. Public resources are not even available for recognized, cost-effective, therapeutic advances in nonoffender patient populations.[80] For the foreseeable future, treatment resources for sex offenders will probably not be abundant, whether in

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> themselves should not have final responsibility in regard to matters of leave or advice to court about the necessity of prolongation of T.B.R. Time and again we see that therapists are prone to overreaction. Sometimes they are overprotective and hesitate to trust the patient's capacity to grow and govern his own life. At other times they can be subtly overaggressive. Because of the frustrations and personal hurts our patients can cause, therapists fight back, creating a situation of mutual distrust. Sometimes therapists are too close, evaluating the patient too optimistically to ally themselves with a patient or out of fear of his aggression. Therefore, forensic administrators must ensure that final responsibility regarding matters of freedom of movement and prediction of dangerousness lies with the general management of the clinic—professionals who are familiar with the patients but have no direct treatment contact with them.

Id. at 344. *See also* Orest E. Wasyliw et al., *Clinical Considerations in the Community Treatment of Mentally Disordered Offenders*, 11 INT'L J. L. & PSYCHIATRY 371, 374 (1988) ("It can be difficult to assess a patient's clinical status objectively, for example, when the therapist knows that a rehospitalization may cost the patient a hard-won job, or when the therapist fears that the court may deal harshly with reports of noncompliance.").

79. WASH. REV. CODE § 71.09.010 (Supp. 1990-91).

80. *See, e.g.*, Dennis A. Revicki et al., *Cost-Effectiveness of Clozapine for Treatment-Resistant Schizophrenic Patients*, 41 HOSP. & COMMUNITY PSYCHIATRY 850, 850 (1990).

the institution or in the community.[81] Much of public sentiment indicates that sex offenders deserve punishment rather than treatment or rehabilitation. Sex offenders enjoy the lowest social statutus even among other prisoners. Funding the predator program will compete with demands to treat the nonoffender mentally ill, to fund forensic mental health settings, and to treat offender populations whether sex offenders or otherwise. Requests for costly specialized evaluation techniques (e.g., plethysmography) or antiandrogen medication[82] (e.g. medroxyprogesterone acetate) used to reduce sexual fantasy and performance are typically difficult to fufill given programmatic needs in multiple facilities.[83] Where the marginal public treatment dollar should be expended should and will be debated.[84] Funding limitations may result in providing only perfunctory treatment (e.g., one form of group therapy for all offenders) and ultimately a custodial system of care, which has been characteristic of many public mental health facilities.[85]

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81. *See* Allen D. Sapp & Michael S. Vaughn, *Sex Offender Rehabilitation Programs in State Prisons: A Nationwide Survey*, 17 J. OFFENDER REHABILITATION 55 (1991). Resource allocation for mental health services often depends upon the political mobilization of the affected parties. *See, e.g.*, David L. Braddock, *Community Mental Health and Mental Retardation Services in the United States: A Comparative Study of Resource Allocation*, 149 AM. J. PSYCHIATRY 175 (1992) (stating that spending for community mental retardation services grew four times more rapidly than spending for community mental health services, which was accounted for by mental retardation consumer advocacy groups). Sex offenders, especially sexually violent predators who are indefinitely confined in institutional programs, are unlikely to gain such consumer support in the near future. Consumer support is improbable, even though treatment is likely to be cost-effective. Robert Prentky & Ann Nolbert Burgess, *Rehabilitation of Child Molesters: A Cost-Benefit Analysis*, 60 AM. J. ORTHOPSYCHIATRY 108 (1990).

82. *See, e.g.*, John M. W. Bradford, *Organic Treatments for the Male Sexual Offender*, 3 BEHAV. SCI. & L. 355, 360-65 (1985).

83. Bowden asks whether our failure to provide antiandrogen therapy to sex offenders when useful is "linked with a covert desire to punish them." Paul Bowden, *Treatment: Use, Abuse & Consent*, 1 CRIM. BEHAV. & MENTAL HEALTH 130, 135 (1991).

84. *See, e.g.*, Kenneth G. Terkelsen & Renée Grosser, *Estimating Clozapine's Cost to the Nation*, 41 HOSP. & COMMUNITY PSYCHIATRY 863, 868-69 (1990).

85. Mental health treatment in state hospitals that fails to provide a humane psychological and physical environment with adequate numbers of qualified staff has prompted class action litigation. *See* Wyatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972) (ordering state hospital to comply with minimum constitutional standards for civilly committed patients), *rev'd in part on other grounds*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974). *See also* E. Haavi Morreim, *The New Economics of Medicine: Special Challenges for Psychiatry*, 15 J. MED. & PHIL. 97 (1990) (discussing how economics determines modes of care in psychiatry).

B. *Are Sexually Violent Predators Treatable?*

That the state may decide to make treatment available to sexual predators under the statute is only the first step. More fundamental is the question of whether such treatment will be useful to the sexual predators. Nearly all forms of mental health treatment require the active participation of the patient to secure success; typically treatment can not be simply administered to the patient in the absence of patient motivation and involvement.[86]

In recent years, considerable progress has been made in developing appropriate treatment modalities and programs for sex offenders.[87] Some limited evidence of treatment efficacy for certain classes of sex offenders has also been obtained.[88] Most of these studies have been conducted in community settings rather than in the institutional treatment setting at issue here. The question posed here, however, is not whether sex offenders are per se treatable, but whether the sex offender committed as sexually violent predator is treatable in this situation. A more particularized perspective asks which offenders are treatable with which techniques under what circumstances.

Offenders who have been committed as sexual predators have most likely failed to participate or benefit from early attempts at treatment whether in the community (voluntary or as a condition of probation and parole) or in prison. Many will have persistently and pervasively denied their sexual offending, externalized responsibility, or claimed (genuine or feigned) amnesia for their offenses. Given that commitment as a predator is the "end of the line" for sex offenders, the predator program will probably receive the least treatable offenders.

Many predators will be committed as predators only after extended periods of incarceration.[89] These extended periods create two important problems for treatability.

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86. *See* James R. P. Ogloff et al., *Treating Criminal Psychopaths in a Therapeutic Community Program*, 8 BEHAV. SCI. & L. 181, 186 (1990) (describing a study finding that psychopaths were less motivated for treatment, improved less, and were discharged from treatment earlier than nonpsychopaths).

87. *See, e.g.*, THE SEXUAL AGGRESSOR: CURRENT PERSPECTIVES ON TREATMENT (Joanne G. Greer & Irving A. Stuart eds., 1983); HUMAN SEXUAL AGGRESSION: CURRENT PERSPECTIVES (Robert A. Prentky & Vernon L. Quinsey eds., 1988); HANDBOOK OF SEXUAL ASSAULT: ISSUES, THEORIES, AND TREATMENT OF THE OFFENDER (William Marshall et al. eds., 1990).

88. *See supra* note 57-61 and accompanying text.

89. WASH. REV. CODE § 71.09.030(1), (2) (Supp. 1990-91).

1. Treatment Delays

Treatment for sexual offending that begins many years after the underlying sex offense is relatively more difficult than that which occurs soon thereafter. Delays before treatment begins permit opportunities for significant distortions and defenses by the offender. Such cognitive distortions[90] (e.g., did the victim consent or resist) become further consolidated over time, making it more difficult for the offender to truly accept responsibility for his earlier behavior. The passage of time also permits loss of memory of the offenses, which, in many cases, were poorly recalled initially because of intoxication. An offender may have little objectively correct recollection of an offense ten or twenty years after an offense, as seen by contrasting offenders' accounts of their crimes with official records.[91]

2. Influence of the Prior Prison Environment

Few, if any, correctional institutions are designed to function as therapeutic environments, much less actually do so. That the committed predator has already spent much of his life in such an environment likely reduces his ability to benefit from treatment. Most maximum security correctional facilities are violent, threatening, antisocial mileus in which an inmate is socialized to avoid disclosing personal weakness or vulnerability, avoid taking responsibility for his crime, or reveal himself to be a sex offender for fear of retaliation.[92] Inmates develop socially acceptable alibis, which are at odds with the real crime, to please themselves as well as family and supporters. Prison gives no incentives for a sex offender to discuss his offense, especially if the case is still on appeal. Again, the prison environment helps to engender a distorted view of the precipitating offense, which later must be dissected and deconstructed during the initial stages of sex offender treatment. Whether this can be thoroughly accomplished has never been studied.

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90. *See, e.g.*, Gisli H. Gudjonsson, *Cognitive Distortions and Blame Attribution Among Pedophiles*, 183 SEXUAL & MARITAL THERAPY 183 (1990); Gene G. Abel et al., *Complications, Consent, and Cognitions in Sex Between Children and Adults*, 7 INT'L J.L. & PSYCHIATRY 89 (1984).

91. This inaccurate recollection is often true initially as well.

92. HANS TOCH ET AL., COPING: MALADAPTATION IN PRISON (1989); HANS TOCH, LIVING IN PRISON (1977).

C. *Coerced and Involuntary Treatment*

Most or all commitments under the statute will be involuntary. Therefore, treatment of the predator should be properly viewed as coerced, whether or not the offender has a legal right to refuse to participate in treatment. Is coerced treatment of sex offenders or mentally ill persons effective? Civil commitment of the mentally ill is common throughout the United States,[93] but in the absence of controlled clinical trials, there is little way to scientifically determine its efficacy.[94] Involuntary treatment of substance abusers has been shown to be effective, largely by keeping the patients in treatment longer.[95]

Mandated or coerced treatment approaches are typical in forensic mental health and correctional environments. This approach creates its own problems, as well as opportunities. In enforced treatment, patients come to view their therapists as their jailers, agents of the state, and punitive authority figures.[96] Involuntary patients learn to minimize symptoms, ingratiate their therapists, and seek forgiveness.[97] The reciprocal, mutual, trusting relationship in voluntary mental health treatment is often reduced to a game of manipulations by the patient and staff in involuntary treatment.[98]

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93. *See generally* Marilyn J. Rosenstein et al., *National Institute of Mental Health, Legal Status of Admissions to Three Inpatient Psychiatric Settings*, 178 MENTAL HEALTH STATISTICAL NOTE 1 (Oct. 1986).

94. *See* Mary L. Durham & John Q. La Fond, *A Search for the Missing Premise of Involuntary Therapeutic Commitment: Effective Treatment of the Mentally Ill*, 40 RUTGERS L. REV. 303, 351-56 (1988) (reviewing efficacy of treatment studies of civilly committed patients).

95. M. Douglas Anglin & Yih-Ing Hser, *Criminal Justice and the Drug-Abusing Offender: Policy Issues of Coerced Treatment*, 9 BEHAV. SCI. & L. 243 (1991); NATIONAL INSTITUTE ON DRUG ABUSE, RESEARCH MONOGRAPH 86, COMPULSORY TREATMENT OF DRUG ABUSE: RESEARCH & CLINICAL PRACTICE (1988).

96. Wasyliw et al., *supra* note 78.

97. *See generally* GEORGE HARRIS & DAVID WATKINS, COUNSELING THE INVOLUNTARY AND RESISTANT CLIENT (1987).

98. Judi Chamberlin, *An Ex-Patient's Respcnse to Solitary*, 173 J. NERVOUS & MENTAL DISEASE 288 (1985). In discussing her views about seclusion in psychiatric hospitals, the author states:

> Most patients are smart; they quickly learn that certain behaviors elicit desirable (or undesirable) reactions from staff. Patients are most likely to be thought "well" when the[y] express the ideology of staff and "sick" when they deny it. Therefore, many patients after an episode of solitary confinement (or forced drugging) will learn that the best way to avoid another one is to acknowledge therapeutic benefit, even if this is not how they really feel. When I was a patient, I remember thanking the staff for putting me into solitary confinement, and stating that it helped me to regain control, being

The milieu of an institution's treatment program is often considered an important aspect of the therapy.[99] The preventive detention basis for retention in the Washington statute[100] is likely to influence the nature of the milieu in a counter-therapeutic direction. Incapacitation is not consistent with therapeutic intent.[101] Further, therapeutic milieus are vulnerable to disruption by character-disordered individuals who are likely to constitute the sexually violent predators. For these reasons, expectations for meaningful progress in treatment under the statute should be guarded.[102]

D. *Absence of Confidentiality*

Confidentiality has traditionally been considered the *sine qua non* of effective mental health treatment.[103] In many cases, treatment cannot proceed without an assurance of confidentiality, although a lack of assurance or a breach of confidentiality may only interfere but not obviate effective treatment. In recent years, increased societal demands for information about a patient and his treatment have rendered confidentiality in medicine, and to some degree, mental health care, less controlling.[104] Absolute confidentiality no longer exits, if it ever did. Regrettably, confidentiality expectations of patients exceed clinicians' actual behavior.[105]

Confidentiality in criminal settings or about criminal con-

> quite conscious at the time that I was deliberately lying (and being quite surprised that no one recognized it as such). I have heard innumerable similar accounts from other patients and former patients. In fact, in the ex-patients' movement, such tactics are known as "learning to play the game," and playing the game is widely recognized as the way to secure one's freedom.

Id. at 289.

99. David E. Raskin, *Milieu Therapy Reexamined*, 17 COMPREHENSIVE PSYCHIATRY 695, 700 (1976).

100. WASH. REV. CODE § 71.09.060(1) (Supp. 1990-91) provides that "the person shall be committed . . . for control, care, and treatment until such time as . . . the person is safe to be at large."

101. PSYCHOPATH LEGISLATION, *supra* note 3, at 925; Michael H. Sacks & William T. Carpenter, *The Pseudotherapeutic Community: An Examination of Antitherapeutic Forces on Psychiatric Units*, 25 HOSP. & COMMUNITY PSYCHIATRY 315, 315 (1974).

102. Keith H. Johansen, *The Impact of Patients with Chronic Character Pathology on a Hospital Inpatient Unit*, 34 HOSP. & COMMUNITY PSYCHIATRY 842, 843 (1983).

103. Donald Schmid et al., *Confidentiality in Psychiatry: A Study of the Patient's View*, 34 HOSP. & COMMUNITY PSYCHIATRY 353, 353 (1983).

104. Mark Siegler, *Confidentiality in Medicine—A Decrepit Concept*, 307 NEW ENG. J. MED. 1518, 1518 (1982).

105. Barry D. Weiss, *Confidentiality Expectations of Patients, Physicians, and Medical Students*, 247 JAMA 2695, 2695 (1982).

duct has often been imperiled.[106] Therapists in community or institutional programs, whether in forensic mental health or corrections, are often pressured to share information about their offender patients with others responsible for, or involved in, release decisionmaking. Therapists nevertheless may attempt to avoid or minimize doing so to protect their relationship with the patient. This pressure not only presents ethical dilemmas for the therapist,[107] but more typically strains the treatment relationship because, if the patient refuses to release this information, he is viewed as uncooperative. Moreover, if potentially favorable information is not shared, his release will be less likely. In the absence of significant confidentiality in the treatment of the sexually violent predator, offenders are unlikely to ever disclose to their therapist the extent of past sexual offending, given the stakes of indefinite detention under the statute.[108] Offenders have an obvious incentive to conceal persistent sexually deviant fantasy and arousal during treatment. Such a problem is not unique to treating sexually violent predators, but certainly appears likely to occur in a

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106. *See* Tarasoff v. Regents of Univ. of Cal., 551 P.2d 334 (Cal. 1976) (finding duty of psychotherapist to protect third party from a violent patient); Jorgensen v. State, 574 N.E.2d 915 (Ind. 1991) (finding no psychologist-patient privilege for homicide information obtained from third party); In re Rules Adoption Regarding Inmate-Therapist Confidentiality, 540 A.2d 212 (N.J. 1988) (challenging Department of Corrections rules concerning the confidentiality of psychological services in prison); People v. Doe, 570 N.E.2d 733 (Ill. App. Ct. 1991) (finding exception to the state's confidentiality of mental health records and communications in the case of homicide); *In re* Kevin F., 261 Cal. Rptr. 413 (Cal. App. 3d 1989) (holding that juvenile's confession of arson during mandatory counseling with psychotherapist not privileged); State v. Beatty, 770 S.W.2d 387 (Mo. Ct. App. 1989) (holding that psychiatrist's telephone call to crime reporting service to report his patient's crime did not violate statutory physician-patient privilege); People v. Wharton, 280 Cal. Rptr. 631 (Cal. 1991) (substance of therapist's warning to potential victim of patient fell within exception to psychotherapist-patient statutory privilege), *cert. denied*, 112 S. Ct. 887 (1992); *see also* Robert J. Kelly, *Limited Confidentiality and the Pedophile*, 38 HOSP. & COMMUNITY PSYCHIATRY 1046, 1047 (1987) (discussing tendency of some therapists to prematurely break patient confidentiality in an effort to avoid legal liability under recent trends of case law).

107. *See infra* notes 129-134, 143-161 and accompanying text.

108. Meg S. Kaplan et al., *The Impact of Parolees' Perception of Confidentiality of Their Self-Reported Sex Crimes*, 3 ANNALS SEX RES. 293, 301-02 (1990) (finding that parolees reported on average twenty-five times as many past child molestations to a psychologist at an outpatient sex offender clinic as compared to incidents reported to a parole officer; the parolees perceived "extensive" confidentiality during the psychological interview and "limited" confidentiality during the interview with the parole officer).

treatment program for them under the statute.[109]

E. Problems in Evaluating Treatment Progress

Under the statute, "[e]ach person committed under this chapter shall have a current examination of his or her mental condition made at least once every year.[110] In addition to the difficulties noted above in initially evaluating sex offenders for purposes of adjudication as a sexually violent predator, there are continuing obligations to evaluate the predators for evidence of response to treatment. Such retention decisions present additional difficulties.

Can treatment response be evaluated in custody? For most offenders, the absence of available victims creates insurmountable problems in assessing treatment response.[111] These problems were described by George Dix who observed the release decisionmaking of hospital treatment teams for a sample of adjudicated sex psychopaths in California.[112] He reported that staff appeared to rely on indirect rather than direct evidence of treatment response in recommending release.[113] Staff decisions to recommend release were influenced by the following factors: the offender's acceptance of guilt and personal responsibility for offending, the offender's ability to manage stressful life events in an acceptable manner, behavior during hospitalization, achievement of maximum benefit from hospitalization, and change in community circumstances during hospitalization (e.g. absence of victims in a new neighborhood).[114]

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109. An exception occurs when the patient has an individual psychotherapist without evaluative or administrative responsibility; *see* Blankstein, *supra* note 78:

> We guarantee as much as possible the secrecy of individual psychotherapy. The psychotherapist is not a member of the treatment team and has no part in policy advices or planning of treatment. On the other hand, the psychotherapist is well informed about the daily events and the conclusions of treatment team meetings. We call his position "semi-integrated" and the psychiatrist, who is a consultant to the treatment team, serves as an intermediary between the psychotherapist and the treatment team.

Id. at 345.

110. WASH. REV. CODE § 71.09.070 (Supp. 1990-91).

111. This would be a lesser problem in the case of a homosexual rapist.

112. Dix, *supra* note 54, at 336.

113. *Id.* at 340.

114. *Id.* at 334-40. For sexual predators, a presumption of dangerousness continues once the individual is in custody.

F. Absence of Conditional or Gradual Release Programming

The statute fails to provide opportunities for the sexually violent predator to make the transition between institutionalization and release to the community.[115] Forensic and nonforensic institutional mental health programs, as well as many prison programs, commonly provide a continuum of care that includes gradual release into the community.[116] This process is particularly important when an individual has been confined to an institution for a period of years. While still hospitalized, patients obtain privileges to leave the building, hospital grounds, or hospital vicinity, for therapeutic purposes. They may then be permitted to live in a supervised residential setting for forensic or corrections patients. Followup treatment in the community can be tightly linked to the institutional programs. These provisions offer staff an opportunity to evaluate the patient's functioning outside of the structured setting, and guide the progress to eventual release. The absence of statutory authority for coordinated services to allow gradual or conditional release for sexually violent predators seriously impairs the staff's ability to evaluate their progress and obtain their release.

IV. ABUSES, COSTS, & RISKS

The Washington statute creates many opportunities for misuse or abuse involving the mental health professions and the clinicians involved in the implementation of its evaluation and treatment components.[117] Some of these abuses will now be considered.

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115. WASH. REV. CODE ch. 71.09 (Supp. 1990-91).

116. *See generally* John Goldmeier et al., *A Half-way House For Mentally Ill Offenders*, 134 AM. J. PSYCHIATRY 45 (1977); Ronald T. Greene, *A Comprehensive Mental Health Care System for Prison Inmates: Retrospective Look at New York's Ten Year Experience*, 11 INT'L J. L. & PSYCHIATRY 381, 383 (1988); Stuart B. Silver & Christine Tellefsen, *Administrative Issues in the Follow-Up Treatment of Insanity Acquittees*, 18 J. MENTAL HEALTH ADMIN. 242, 242 (1991); Patricia A. Griffin et al., Designing Conditional Release Systems for Insanity Acquittees, 18 J. MENTAL HEALTH ADMIN. 231, 231 (1991).

117. As previously noted, under the Washington law, mental health professionals are involved in evaluating offenders for the presence of mental abnormalities, personality disorders, and long-term likelihood of predatory sexual violence. The mental health professional also may evaluate the safety of the person for release into the community, as well as recommending treatment. *See* discussion *supra* Part II.

A. *Abuse of the Mental Health Professions and Professionals*

Much has been written about the extent and significance of medical and psychiatric authority in the United States. Terms such as "medicalization" and "psychiatrization" convey this notion.[118] Psychiatric and psychology evaluations and testimony are used in a wide array of criminal and civil litigation to accomplish both treatment and nontreatment purposes. In addition, society delegates authority to clinicians in innumerable areas outside of litigation: employment screening,[119] work disability, disability income, securing abortions or sterilization, and attending school.[120] It is now well accepted that such authority, independent of the service to the patient, serves a social control function no less than that of policeman or judge. Thomas Szasz described psychiatrists as "social tranquilizers" who "attempt to harmonize, or tranquilize, interpersonal and social discord."[121] A commonly stated notion is that clinical authority should be clearly limited in scope.[122] It is unclear to what degree clinicians have sought such authority in contrast to having it imposed upon them by society.

Clinicians are ambivalent about the social control function assigned or offered to them by society. Many clinicians and even some facilities do not, for example, work with involuntarily hospitalized patients even though every state permits civil commitment of the mentally ill.[123] Further, psychiatrists are sometimes reluctant to pursue involuntary medication of

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118. "Medicalization" and "psychiatrization" generally reflect the extent to which nonmedical social or legal problems are redefined as medical problems with corresponding medical solutions. *See* DOROTHY NELKIN & LAURENCE TANCREDI, DANGEROUS DIAGNOSTICS: THE SOCIAL POWER OF BIOLOGICAL INFORMATION (1989).

119. Indeed, clinicians also retain authority to assess professionals practicing law or medicine.

120. The medical excuse: "The idea that some mental states should be used as the reason either to deprive people of some legal rights or to give them some extralegal benefits goes back to the earliest records of our legal system." JONAS ROBITSCHER, THE POWERS OF PSYCHIATRY 20 (1980). *See generally* Seymour L. Halleck, Commentary, *The Power of the Psychiatric Excuse*, 53 MARQUETTE L. REV. 229 (1970).

121. THOMAS SZASZ, LAW, LIBERTY & PSYCHIATRY 196 (1963).

122. "Psychiatrists should not have the authority of medicine in areas where their expertise is not medical or even scientific: for example, claims that they can use therapy to clear up problems of criminal deviancy should be exposed as overreaching." Jonas Robitscher, *The Limits of Psychiatric Authority*, 1 INT'L J.L. & PSYCHIATRY 183, 202 (1978).

123. *See* BRAKEL EL AL., *supra* note 58; Kenneth Tardiff, *A Survey of Psychiatrists in Boston and Their Work with Violent Patients*, 131 AM. J. PSYCHIATRY 1008, 1009 (1974) (stating that results of a survey revealed that fewer than half of Boston psychiatrists evaluate or treat violent patients).

civilly committed patients, even if this practice has been or could be legally authorized. Though clinicians have acquiesced to the imposition of a legal duty to protect third parties from potentially violent patients, they are anxious and apprehensive rather than enthusiastic about this responsibility.[124]

Beyond clinicians' reluctance to exert social control functions in civil treatment contexts, forensic mental health and correctional settings have historically had difficulty attracting well-trained, high quality, mental health specialists in sufficient numbers.[125] Few universities or medical schools have academic affiliations with these programs, despite the growing presence of post-graduate, sub-specialty fellowships in forensic psychiatry and psychology. Few psychologists or psychiatrists are trained in evaluating and treating sex offenders, and few work in this area.

Several larger professional policy questions are created by the Washington statute. Do organized psychiatry and psychology need or want the social control responsibilities entailed in the statute? Do clinicians want their social control authority to be used to preventively and perhaps indefinitely detain sex offenders in a largely custodial fashion? Further, do mental health professionals have an obligation to work in such settings or rather *an obligation to refuse* to work in such settings? The committee of psychiatrists preparing the *1977 Group for the Advancement of Psychiatry Report* clearly opposed sexual psychopath legislation[126] as did the Washington State Psychiatric Association.[127]

The Washington statute and similar sexual psychopath programs arguably constitute a misuse of the mental health professions and the mental health professionals involved. Using a pretext of offender treatability, with an offer of treatment, to conceal the underlying agenda of indefinite, preventive detention constitutes an abuse; it allows clinicians to collude with a nonclinical social agenda, with substantial likely harm to the offender through excessive false positive predictions of sexual violence.[128]

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124. Gregory B. Leong, *The Expansion of Psychiatric Participation in Social Control*, 40 HOSP. & COMMUNITY PSYCHIATRY 240 (1989).

125. ROBITSCHER, *supra* note 120, at 44, 50.

126. PSYCHOPATH LEGISLATION, *supra* note 3, at 843.

127. Amicus Curiae Brief of the Washington State Psychiatric Ass'n, *In re* Young (Wash. filed Sept. 20, 1991) (No. 57837-1).

128. *Compare* Anthony D. Oliver, *The Sex Offender: Lessons from the California*

B. Abuse by Mental Health Professionals

The professional and popular literature contains an abundant critique of the roles and practice of mental health professionals in the courts.[129] Clinicians have several opportunities to misuse their roles and responsibilities under the statute. Clinicians may misread the scientific literature, or overestimate their clinical expertise, and conclude that their ability to assess and predict long-term sexually violent behavior is sufficiently sound so as to justify indefinite incarceration. Risk assessments are notoriously judgment-oriented and subjective, given the absence of actuarial data and formal decisionmaking rules.[130]

A clinician who has a concealed social control or emotional agenda (countertransference hostility to sex offenders and criminals[131]) has ample opportunity to conduct biased risk assessments and testify accordingly.[132] Such misuse is more

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Experience, 5 INT'L J.L. & PSYCHIATRY 403, 407 (1982); *with* the American Medical Association's prohibition of participation in capital punishment under its Principles of Medical Ethics, AMERICAN PSYCHIATRIC ASS'N, OPINIONS OF THE ETHICS COMMITTEE ON THE PRINCIPLES OF MEDICAL ETHICS WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY § 1, n.4 (1989) [hereinafter MEDICAL ETHICS].

129. David Faust & Jay Ziskin, *The Expert Witness in Psychology and Psychiatry*, 241 SCIENCE 31, 32 (1988); *see also* SZASZ, *supra* note 121, at 69-70; SEYMOUR L. HALLECK, THE MENTALLY DISORDERED OFFENDER 137-39 (1986); *see generally* Alan A. Stone, *The Ethical Boundaries of Forensic Psychiatry: A View from the Ivory Tower*, 12 BULL. AM. ACAD. PSYCHIATRY & L. 209 (1984).

130. Faust & Ziskin, *supra* note 129, at 33 (discussing factors limiting clinical judgment including limits in scientific knowledge, limits in clinical judgment, overconfidence, and an expert's claim that limitations in scientific evidence do not apply to him).

131. *See generally* John R. Lion & Stephan A. Pasternak, *Countertransference Reactions to Violent Patients*, 130 AM. J. PSYCHIATRY 207 (1973); Friedemann Pfäfflin, *The Contempt of Psychiatric Experts for Sexual Convicts: Evaluation of 936 Files from Sexual Offense Cases at Courts in the State of Hamburg, Germany*, 2 INT'L J.L. & PSYCHIATRY 485 (1979).

132. "Professionals who testify as experts are always defenders of their opinions. It is not at all unusual, however, for an expert witness to go further and become an advocate for a party, or political or social point of view. Indeed, attorneys commonly endeavor to have an expert witness become an advocate for one 'side' of the case." Steven R. Smith, *Mental Health Expert Witnesses: Of Science and Crystal Balls*, 7 BEHAV. SCI. & L. 145, 154 (1989). *See also* ROBITSCHER, *supra* note 120, at 24: "Many testifying psychiatrists are prosecution-minded. . . . [P]sychiatrists are not always merciful with the feeling that everyone should be treated and no one should be punished. There are hanging judges, and there are hanging psychiatrists."

Psychiatrist James Grigson, M.D., has been dubbed "Dr. Death" for his repeated testimony in Texas capital murder cases claiming "100 percent certainty" that the defendant is a sociopath and will again be violent in the future, without having personally examined the defendant. As of February 1992, Dr. Grigson had testified in 144 death penalty cases; of these cases, 139 were for the prosecution. In 131 of the 139

likely to occur because sex offenders typically provoke strong countertransference feelings or primitive emotional feelings such as rage and vengeance in evaluators and therapists, as well as the public. Michael Saks has referred to those experts as "imperial" when they "display a willingness, first, to disregard what knowledge has been developed by the field from which they claim to derive their expertise and to substitute for that their own guesses."[133] It is difficult to decide how to manage and regulate these abuses.[134]

C. *Abuse of Other Prison Inmates*

Implementation of the statute is likely to adversely affect sex offenders in prison who have not yet been adjudicated sexually violent predators. Conceivably, the statute will undermine the voluntary prison treatment of sex offenders should offenders come to realize that it is disadvantageous to reveal the extent of their past sexual offending. One need not be paranoid to believe that such information would later find its way to those interested in indefinitely detaining the offender as a predator. A pervasive lack of confidentiality, with the possibility of indefinite detention as a predator, would likely deleteriously affect all assessment or treatment programs for sex offenders, whether in the community, or in institutional settings.[135] Alternatively, the creation of the predator treatment

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cases, the defendant was sentenced to death. On one occasion, he was reprimanded for an ethics violation for this testimony by the American Psychiatric Association. THE DALLAS MORNING NEWS, February 16, 1992, at E1-2. *See also* Mary Ann Deitchman et al., *Self-Selection Factors in the Participation of Mental Health Professionals in Competency for Execution Evaluations*, 15 LAW & HUM. BEHAV. 287 (1991) (finding that clinicians' decisions to participate in competency for execution evaluations were partially a function of attitudes toward capital punishment).

133. Michael J. Saks, *Expert Witnesses, Nonexpert Witnesses, and Nonwitness Experts*, 14 LAW & HUMAN BEHAV. 291, 294 (1990).

134.

> Teaching legal psychiatry has taught me that most psychiatrists are almost totally uninterested in questioning the legitimacy of their psychiatric power . . . Neither psychiatrist nor lawyer has carefully addressed the problem of the proper limits of psychiatric authority. Yet I am convinced that psychiatric decision making has become so threatening, so invasive, that it deserves serious attention now.

ROBITSCHER, *supra* note 120, at xvi-xvii.

135. Information obtained in previous psychiatric evaluations conducted for sentencing purposes becomes part of the offender's corrections records. This information could later be used to adjudicate him as a sexual predator, even if the evaluating psychiatrist had warned the evaluee of its nonconfidentiality at the time. It is doubtful, however, that such a waiver of confidentiality would be adequate because the offender would not have been aware of its potential use under the statute years later.

program may motivate prisoners to seek treatment on a voluntary basis to ensure that they will not later be indefinitely detained as a predator.

As already noted above, the predator program could compete for funding with sex offender treatment in corrections. It could divert resources from voluntary treatment programs that might be more successful on an individual or societal basis given the larger numbers of that group and the earlier opportunities for intervention.

D. *Abuse of the Patients*

Conceivably, an indefinitely detained offender under the statute might elect surgical castration (orchiectomy) as a means to ensure his release to the community as safe. A court or jury might be persuaded that, although there are no guarantees that a castrated male could not sexually reoffend,[136] castration could provide adequate assurance of safety to accomplish release from incarceration. Assuming that the necessary personnel and resources were available to the offender, would such a result be socially or ethically desirable? Would such consent be considered unduly coerced or involuntary given his indefinite incarceration?[137] Would the presence of the statute, by inculcating an offender's fear of indefinite detention, indirectly promote an excessive, punitive response (i.e., unnecessary castrations)? On the other hand, would the unavailability of chemical (medroxyprogesterone acetate) or surgical castration in the treatment program improperly deny a legally competent individual the opportunity to procure his release when no alternative is available? Similar concerns have been raised with the issue of behavior control or modification techniques for those involuntarily detained.[138]

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136. Nicholas Heim & Carolyn J. Hursch, *Castration for Sex Offenders: Treatment or Punishment? A Review and Critique of Recent European Literature*, 8 ARCHIVES SEXUAL BEHAV. 281, 298 (1979) (discussing the percentage of castrated males whose sex drive was unaffected).

137. *See generally* Jim Rees, *Voluntary Castration of Mentally Disordered Sex Offenders*, 13 CRIM. L. BULL. 30 (1977); Kaimowitz v. Department of Mental Health No. 73-19434-AW (Mich. Cir. Ct., Wayne County, July 10, 1973) *reported in* 1 MENTAL DISABILITY L. REP. 147 (1976); Dennis H. Rainier, Comment, *The Use of Depo-Provera for Treating Male Sex Offenders: A Review of the Constitutional and Medical Issues*, 16 U. TOL. L. REV. 181 (1984).

138. *See generally* Richard Singer, *Consent of the Unfree (Parts 1 & 2)*, 1 LAW & HUM. BEHAV. 1, 101 (1977); Michael H. Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237

Creation of a special class of sex offenders provides opportunities for stigmatization and scapegoating by society, enraged by the well-publicized failures of the criminal justice system to prevent or control crime. A false sense of physical and psychological comfort is offered when we judge others to be different from the rest of us and to then isolate and send them away. It is unlikely that the program will appreciably reduce the incidence of sexual offending in the community, unless unusually large numbers of offenders are indeterminately detained.

V. ETHICAL ISSUES

The sexually violent predator statute presents many potential ethical problems to the clinicians involved in the evaluation, treatment, and release of the offenders. I will attempt to address only one of these ethical dilemmas, that relating to mental health expertise and testimony.[139]

It should initially be noted that the ethics of the forensic (i.e., testifying evaluator) clinician are not so clearly, if at all, predicated upon the well-recognized principles of medical ethics[140] that apply in the ordinary clinical or treatment setting.[141] The principles of beneficence (seeking to do good) and nonmaleficence ("do no harm"), that are applicable to an identifable physician-patient relationship, seem incongruous in the context of an evaluation of criminal responsibility, or of future sexual violence, where the client is a litigant or the adversary system itself. As indicated below, forensic evaluators have responsibilities to avoid harming the evaluee (e.g., truth-tell-

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(1974); R. SCHWITZGEBEL, DEVELOPMENT AND LEGAL REGULATION OF COERCIVE BEHAVIOR MODIFICATION TECHNIQUES WITH OFFENDERS (1971).

139. Other ethical issues presented by the statute, though not necessarily unique to it, include involuntary treatment, the competency of sexually violent predators to consent or refuse treatment, and confidentiality. The issue of confidentiality assumes such importance because expert testimony is the "ticket" through which an individual is adjudicated a sexually violent predator and involuntarily detained, potentially for a lifetime. Dix reported that "[t]he California program and virtually all other existing programs for special processing of abnormal [sex] offenders rely heavily upon recommendations for clinicians such as examining physicians or psychiatrists." George E. Dix, *Differential Processing of Abnormal Sex Offenders: Utilization of California's Mentally Disordered Sex Offender Program*, 67 J. CRIM. L. & CRIMINOLOGY 233, 236 (1976).

140. *See generally* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (3d ed. 1989) (discussing the ethical principles of the medical profession).

141. *See* Paul J. Appelbaum, *The Parable of the Forensic Psychiatrist: Ethics and the Problem of Doing Harm*, 13 INT'L J. L. & PSYCHIATRY 249, 251 (1990).

ing). However, forensic evaluators serve the ends of promoting justice and protecting society, quite clearly apart from the individuals whom they evaluate.[142] Thus, the harm that derives from their expert testimony (i.e., indefinite commitment as a sexual predator, capital punishment, loss of child custody) cannot be equated with the harms that occur due to negligence in patient care.

Expert testimony by mental health professionals is legally[143] and ethically acceptable only when predicated upon legitimate expertise.[144] Such testimony must also be honest and objective. Though expert testimony regarding the prediction of long-term violence has met constitutional standards at least in the context of capital punishment,[145] such testimony does not necessarily meet ethical standards, either in general or in a given case. Given the uncertain empirical support of clinicians' abilities to predict future violence whether sexual or not, it is reasonable to question the ethics of clinical predictions of sexual violence by which an offender is initially adjudicated a sexual predator, and then is retained within the program as unsafe for release. The codes of ethics governing general and forensic psychiatry as well as general and forensic psychology address some of these issues, which will now be considered.

Clinicians have a general ethical obligation to maintain the highest standard of professional competence, as well as recognize their professional limitations.[146] Further, in the evalua-

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142. PSYCHIATRY TASK FORCE REPORT, *supra* note 63, at 7.

143. FED. R. EVID. 702.

144. "Forensic psychologists have an obligation to present to the court . . . the factual bases (knowledge, skill, experience, training, and education) for their qualification as an expert, and the relevance of those factual bases to their qualification as an expert on the specific matters at issue." Committee on Ethical Guidelines for Forensic Psychologists, *Specialty Guidelines for Forensic Psychologists*, 15 LAW & HUM. BEHAV. 655, 658 & § IIIB (1991) [hereinafter *Forensic Psychologist Guidelines*].

145. Barefoot v. Estelle, 463 U.S. 880 (1983) (upholding use of psychiatric testimony based upon hypothetical questions about a defendant who had never been examined).

146. "Psychologists recognize the boundaries of their competence and the limitations of their techniques. They only provide services and only use techniques for which they are qualified by training and experience . . . Psychologists accurately represent their competence, education, training, and experience." American Psychological Association, Ethical Principles of Psychologists (amended June 2, 1989), 45 AM. PSYCHOL. 390, Principle 2, 391-92 (1990). "A psychiatrist who regularly practices outside his/her area of professional competence should be considered unethical." MEDICAL ETHICS, *supra* note 128, § 2, n.3.

tive or forensic context, the forensic clinician can only claim expertise when deserved, and must present his qualifications accurately.[147] Thus, the ethical clinician may not undeservedly claim expertise with a particular clinical population (e.g., mental retardation, organic mental disorders, schizophrenia, pedophilia), particularly in court testimony. Forensic clinicians must present their findings and opinions in a fair and objective manner[148] and must guard against the possible misrepresentation of their work.[149] They must resist the potential for abuse resulting from personal issues[150] or from having been retained by one party to the litigation.[151]

Whether a clinician may ethically testify about another person's psychiatric diagnosis, mental capacities, or future behavior without a personal examination is also relevant to the administration of the statute. What limitations does an inmate's refusal to submit to an examination pursuant to the statute impose on the clinician's findings and conclusions? This, too, has been addressed in several ethical codes. The American Psychiatric Association has expressed the view that it is unethical to offer a professional opinion "about an individual who is in the light of public attention, or who has disclosed

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147. "Expertise in the practice of forensic psychiatry is claimed only in areas of actual knowledge and skills, training, and experience." AMERICAN ACADEMY OF PSYCHIATRY AND THE LAW, ETHICAL GUIDELINES FOR THE PRACTICE OF FORENSIC PSYCHIATRY § V (rev. 1989) [hereinafter FORENSIC PSYCHIATRY GUIDELINES].

148. "When testifying, forensic psychologists have an obligation to all parties to a legal proceeding to present their findings, conclusion, evidence, or other professional products in a fair manner . . . Forensic psychologists do not, by either commission or omission, participate, in a misrepresentation of their evidence, nor do they participate in partisan attempts to avoid, deny, or subvert the presentation of evidence contrary to their own opinion." *Forensic Psychologist Guidelines*, *supra* note 144, § VIII(D), at 664.

149. "Forensic psychologists take reasonable steps to correct misuse or misrepresentation of their professional products, evidence, and testimony." *Id.* § VII(A)1, at 663.

150. Forensic psychologists recognize that their own personal values, moral beliefs, or personal and professional relationships with parties to a legal proceeding may interfere with their ability to practice competently. Under such circumstances, forensic psychologists are obligated to decline participation or to limit their assistance in a manner consistent with professional obligations.

Id. § III(E), at 658.

151. Being retained by one side in a civil or criminal matter exposes the forensic psychiatrist to the potential for unintended bias and the danger of distortion of his opinion. It is the responsibility of the forensic psychiatrist to minimize such hazards by carrying out his responsibilities in an honest matter striving to reach an objective opinion.

FORENSIC PSYCHIATRY GUIDELINES, *supra* note 147, § IV cmt.

information about himself/herself through public media"[152] without having conducted an examination. This "Goldwater Rule" was developed to apply to public political figures rather than criminal defendants and would not bar testimony without an examination in the latter case.[153] The American Academy of Psychiatry and the Law also permits such testimony as a last resort, and only if the expert acknowledges the limitations of such testimony.[154] Forensic psychologists are similarly cautioned about testifying without conducting an examination, but are not forbidden from doing so.[155]

Thomas Grisso and Paul Appelbaum reject the argument that it is unethical per se (i.e., in theory, in all cases) to offer predictions of future violence in expert testimony because of the lack of scientific data.[156] Their contention is based in part upon the ubiquity of such predictions in many forensic mental health contexts including civil commitment where general data supports such risk assessments or predictions for persons or diagnostic groups similar to the particular patient at issue.[157]

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152. MEDICAL ETHICS, *supra* note 128, § 7, n.3.

153. *Id.* § 7-A, at 37-38.

154. Honesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination. While there are authorities who would bar an expert opinion in regard to an individual who has not been personally examined, it is the position of the Academy that if, after earnest effort, it is not possible to conduct a personal examination, an opinion may be rendered on the basis of other information. However, under such circumstances, it is the responsibility of the forensic psychiatrist to assure that the statement of his opinion and any reports or testimony based on this opinion clearly indicate that there was no personal examination and that the opinion expressed is thereby limited.

FORENSIC PSYCHIATRY GUIDELINES, *supra* note 147, § IV cmt.

155. Forensic psychologists avoid giving written or oral evidence about the psychological characteristics of particular individuals when they have not had an opportunity to conduct an examination of the individual adequate to the scope of the statements, opinions, or conclusions to be issued. Forensic psychologists make every reasonable effort to conduct such examinations. When it is not possible or feasible to do so, they make clear the impact of such limitations on the reliability and validity of their professional products, evidence, or testimony.

Forensic Psychologist Guidelines, *supra* note 144, § VI(H), at 663.

156. Thomas Grisso & Paul S. Appelbaum, *Working Paper Series 2: Is It Unethical to Offer Predictions of Future Violence?* (1991), L. & HUM. BEHAV. (publication forthcoming).

157. In summary, not all predictive statements about future violence are unethical due to lack of scientific support, because predictive testimony stated as a risk estimate sometimes is scientifically supported. Moreover, the fact that the scientific evidence manifests significant false-positive rates does not detract from the potential value of risk estimates for courts' legal decisions about restrictions of liberty.

Even if one were to accept their view, however, expert testimony regarding the prediction of sexual violence under the statute might be considered unethical in some cases, especially because the consequences of such testimony are substantial. Such clear cases would include the "expert" without true expertise (i.e., no clinical training, knowledge, or experience with a specific population such as mentally retarded sex offenders or a particular paraphilia),[158] where the data base (i.e., base rates of sexual offending) for a particular population is inadequate to offer risk assessments about the individual in question, or testimony beyond one's expertise (e.g., assertions of infallibility or omniscience, misreading scientific data, equation of short-term and long-term predictions). Having failed to conduct an examination of the alleged sexual predator, while still testifying that he is "likely to engage in predatory acts of sexual violence,"[159] cannot by itself seemingly constitute unethical conduct, but this factor can be used in conjunction with other elements to decide whether an expert's conduct and testimony in a given case was ethical.

While it may not be possible at present to condemn as unethical every long-term prediction of sexual violence offered in a Washington court,[160] even those made without a personal examination or contemporaneous testing, we should be ethically wary of expert testimony that pretends to great validity about the long-term predictions of sexual violence. Such testimony should be rigorously scrutinized.[161] Caution is especially important given the stakes of indefinite confinement as a sexual predator.

VI. CONCLUSION

I have attempted to argue that Washington's Sexually Violent Predator Act, part of the larger Community Protection

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Id. at 12.

158. *See, e.g.*, Skaggs v. Commonwealth, 803 S.W.2d 573 (Ky. 1990) (finding that forensic psychologist testifying at trial for a criminal defendant was a fraud), *cert. denied*, 112 S. Ct. 140 (1991); Joseph v. Board of Med., 587 A.2d 1085 (D.C. 1991) (finding that physician testifying as expert in medical malpractice case misrepresented his credentials and was reprimanded by State Board of Med.).

159. WASH. REV. CODE § 71.09.020(1) (Supp. 1990-91).

160. Paradoxically, ethically prohibiting long-term predictions of sexual violence could bar long-term predictions of sexual nonviolence.

161. I am not here concerned with legal procedures such as cross-examination that are often not adequate to impeach the purportedly unethical testimony; *see* Smith, *supra* note 132, at 164-65.

Act, establishes a mechanism of indeterminate preventive detention rather than a treatment program under the *parens patriae* authority of the state. Purporting to offer treatment to a group of sex offenders in this context is a facade for the underlying social control that is established.

The statute's conceptualization and designation of a special category of sex offender as a sexual predator largely fails to coincide with clinical or empirical knowledge regarding sex offenders. The vagueness of the definition of a sexual predator permits widely discrepant and subjective inclusion criteria. The statute creates insurmountable problems for clinicians in the prediction of sexual violence, especially over the long term.

It is uncertain, perhaps unlikely, whether the program will receive treatable sexual predators or be able to provide meaningful treatment to them. Of great import for the mental health professionals and professions involved, there are potential abuses by or of the participants in the process (society, evaluators, therapists, inmates, sexual predators). The statute will again raise questions about the role and responsibilities of clinicians when they work in criminal settings.