

Engle

I would like to thank Chairman Gannon and the other members of the House Judiciary Committee for inviting me here to testify today. In October of 1997, I testified before the Senate Judiciary Committee and attempted to explain the significance of a study conducted at Villanova University which sought to ascertain the attitudes and opinions of individuals who are involved in the treatment of violent sexual offenders. The Violent Sex Offender study was conducted by members of the sociology department at Villanova, specifically Dr. Bernard J. Gallagher, III, Dr. Joseph A. McFalls, Jr. and myself. This study focused on the attitudes and beliefs of members of an organization known as ATSA, the Association for the Treatment of Sexual Abusers, and it explores issues surrounding the treatment and release of violent sex offenders. Violent sexual offenders were defined as those who have a predilection for committing violence during an act of non-consensual sex, where the violence involved goes above and beyond the inherently violent nature of the sex crime. The study sample included 1040 members of ATSA from the United States, of which 540, or 52%, responded to the mail survey. The ATSA respondents included individuals from many fields including, psychiatry, psychology, social work, corrections, parole and the like.

I must caution this committee that the Violent Sex Offender study was never designed with the intent, or for the purpose, of investigating the specific issue which House Bill No. 1811, the Sexually Violent Predator law, contemplates. The involuntary civil commitment of sexual predators was not directly examined by the study, nor can the data serve as the basis for any legislative intent behind a law such as the one being considered here today. However, the results of the study can provide some insight into aspects of this legislation. For example, the Sexually Violent Predator law is premised on the belief that sexually violent predators have personality features which are unamenable to existing mental illness treatment modalities, nevertheless the

data suggest that this assertion does not conform to the information gathered from ATSA members.. In response to the statement “ it is not safe to release some sexual offenders into the community after their period of incarceration and treatment has been completed” 88.3% of those surveyed either agreed or strongly agreed, while 5.4% were not sure, and only 6.3% disagreed or strongly disagreed. That data indicates that some violent sex offenders are not safe to be released while others can be. Therefore, some sex offenders are amenable to current treatment modalities.

TP The study further supports this proposition because the first item on the questionnaire asked the respondents to evaluate the effectiveness of various treatments from completely ineffective to strongly effective. All of the respondents indicated that some form of treatment was, at the very least, effective. This means that some of today’s treatment modalities work for certain categories of sexual offenders. Violent sexual offenses constitute a very broad category of behavior engaged in by a very diverse group of offenders, some of whom are amenable to treatment, while others are not. TP Unfortunately, this research did not, and in many respects could not, ascertain the opinions of ATSA members with respect to which types of sexual offenders are able to be successfully treated. Nonetheless, this legislation is overbroad because it will allow for the involuntary commitment of people who suffer from a mental illness that can be treated when the law seeks to commit those sex offenders who are unamenable to treatment.

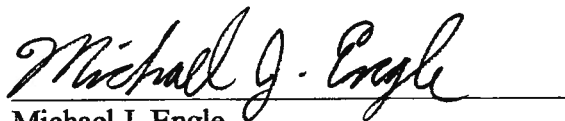
Another significant limitation when studying the field of violent sex offender treatment involves the difficulty in generating a definition for this broad category of offenders. There are many types of sex offenses and various kinds of sexual offenders with a host of similarities and differences. House Bill 1811 defines a sexually violent offense in terms of statutory violations that contemplate a wide variety of criminal behavior, while it deems someone to be a sexually violent predator if that person is convicted of one of these crimes and also suffers from a mental

abnormality or personality disorder. A language barrier continues to exist between law and psychiatry, whereby legislation identifies candidates for commitment based on violations of the criminal law, while the people responsible for treating sex offenders categorize based on a medical diagnosis. These two separate and distinct methods of classifying sex offenders do not fit together well. This legislation designates crimes such as prostitution, kidnapping, and misdemeanor indecent assault as sexually violent offenses, however, none of these crimes are necessarily committed because the individual is a pedophile or suffers from antisocial personality disorder. The existence of a mental illness in conjunction with a conviction for prostitution does not establish that the crime was committed as a result of the mental disorder or that the offender is unamenable to treatment and, therefore, must be involuntarily committed for the sake of safeguarding society.

The results of the Violent Sex Offender study do indicate that many ATSA members agree with the legislation's statement that the prognosis for rehabilitating sexually violent predators in a prison setting is poor. In response to the statement "violent sexual offenders would be better maintained within a prison-like setting rather than in their own treatment facilities" 48.7% strongly disagreed or disagreed, 26.6% were not sure, while 24.7% agreed or strongly agreed. If it is true that rehabilitation does not occur while a sex offender is incarcerated, then treatment cannot have any chance of success until after the individual is released from prison. However, if that person is involuntarily committed without having been treated in prison, and treatment is not provided during the period of commitment, then it will be impossible for anyone to provide the evidence necessary to establish probable cause to believe that the person is no longer a danger to the community because their mental abnormality or personality disorder has changed. In essence release will be virtually impossible once someone is committed.

In conclusion, the data from the Violent Sex Offender study tells us that ATSA members acknowledge the fact that some sex offenders cannot be treated successfully and that some offenders are not safe to be released into the community. However, there are other people who fall within the scope of this legislation who are amenable to treatment. The question is whether we as a society choose to throw our hands in the air and give up on the prospect of treatment and rehabilitation in favor of mere incapacitation, or will we advocate the continued study of violent sex offenders with the hope of constantly improving treatments. From the written comments of the ATSA members who responded to the study, it is readily apparent that the individuals who treat sex offenders are not willing to simply give-up, but rather they need support in order to continue to their important work. I wish the data collected thus far could provide definitive answers to the questions surrounding the utility of involuntary civil commitments of sexually violent predators, nevertheless I cannot proffer such information today. More research must be conducted before any conclusions can truly be made with regard to the appropriateness of commitments contemplated by House Bill 1811. Thank you for your time and attention, I hope that I can answer any questions you may have concerning the Violent Sex Offender study.

Respectfully submitted,



Michael J. Engle
Project Director
Violent Sex Offender Study
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VILLANOVA UNIVERSITY

HONORS PROGRAM

Dear ATSA member:

I am an Honors student at Villanova University currently involved in a study concerning violent sexual offenders. As part of this project, I am attempting to ascertain what professionals think about the conditions and treatment of violent sexual offenders—those who have a predilection for committing violence during an act of non-consensual sex. Along with this short survey, I have included a self-addressed, stamped envelope for your convenience. I am extremely grateful that ATSA has approved this project, and I would be very appreciative if you would take one minute to complete this anonymous survey, which will help me so much in my thesis work. Thank you for your help.

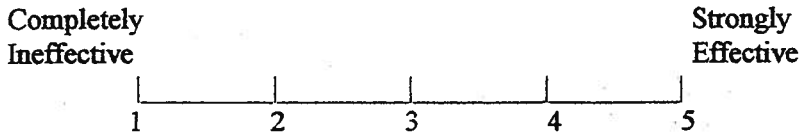
Sincerely,

Michael J. Engle

Michael J. Engle

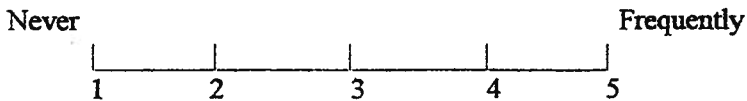
VIOLENT SEXUAL OFFENDER STUDY

1. Please evaluate the following treatment modalities by using the 1-5 scale below.



- A. Interactive Psychotherapy _____
(e.g., Psychoanalysis, Psychotherapy, Group Therapy)
- B. Behavior Therapy _____
(e.g., Classical Conditioning, Operant Conditioning, Aversion Therapy)
- C. Cognitive Restructuring _____
(e.g., Skills Training, Sexual Education, Violence Control, Gender Role Playing)
- D. Antilibidinal Treatment _____
(e.g., Castration, Estrogen Therapy, Pharmaceutical Treatment)

2. Using the scale below, please indicate how often you have used these modalities.



- | | |
|--------------------------------------|----------------------------------|
| A. Interactive Psychotherapies _____ | C. Cognitive Restructuring _____ |
| B. Behavior Therapies _____ | D. Antilibidinal Treatment _____ |

(OVER)

3. Please use the following scales to respond to the statements below:

Strongly Agree
SA

Agree
A

Not Sure
NS

Disagree
D

Strongly Disagree
SD

- A. Mental health professionals have a clear understanding about the causes of violent sexual behavior. _____
- B. It is necessary to treat violent sexual offenders differently than other felons in the criminal justice system. _____
- C. It is not safe to release some sexual offenders into the community after their period of incarceration and treatment has been completed. _____
- D. I am often concerned about the legal and/or moral ramifications of a patient of mine failing to control his violent sexual urges after being released into the community. _____
- E. I have often treated patients who continue their violent sexual behavior after being released into the community. _____
- F. I suspect that many violent sexual offenders have relapses after completing treatment programs. _____
- G. Violent sexual offenders would be better maintained within a prison-like setting rather than in their own treatment facilities. _____

4. Which official psychiatric diagnosis is most frequently associated with violent sexual behavior?

DEMOGRAPHICS

Age _____

Sex Male _____ Female _____

Occupational Title _____ Years in Occupation _____

Political Orientation Conservative _____ Liberal _____
 Moderate _____ Left Liberal _____

Other Comments

Violent Sex Offender Study

Question #3	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
A.	1.5%	20.2%	12.4%	49.4%	18.0%
B.	41.3%	39.6%	7.1%	10.1%	1.9%
C.	50.3%	38.0%	5.4%	4.3%	2.0%
D.	21.6%	48.9%	9.5%	17.9%	2.1%
E.	3.1%	12.4%	19.8%	42.1%	22.7%
F.	16.1%	46.8%	22.1%	14.2%	0.7%
G.	7.5%	17.2%	26.6%	33.8%	14.9%

Not Safe to Release

Question #3C	Strongly Agree/ Agree	Not Sure	Disagree/ Strongly Disagree
Members involved in treating sex offenders ¹	88.5%	5.3%	6.2%
Members working in Crim. Just. System ²	92.9%	7.1%	0.0%
Members working in other capacities	88.5%	4.9%	6.6%

¹ Those involved in treatment include psychiatrists, psychologists, psychotherapists, social workers, counselors, and administrators in treatment facilities.

²Those in Criminal Justice System include parole officers, probation officers, correctional workers (counselors).

Relapses After Completing Treatment

Question #3F	Strongly Agree/ Agree	Not Sure	Disagree/ Strongly Disagree
Members involved in treating sex offenders	64.5%	20.9%	14.6%
Members working in Crim. Just. System	64.3%	14.3%	21.4%
Members working in other capacities	62.3%	27.9%	9.8%

Legal/Moral Ramifications

Question #3D	Strongly Agree/ Agree	Not Sure	Disagree/ Strongly Disagree
Members involved in treating sex offenders	69.7%	9.3%	21.0%
Members working in Crim. Just. System	78.6%	7.1%	14.3%
Members working in other capacities	73.7%	10.5%	15.8%

Different Than Other Felons

Question #3B	Strongly Agree/ Agree	Not Sure	Disagree/ Strongly Disagree
Members involved in treating sex offenders	79.6%	7.6%	12.9%
Members working in Crim. Just. System	100%	0.0%	0.0%
Members working in other capacities	86.9%	4.9%	8.2%

Not Safe to Release

Question #3C	Strongly Agree/ Agree	Not Sure	Disagree/ Strongly Disagree
Conservative	85.7%	6.1%	8.2%
Moderate	89.3%	5.2%	5.6%
Liberal	86.6%	5.9%	7.4%
Left Liberal	96.8%	3.2%	0.0%

Relapses After Completing Treatment

Question #3F	Strongly Agree/ Agree	Not Sure	Disagree/ Strongly Disagree
Conservative	71.4%	20.4%	8.2%
Moderate	61.3%	23.0%	15.7%
Liberal	64.5%	21.5%	14.0%
Left Liberal	71.0%	12.9%	16.1%

Legal/Moral Ramifications

Question #3D	Strongly Agree/ Agree	Not Sure	Disagree/ Strongly Disagree
Conservative	63.3%	14.3%	22.4%
Moderate	75.3%	9.3%	15.4%
Liberal	68.9%	7.7%	23.5%
Left Liberal	60.0%	16.7%	23.3

Different Than Other Felons

Question #3B	Strongly Agree/ Agree	Not Sure	Disagree/ Strongly Disagree
Conservative	77.6%	2.0%	20.4%
Moderate	85.8%	5.6%	8.6%
Liberal	77.2%	9.4%	13.4%
Left Liberal	76.7%	6.7%	16.6%