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COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
JUDICIARY COMMITTEE
SUBCOMMITTEE ON COURTS

IN RE: House Bill 1992

Record of hearing held in Green Tree Municipal Building, Sycamore Room, 10 West Manilla Avenue, Pittsburgh, Pennsylvania 15220; Friday, September 24, 2004 at 10:00 a.m., Honorable Allan Egolf, Acting Subcommittee Chair.

T2004-090

APPEARANCES

MEMBERS OF THE HOUSE OF REPRESENTATIVES

Honorable Allan Egolf, Acting Subcommittee Chair

ALSO PRESENT:

David Thomas

Michael Fink

Jane Mendlow

William E. Weber, RDR
Steffan & Stauffer
Chamber of Commerce Building
411 Seventh Avenue
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HEARING

September 24, 2004

HONORABLE ALLAN EGOLF: Okay, the time is about 10 o'clock. We will get the meeting underway. Good morning.

DR. KUHN: Good morning.

HONORABLE ALLAN EGOLF: I want to welcome you to the informational meeting on House Bill 1992, it's being conducted by the Subcommittee on Courts, a subcommittee of the House Judiciary Committee. And I want to thank all of you for your willingness to attend here and share your expertise and knowledge and research results with the committee on this somewhat controversial subject.

I'm sorry we don't have more members here of the committee present, but due to various things the last minute, primarily flooding in our state, we have had a number of people that had to cancel at the last minute. I'm not on the committee actually, but I was asked to chair it, since I'm the prime sponsor of the legislation.

When Chairman Craig Dally who was definitely planning to be here had to cancel, because of flooding in his district, I was asked then to fill in and chair the meeting. It was decided by the

Judiciary Committee Chairman to conduct this as an informational meeting rather than a formal hearing because of the, and because of the small number of distance, lead a round table discussion. The discussion is being recorded as you see. And we've asked them for a copy of your presentation afterwards, I understand we are going to have.

I would like to have introductions now and I'm Representative Allan Egolf, I represent the 86th District, which is Perry and Franklin Counties near Harrisburg. I will have staff introduce themselves please.

MR. THOMAS: My name is David Thomas, counsel to the House Judiciary Committee.

MR. FINK: Mike Fink, analyst, house research.

MS. MENDLOW: Jane Mendlow, research analyst, House Judiciary Committee.

HONORABLE ALLAN EGOLF: Dr. Kuhn, do you want to start and introduce the others, however you want to do it.

DR. KUHN: I think we are going to project up there, if I can invite you to come down here and make yourself comfortable.

HONORABLE ALLAN EGOLF: Very good.

DR. KUHN: Good morning. What we are going to do is present the results of our study and its comparison of standard psychotherapy versus Leuprolide acetate with standard psychotherapy for suppression of aberrant sexual arousal. Our chief investigator is Justine Schober, MD, she's a pediatric urologist, extraordinary unique experience in she is treating both the children who were abused and the abusers which attest to her compassion as a physician.

I'm Dr. Phyllis Kuhn, your project director. Our co-investigators are Paul Kovacs, a psychotherapist, James Earle who is here and Dr. Earle is our polygraph expert and the chief polygraph examiner for JHE Consulting Group Incorporated. His expertise is in polygraph in sexual offenders. We will discuss each of the participants' background a little bit more as they present their sections.

Dr. Peter Byrne is here from Salt Lake City, the president and CEO of Behavioral Technology, Inc., and he manufactures plethysmography equipment. Dr. Byrne received his Ph.D. degree and his thesis was actually on plethysmography.

Ruth Fries is not here, research study coordinator, actually collected and managed all the data.

Our consultants include Dr. Gene Abel and he is the inventor of the Abel Assessment, he actually presented part of this when presenting at a sex offender conference.

We also have an ethical consultant the Very Reverend Joseph Gregorek and also Monsignor James Peterson, the spiritual consultant.

Other consultants include Bradley Foulk, Esquire, District Attorney in Erie, Pennsylvania, William Cunningham, the President Judge Erie County Court of Common Pleas. And Paul Goebel, former associate director of human subject protection from the FDA. Possibly the national expert on consents and consent documents.

Dr. Schober is going to present the introduction, she is board certified in urology, a Fellow in American Academy of Pediatrics, Society of Pediatric Urology and European Society of Pediatric Urology, North American TASK Force on Intersexuality and European Scientific Advisory Board German Ministry of Science and Research. Her reputation is national and international. Dr. Schober.

DR. SCHOBER: I suppose that tells you I have had a little bit to do after the last 18 years. That I finished my fellowship in Pediatric Urology

Institute of Neurology London, and while I was there, my fellowship basically was concentrated research wise on not simply just pediatric adolescent urology, basically sexual medicine. So, over the years I have done a lot of work sort of international policy making, I supposed you don't get that from this, but you know, we have international policy in relationship to surgery and medical care of somatosexual disorders, so I sit on both a national task force which includes the United States and Canada and now, of course, policy making board, which will precede sort of the European communities research effort on somatosexual disease. I do a loft work in intersexuality and sexual dysfunction.

Of course, sex offender treatment falls under the category of sexual medicine. It all has to do with the same thing, orientation and investigation of orientation and how one might investigate it objectively as well as psychologically, objectively physiologically as well as psychologically. So, when we start to think about this subject as applies to sexual medicine and sex crimes, which is what we are addressing here in this bill, what we, the way we categorize the people we are going to be discussing today is we think of people as, who have this sort of

orientation, called pedophiles, but they are very distinct definitions of pedophiles, so in order to classify people for the study, what we wanted to do was to very tightly classify pedophiles as to those people who have inappropriate sexual object and sexual fantasy structures oriented toward prepubertal children, not specific Perry prepubertal children, but prepubertal.

Often self-reported victims of sexual abuse known in the literature. What we recognize because they have an altered orientation, they are quite often socially divorced from the rest of society and for that reason they are quite often remorseful although they don't particularly have control over their orientation.

It is most frequently their only crime and they are generally nonviolent. Preferential child molesters have a need for frequent and repeated sex, more so than the person of a heterosexual orientation or even sometimes more so than those in the homosexual orientation. They have potential for molesting large numbers of children that has been recorded in the literature, and it appears the average number of children each pedophile molests is approximately 380 or more.

So, they become a very interesting group to study and also a very interesting group to target as far as legislation and as far as control and as far as safety measures within society, because they have such a potential for interfering with or molesting such a large number of people.

And so, in fact, with that sort of categorization, we proceeded to look at the numbers within the state prison population. We found out that our state prison has approximately a population of approximately 37,500. We know the number of them that are incarcerated with the designation of sex crime is approximately 13 percent. But because of the way their crimes are listed, they are not always caught when you look at statistics, because they are not always given a sex crime conviction. They are often given other assault crimes that don't have a sexual designation.

So, we would approximate, we are told the approximate figure is really probably about two times that 13 percent figure, it is probably more like 26 percent of those in prison have some type of sex crime background. I would say to you they also reflect a very small part of what actually happens in society, because we are only looking at the people who have

been convicted, but in fact, there are probably a large number of people who are within the community who are not convicted who have that sort of orientation and that sort of repertoire.

So, in fact, when we also look at people who are pedophiles, and who are convicted and/or who have offended, we know they have a very high re-offense rate if nothing is done. By that I mean imprisonment doesn't exactly do anything for stopping them from committing the crime after they are out of prison. And if nothing at all is done, if they are just counseled or just imprisoned and then they are released and they are not treated in some fashion, their re-offense rate is gauged to be incredibly high, may approach 100 percent. But generally figures in literature somewhere between 43 and 83 percent. If you give them simply standard psychotherapy for the period they are receiving the standard psychotherapy, their re-offense rate drops to about 24 percent. But the minute psychotherapy is stopped, we go back to the untreated re-offense rate.

Now, the Scandinavian countries, Denmark, Norway have always addressed this type of a crime with castration. I mean for a long time now, 30 or 40 years they have been looking at castration as one of

the answers. And they plotted the re-offense rates of pedophiles once they are castrated. They found re-offense rate obviously drops dramatically. In their type of treatment, they are looking at surgical castration as a treatment for pedophilia. So, you can see the re-offense rate is incredibly low after that happens.

But the re-offense rates vary. Why are they so variable in the literature, because recidivism definitions vary. Recidivism means they have done it again. But they've done it again, has a variety of definitions, they have done it again by fondling someone, they have done it again by orally stimulating someone, they have done it again by pornography, they have done it again by actually sexually molesting or raping somebody. You can see how broad the definition of recidivism can be. It varies by length of follow-up.

The longer you follow a person, the greater the chance for recidivism. Most of the recidivism in the literature happened five years perhaps after incarceration. But as you know, most people have much more than five years of life after incarceration so, the recidivism probably is much, much higher plus tracking recidivism is difficult. If you are looking

to find out someone not incarcerated, just out in the community has once again offended, because it's a crime, because it is immoral, the likelihood of them telling you or the likelihood of you finding out they offended again is probably very, very, low. So, recidivism is kind of a very vague concept.

All testosterone lowering therapies, castration, and drug therapy, cyproterone acetate which is available in Canada and Europe, Medroxyprogesterone acetate which is a drug that's been used probably for the last 30 to 40 years in treatment of pedophilia or sex, have produced lower levels of recidivism. And that's a well-known fact.

Dosing. Now, there are several different kinds of testosterone lowering agents. Medroxyprogesterone is the classic, the one that has been used for the last say 30 years. It is, it was originally given orally and now it is an injectable. It started off as an injectable every one month now injectable every three months.

The second drug is something called Tritoriline. It is very similar to Leuprolide acetate. It is also injectable injected every month. Cyproterone acetate is an oral drug but is also, there is an injectable form. Cyproterone acetate because

most usually given in oral form, it is very difficult to control its administration, in other words, it is difficult to assure the person is taking the drug.

Unless you can look at testosterone levels, but the truth is any person who takes oral drug has a falloff rate of about 15 percent. If you don't want to take the drug, if you are looking at the drug as something that is therapeutic you don't want therapy, the likelihood of you taking the drug is even worse. And it would be very difficult to have to monitor people with an oral drug.

The last drug of course is Leuprolide acetate, it is also an injectable. An injectable that we give and traditionally given once every three months. Newer forms coming out of it are implantable, small implantable rods that last a year which makes of course the disposition of the drug and the assurance that the drug is in the system much higher. And it makes it much easier to supervise. Anyway, they all have side effects.

And when you are choosing a drug for research purposes, therapeutic purposes, of course you are looking for the lowest side effect profile if you are a physician.

Medroxyprogesterone acetate, one of the

longest used drugs originally -- has a really high side effect profile. The side effect profile is difficult because, of course, the side effect is thrombosis which means blood clots, fatigue, weight gain, depression, you see there will be heart side effects related to Medroxyprogesterone acetate, very high weight gain.

Cyproterone acetate although it is somewhat safer, still has a rather high side effect profile with depression, fatigue, weight gain, a higher rate of feminization, although rare, it has a terrible risk for sudden hepatic failure and death. That makes it a little bit less desirable as a drug for therapeutic purposes.

Tritoriline, there's just one report in the literature that used Tritoriline, used in Israel, very similar to Leuprolide acetate, once again a slightly higher side effect profile than Leuprolide acetate, and that being sort of flushing, sudden sweating, rapid mood changes, vomiting, diarrhea.

And of course, if the side effect profile is something that makes a person feel sick every day, they are very unlikely to want to take it. It is a little bit more difficult as far as the administration over a long period of time.

Leuprolide acetate, we chose it because it has been used for a long time. It has a lot of safety efficacy data because it was used for prostate cancer. So, in fact, it has a low side effect profile. Probably the most, the most frequently reported side effects are hot flashes and decreased libido and weight gain. Of course, decreased libido is one of our chosen side effects, we want it to do that for this specific purpose. It has a ton of safety efficacy data because it has been used probably 20 to 25 years for prostate cancer.

It is so safe it has FDA approval, the hardest FDA approval to get, use in children. So, in fact, Leuprolide acetate had approval to be used in children for precocious puberty, so that shows, that indicates it is really relatively a safe drug to use.

How well does it decrease testosterone, that is another one of the qualities we are looking at for use for this purpose. The Medroxyprogesterone acetate probably only brings testosterone down to half of the normal serum level. Half of testosterone is really a lot of testosterone. It does allow one to maintain libido for the most part, and erectile capacity much more so than the other three drugs.

Cyproterone acetate, Tritoriline all bring

the testosterone level down to castrate levels probably under 10th of the normal serum level of testosterone.

Leuprolide acetate once again things about it that are good, an injection given once every three months or implant once a year. It has minimal side effects, large amount of safety efficacy data has been used in the past for prostate CA and precocious puberty.

How does it work? Well, when we think about sexual abuse and sex in general. Specifically sexual abuse.

Because sexual abuse is something -- it is an altered orientation. It is an altered orientation where it has a societal implication of wrongness. And so people for the most part that have that kind of orientation are generally, because they recognize they are doing something that is not like the rest of society, they have to deal with that, they have to adjust to that. And it isolates them from the rest of society because they are different. And so, as they become isolated, they become lonelier. And of course, isolation and loneliness increases depression so you have a lot more time to think about your, what would make you feel better.

And so when people want to feel better, they

think about things like sexual fantasies because if they can feed into what makes them feel good, they feel better to some extent. So, once they start to become isolated, lonely and let themselves go into sexual fantasies, then a cascade starts to build up. What happens after you feel the fantasy, you have the urge to do it, you know that, have remembrance doing it, makes you feel better. So, you do the thing that makes you feel better, you masturbate, that gives you some sort of a relaxational release, and then once you've done that in relation to the fantasy, you want to have the real thing.

So you start to rationalize, all right, this is not really a good thing to do, but I can do it because of all different kinds of rational reasons. That is what pedophiles do, that is what most people when they do something wrong. They start to find reasons in their head that what they are doing is okay. They start to plan how they are going to do it. And then they carry out the act.

So, we are trying to break the cycle. So we are trying to look at ways that we can break the cycle. How can we break the mental beginnings of sexual fantasy, how can we drop libido? What can we do to make negative feedback once one has libido the

urge to masturbate, what if masturbation didn't come out with the outcome they anticipated. And it wasn't a pleasant outcome, couldn't get erection, couldn't ejaculate, they didn't have the release.

So how can we build that up to be negative feedback or not as beneficial feedback so somebody wouldn't want to do it. We have to break the steps. We think Lupron works in a couple of different ways. Because it centrally suppresses hormones, it works kind of -- it works at the brain level. So, it stops people from fantasizing. And if they are not fantasizing, then maybe they don't have so much of an urge or so much of a motivation to do behavioral things that come from the fantasy.

So, in fact, it also makes one less likely to get an erection and perhaps also almost unlikely to have an ejaculation. So if one were to try to masturbate, the outcome would be negative because of the drug. So, it becomes sort of negative feedback mechanism, and it breaks the cascade. So if you can't get all those things going, the likelihood you are going to rationalize and plan an activity like molestation becomes less and less and less because you know you are not going to have the positive feedback outcome that you originally expected, originally come

to find would be the outcome.

So, we designed the study in this way. And with that theoretical background. So Dr. Kuhn is now going to tell you a little bit more about the study design and assessments we have built into the study and why we built them in.

Dr. Phyllis Kuhn is a Ph.D. in microbiology. She is board certified in microbiology, but she has a very long history of being Director of Research, overseeing all kinds of research, medical research, so she has a very long background in that. And springing from the background she just put together even more, even more broad research institute which interrelates both medical and device creation with industries and universities. She now has a very broad job as the Director of Research.

And I think it qualifies her to look at this research in a very objective way and in a very broad way from a lot of different areas. She is going to tell you about the technical considerations of this study.

DR. KUHN: Thank you, Dr. Schober. Dr. Schober and I were invited to write a commentary on the study for the British Journal of Urology. I think this pretty much captures how difficult this project

was to do.

Few illnesses elicit societal scorn that pedophilia engenders with the possible exception of leprosy, and more recently, AIDS. Most of your illnesses manifest an array of signs and symptoms that facilitate diagnosis and treatment. Treatment generally results in cure, or at very least suppression of symptoms. The psychosocial disorder of pedophilia produces no signs and the symptoms are all transient and unlike any other disorder, carefully concealed by the afflicted.

Because the study subjects lived in the shadows with their disorders, we were told by experts across the country that absolutely no one would volunteer for our study, our carefully planned study. In actuality, what happened was five men volunteered in a two-month period, one was begging to come in. Simply, we didn't have the funds to take him.

We have five men, age 18 or older in fair to good health. They are all psychologically diagnosed pedophiles, out of denial. All satisfied the diagnostic criteria for pedophilia DSM-IV all medium high to high risk on a special test called Static-99. We tell you when the men first came to us, two of them were actually shaky. And I personally gave them

credit for coming forward to ask for help.

We did have exclusion criteria which included seizures, steroid use or hormone use. Because you can negate the effects of Lupron by taking testosterone. Disorders of the kidney, heart, liver or respiratory system. Other criteria, drug and alcohol abuse, unresponsive on plethysmography. And Peter will describe that. An IQ less than 70. It isn't the therapy wouldn't be efficacious in individuals with an IQ less than 70, just for study protocol, there were so many surveys that they had to take that the study designed negated their inclusion.

Our mean age was 50, range 35 to 58 years old. These men have already done a lot of damage. We did -- some of them had a variety of medical conditions. Because of their age we did have to qualify our study to take men in fair health. Some had diabetes, heart decease, arthritis, allergies, one had cerebral palsy generally that strike populations as they age.

Occupations, interesting. Clergy, handymen, photographer, McDonald's food handler, former professor. You can see it actually cuts through the entire society strata. Every single one of the subjects except one had been victimized.

Check the ages, 8, 12, 12 and 18. These are self-reported number of victims for five pedophiles, 803. Episodes over 3,000. So these children weren't just molested once, they were molested over and over and over.

Our study population, total incarceration 31 years, estimate 200,000 a subject.

This slide is interesting because it shows you the victim age as well as the age the subject was victimized. You will see number one, go to number two. The victim age was 8 to 14. The age of the subject victimized was 8.

Number three, victim age, 0 to 17. This gentleman was sodomizing his 7 week old son. Age subject victimized 12.

On number four, three to 11 years old, age he was victimized was 12. What we are getting at here, there seems to be a correlation between the victim age, and the age the subject himself was victimized.

This project was very, very expensive. It was funded by a joint effort of Hamot Medical Center in Erie, Pennsylvania and Saint Vincent Health Center, one of the very few things they collaborated. TAP Pharmaceuticals provided $25,000. They subsequently

provided another $20,000 for continuation of the study and they provided study drugs for the first part of the study now in the third part. The project continues.

Five subjects total cost approximately $125,000. And approximately $12,500 per subject per year.

The study design. They were injected with Leuprolide acetate at month one. They were sequestered and they received injections, higher injection of Leuprolide acetate every three months, months two through 13. Subsequently they were given a placebo. They were always on standard psychotherapy.

Because of the slight testosterone rise at the initial injection for the first week to ten days of therapy, subjects were isolated. Here you can see the testosterone rise, and then subsequent crash to castrate levels. The red is all through prime, green omni prime. The reason the end of the chart shows green and red, some subjects were taken off, they were so distressed the blind was broken and reinstated on Lupron at their request.

Group initiation. We had a remote location, contributed so significantly to the cohesiveness of the group, you always have some unexpected study

findings. Because they were together, the emotional bonding accelerated the ability to disclose and confront with each other and the psychotherapist thought it was three to four months they were ahead.

Initial testing included the consent. The consent was reviewed by Paul Goebel who was a former Assistant Director of Human Protection for FDA. Paul Goebel is possibly the nation's leading expert on consents.

We also had Dr. Benekos act as a prisoner advocate on IRB. Keep in mind this is several years ago, it was not required at that time. But we nonetheless took all the precautions we could to ensure there was no element of coercion, no one could say the consent document failed to include so and so, etc. They did go through a very rigorous testing. They continue to go through all this testing.

Many of these are what we called objective methods of measure, here you have men that come volunteer, they not only come to weekly psychotherapy, they tolerate in this particular study eight solid hours of testing every three months. It is the most, I won't say invasive, in a sense, quite invasive. Because it explores the deepest areas, areas they are most ashamed of, would most likely want to hide.

Our outcome measures. Again the unique part of the study is we drew in experts and the people we have sitting here are recognized national experts in their particular areas. The unique thing about the study was we brought the experts in, it was a multi-disciplinary approach of this problem. We used objective methods of measure which differ from subjective methods of measure.

Objective method of measure, you have to level or value you can point your finger at. Subjective is when you ask the patient how are you feeling, how is your pain level. The patient says I hurt a lot. That is subjective. The problem with most of the studies, they garner information by survey. How do feel? Do you still have urges? These men lie. If there is one thing we learned from the study, it is most of the testing that had gone on before, in many of the studies that had gone on before had a problem in this aspect because you can't ask these people how you feel initially. Because they are going to lie to you. So a lot of the surveys and things done the results that were gathered, you know basically come into question.

So, testosterone level is a blood test. You draw, you can tell what the testosterone level is.

Interest preference, you know, what age are they interested in? Because pedophiles are interested in different age groups, different sexes, very specific age ranges. And we use a product called Abel Assessment and Monarch PPG. We use them together. There are two interesting methods of measure. The Monarch measures penile tumescence, the gold standard subjected to say a variety of audiovisual stimuli, there is actually a place on their penis, their erection is measured.

If that is not putting yourself out there, I don't know what is. The Abel Assessment is a different tool to assess sexual preference. You simply look at slides. They are non-sexual, men, women, children, all clothed, and depending how long you look at that slide, correlates like 90 percent with yourself reported sexual interest. Our idea was to couple the two procedures, as these men were given Lupron and testosterone dropped the thier ability to have erection dropped, we wanted the second method to be able to assess if that urge or interest was actually still there, so we chose the Abel Assessment.

Then we enriched the mix by throwing in the polygraph with Dr. Jim Earle and again penile responsiveness.

We asked four research questions. What effect did LA have on testosterone levels, interest preference, sexual ideation regarding urges and thoughts of masturbation and penile responsiveness.

Dr. Schober is going to present part three, the psychotherapeutic component. Dr. Schober.

DR. SCHOBER: A study like this has very basic ethical requirements. And in fact, a study like this would be remiss not to include a psychotherapeutic component to it.

Psychotherapy is used to address this problem for the last 40 years. It's necessary because it helps us to look at how people actually respond to what we do to them drug wise. It is always asked, can't you just give the drug and just let them go. But the truth is, it helps us to track exactly what people are feeling and doing and it helps us to modify their behaviors when they are in a more receptive condition. That has been the problem with psychotherapy all along.

I personally would say because if you are not receptive to psychotherapy, if you are continuously distracted by compulsive thought, it makes it very difficult to incorporate psychotherapeutic concepts, so in fact, psychotherapy in this fashion is given in

a very standard way. It is given with two different components.

First of all, we made the diagnosis in a psychiatric way through DSM-IV. Our clients were, our study people were all medium high or high risk pedophiles. They had fantasies, urges, behavior involving sexual activity with prepubescent or peri-pubertal children greater than six months, they all had the quality about them.

Most reported decades of activity. They felt their behavior interfered with their social functioning. Each of them was greater than 16 years of age and at least five years older than their victim.

We did do obsessive compulsive scale scores on all of them. In fact, we do believe some types of altered orientation have obsessive compulsive component, that is why there is such a need for frequent repeated sex, why there is such a large number of victims. You can't break the obsessive compulsive cycling. In fact, these guys all scored by Bydox, very high, severe, moderate on the obsessive compulsive scale.

So, they were then after classification, they were replaced in psychotherapy groups that met weekly, met 90 minutes each week, adjust the study

group. They had standardized focus identifying the number of victims, the assaultive episodes and deviant behavior of each subject.

It had a standardized program which involved cognitive and behavior psychotherapy, it was co-facilitated by two people, Paul Kovacs who is a Ph.D. psychologist and myself.

It once again, the cognitive aspects that were included were -- cognitive just means what you are thinking. Identify factors that contributed to an offense.

So, the pedophile, each pedophile was asked to identify factors that contributed to his offense. And offending. He was to explore feelings, thought, attitudes about his specific pedophilia and offenses. He identified high risk situations. And we tracked deviant and healthy daily occurrences. That was the cognitive portion of this behavior therapy.

The behavior aspects. Once you develop the cognitive appreciation of what you are doing, then you are able to think through and say well, how would I change my behavior. So number one, of course, the first thing is to avoid high risk situations, identify high risk situations, you avoid them.

You recognize the things that might make you

go on to a pedophilic episode, fantasy urges, masturbations you alter the response. You recognize your offense cycle and you alter the response. You develop victim empathy. You think about the victim. You think about all the things you did wrong to the victim and how it might affect their life and you alter your responses so that you do not do that again. So that's what behavioral cognitive psychotherapy really means to us.

Offense cycles. We just explore the offense cycles of the five subjects in this study group. Subject number one, a 51 year old clergyman. He had feelings of homosexual orientation toward adolescent males. He utilized his clergy office and his clergy automobile for privacy and solicitation of the people he was going to offend. He began the offense cycle with provocative talk with the person he wanted to offend and then touching above and then touching below the young person's clothing. He provided them with alcohol. He had an unfortunate sort of violent component to his offense cycle, part of what made him feel very sexually stimulated was to pull the leg hairs out of the person he was offending.

Subject number two was a 58-year-old laborer. He had been victimized in his childhood by

his uncle. He said the victimization of himself impaired his self concept. He reported sexual assaults in children were his distorted attempt to be accepted by children while working through his own rage of being victimized.

Subject number three. Intellectually challenged and socially retarded from a small rural urban community with access to youthful family members. It is the unfortunate situation that this man was in an entire family cohort of people who had sex with one another. That means that most of the people in his family generationally had broken their generational boundaries, you know, uncles had sex with nephews, had sex with nieces, they had sex with other people in their families. They had sex between two and three generations and almost everyone in his family was involved in this.

So, in fact, it made it very hard to sort of incorporate sort of the immorality of it because it had persisted through so many generations and was so tightly woven into his family's sort of social context. He was the one person who probably had the greatest number of offenses and he is the one person who in fact was sexually abusing his children from the time they were just weeks old.

And that sort of person is probably about the most dangerous you can see because you can't take him out of context of his community and say this is immoral, because everyone in his whole family situation was doing it. So he didn't particularly see it that way. He never had been caught. Sorry, his children were taken away from him, but he had never been charged, the only one in the group never charged had never entered prison.

And he to this day is still part of that community. He was seen within his family as the most functional member of his family. So he had very easy access to like every niece and nephew and great niece and great nephew because he was the one providing baby sitting and car rides within the family. So that was a very difficult person.

Subject number four, a laborer, as an infant he had cerebral palsy from birth injury. He had a very unfortunate attachment situation. He was abandoned first by his mother then by his father. He was in a lot of foster homes. And abandonment issues perhaps created what one might see in society as a lack of sort of generational boundaries and a lack of boundaries that one might see between siblings and parents. He had a very distorted psychosocial image. He had a lot

of sadism and anger.

He saw a movie that made a huge impact on him, something called "Stranger Among Us." It formed sort of his sort of attack profile or his profile of what he did with children. He quite often baby-sat toddlers, that is how he had access but what he would do was to attempt to replicate the torture he had seen in the movie. Quite often he would get to the point of contemplating murdering victims rather than allowing victims to spill the beans or say what had happened to them.

And he came very close on many occasions and, of course, that frightened him, he was able to walk away from it. And I think he became more frightened because every time he would get a little closer to that sort of murder situation.

So again, a very serious individual.

Subject number five is a professor. He came from a Roman Catholic household. He started masturbating very early. For some reason that told him that he was a very immoral person. He thought that had something to do with him going on to his pedophilic acting out behavior. He didn't, he felt it made him not integrate very well with other children.

He had continuous urges from very early on

to look at genitalia of young girls and his main offense was neighborhood girls and his wife's pre-pubertal sister. So those were our group, the dynamics of our group.

Our therapeutic goal was to get the guys to take responsibility for their deviations and modify their behaviors. We provided them with, in order to help them do that, we provided them with medication, a humanistic therapeutic approach, and a supportive environment to maintain psychosexual, cognitive and behavioral appropriateness. Of course, you probably see this as a very big deviation in what happens in prisons as far as counseling. And probably in the probationary sector at large as far as counseling.

But, we see it as a situation where it, if in fact someone looks at you, they consider you a patient, they don't form a bias towards you, and you are respected, I'm not saying respected for what you did, but you are respected as a human individual, the goal is mainly to work through a problem, you are more likely to come back and you are more likely to use the concepts that we give than if somebody says, you know, you are really a scummy individual and you are evil and we really hate you and we are going to do these things to you to stop you from doing this again.

So we felt the premise at the beginning of the research that we were going to treat these people for what we see them as, having a behavior biologic disorder sexual orientation. We are going to treat them as a medical patient and we are going to treat them in a way that is humanistic to help them work through and control their problem because we feel that doing that, they may have a better outcome in the long run. But of course, let us not forget we are not divorcing these people from the legal system.

These people still have all of the legal parameters of probation, as a part of their follow-up. So, they still have a probation officer, all the ones that were in prison, and they still have to deal with the probationary system as it is.

We don't take those controls away nor do we recommend taking those controls away. But we see ourselves as a separate therapeutic issue.

Our treatment effects. We expect the subjects will self report, decreased sexual fantasies and urges. We think that if in fact they control their sexual fantasies or urges or decrease them, it will help them benefit from psychotherapy.

We feel honesty regarding past offensive urges and fantasies were consistent with objective

measures. That is why we put the polygraph in there, because we wanted these people to at the outset recognize that there was going to be some objective parameters in there that would say how am I responding, am I responding in a deceptive manner or non-deceptive manner. We felt that would increase their truth telling after a period of time.

If they were truthful, then they would be more likely to respond psychologically, socially, medically. Anyway, there we are.

Lupron part four are side effects, clinical findings, laboratory finding. What happened with the drug? What did we see? What did patients or clients or subjects report? It is very important for us to know the side effects of the medicine we are going to use.

WHO, the World Health Organization, looks at treatment protocols. They are looking at not what a physician recognizes as good or better, they are looking at how a patient or subject looks at their treatment. Does the subject look at their treatment and say this treatment helped me and what were the side effects that are important to me rather than the doctor saying, well, I think that worked for him, I didn't see any side effects or I saw this side effect,

that side effect was important to me.

It is a more patient-generated system of side effect profiles. So what did they report? They reported to some extent a couple of them transient mood disorders. One of them reported gynecomastia. Three of the five reported transient hot flashes that went away after a short period of time after the initiation of the drug.

What other self-reported side effects did they note? Only two of them noted complete loss of erections. Three noted partial loss of erections. Two noted their penile size got smaller. One noted testicular size got smaller. One noted testicles were softer.

Self report. Now, of course, we are using the Monarch PPG questionnaire about masturbation frequency. Once again we will orient you to the chart to tell you the red bar is when they are not on Lupron, the green bar is when they are on Lupron.

So, at baseline there is no Lupron there. That's the masturbation frequency per week, almost two times per week they were masturbating.

They got their first dose of Lupron. Before the first month was out, the very first month, they got it in the initiation they were still masturbating about

the same amount. But then within the first two weeks, about two weeks from giving the shot, testosterone level basically bottoms out. And by the third month testosterone is pretty much at castrate levels.

As you can see, masturbation frequency drops, drops, drops, drops, drops until 13 months. And 13 months was where we crossed over with placebo. Instead of giving them shots of Lupron, we gave them shots of saline. They didn't know they weren't getting Lupron any more. And we wanted to see what would happen when they were on a placebo. Will they recognize they are not on the drug anymore? And will they tell us? What will happen to their self report masturbation frequency? As you can see, when they came off, they started to rise, they started to masturbate more. They didn't know that.

In fact, what happened was to some of them it was very alarming. They started to think well, our drug isn't working any more. And so after about three or four months of that, some subjects were so distressed once again we were forced to break the blind because they were upset by the fact that they no longer had the control and they wanted it back. So we broke the blind and they were given their Lupron back again, when given Lupron back again, once again

masturbation frequency started to go down.

Polygraph. You know, polygraph is wonderful as far as I'm concerned. It gives deceptive responses, that means when you know you are saying something not true, all things change, your heart rate changes, galvanic skin changes, we have clues whether you are telling, probably telling the truth or probably not telling the truth. We call those deceptive and non-deceptive responses. Once again, to reorient you, red is when they have no Lupron, baseline, after 13 months, then blue or green is when they are on the Lupron.

So, we are looking at deceptive and non-deceptive responses. But when we are asking them questions about masturbation, how often do you masturbate, do you masturbate at baseline no drug on board, all their responses were deceptive. They didn't tell the truth. You can see right every single solitary one of them deceptive responses. As their testosterone level started to drop, they were masturbating less, you can see non-deceptive responses started to peak.

When they went off the drug, they got the saline placebo, testosterone levels started coming back again, so did their deceptive responses on

polygraph about masturbation.

What other things happened, physical findings? What we did find was all of them had a significant weight gain. During the course of 13 months they got, weight gain was about 22 pounds on the average. When they went off Lupron, once again the weight dropped. It didn't drop back to baseline, but again this is only a 12 month cycle. They probably go close back to baseline but they didn't get quite back to baseline.

Physical findings, penile circumference, this is a lot to do with testing tools because we are using indium-gallium string gauge around their penis to measure their penile responsiveness while they are looking at audiovisual stimuli.

What we did notice on Lupron, a very significant change in the size of their penis, of course we had to change gauges to reflect the size change. The size change went from average centimeter at the shaft of the penis of 9.7 down to, the lowest it got was eight centimeters average. We didn't give average, because there is a bunch of different times, some people went back on the Lupron. We didn't give you average for all Lupron whether the penile size came back again.

Penile size related to testosterone depletion. Obviously, the penis is a target organ for testosterone. If you don't have it, your penis doesn't grow, and probably does all the sex accessory glands shrink when deprived of testosterone, your penis, your prostate, testicles all shrink in size when you have no testosterone.

Also, penile size is also related to lack of cyclic erections. If you don't have cyclic erections, penile size drops, people plastic spinal cord reasons for not have being cyclic erections, penile size shrinks.

Hormone levels. We just wanted to show you basically what baseline testosterone levels were like, average baseline was 404. When Lupron really kicked in, the nadir or lowest it got, average was about 11.2. They sort of stay, what testosterone stays at when they are on Lupron. But when they come off Lupron, testosterone rises slowly. That is what we were trying to track, how long it would take them to get back to baseline testosterone. And it probably takes in excess of 12 months to get back to baseline as you can see.

Testosterone levels, this is just, you know, on with no Lupron, red bars, with Lupron is the blue bars, you can see how quickly testosterone level falls

off and how nicely it stays down on the drug. Once again, when you come off the drug, it rises back again.

Also Lupron affects sort of more central hormones. Luteinizing hormones and follicle-stimulating hormones, they drop when on Lupron. Those are some of the more brain oriented sort of target hormones as well as testosterone.

One of the things that we were trying, continuing to try to look at is basically how people's brains change when they are given a drug like this. We recognize there are certain parts of the brain that are associated with sex drive, sex orientation. You probably read some of the stuff in the literature about people who are homosexual and heterosexual, and the differences in certain parts of their brain. So what we did include in the study, although the results aren't, you haven't exactly published the results because we are trying to do very, very careful testing on them, we got a PET scan, which is an activity scan tells us how the brain works, metabolizes glucose and a CAT scan an anatomy scan. These two things are co-registered, we can tell basically what part of the brain works at baseline and how Lupron changes the specific parts of the brain. We are looking at

different parts of the brain and how Lupron acts to change it.

So you don't really get to see all those results yet. What we will tell you is one of our subjects had what we could see on PET scans as coup-contra-coup injury, a birth injury long-standing, that did not of course change with Lupron. One of the patients actually had an area of increased activity in the cortex of the right insula in the deep right sylvian fissure. Which means some kind of lesion in the area of the brain that does in fact control sexual activity. And when they were given Lupron, the area of activity disappeared.

So there may be brain lesions associated with pedophilic orientation, pedophilic behavior. This is what we are trying to track, what part of the brains we actually change with this type of therapy, what kind of alterations there may be in the brains of people who have an altered orientation, and how we might change that hormonal therapy. Also in the future what parts of the brain had androgen and estrogen receptives, and how we might make designer drugs, drugs that target only that specific part of the brain and no other part of the body.

So, let me give you some more technical

stuff. With another viewer.

DR. KUHN: If permissible, we could take a five to ten minute break.

(**WHEREUPON**, a recess was held).

DR. KUHN: I introduce James Earle. Dr. Earle is a Ph.D. in criminal justice from the University of Colorado, on the Colorado Sex Offender Management Board, former Vice Pesident of American Polygraph Association. So when I tell you we chose the national experts in the field to come to Erie once every three months, we really did. I commend them on coming through in all kinds of weather.

For those of you from Erie, you know exactly what I'm talking about. The former president of the Colorado Polygraph Association. He is a retired Special Agent from the FBI. I will tell a little story, he was in the Navy Seals when he came in, he does have a persona, very straight posture. You can tell he was in the military. And he would only have to walk in a room and people would fess up. He can tell you stories about that. He has 25 years experience, 12 years of treating polygraph convicted sex offenders. Dr. Earle.

DR. EARLE: Thank you, Dr. Kuhn. We all have our secrets. Polygraph, one of the questions

that comes up about the polygraph is how accurate is it. There has been several scientific studies connected that show the accuracy level that goes between 82 to 95 percent.

(**WHEREUPON**, there was an off record discussion).

DR. EARLE: So one of the issues we address with the polygraph is how accurate is it. You can see, it's very accurate when you compare to other evidentiary type instrumentation, the polygraph rates up there very high. Eyewitness testimony is in the 60 percentile. Fingerprints the only thing higher than polygraph. So, one of the things we wanted to show, we had a pretty good idea. One of the things about polygraph is how effective it is how experienced and well trained are the examiners. The higher training, the more experience they get, the more accurate they are going to be.

Again, we are talking about how would you go about selecting an examiner, so, we talk about all this stuff about periodic training, good initial training, so forth.

What we did in this particular study, we took a standard test format, one that had been through a number of studies to verify validity and reliability of the format. The format we chose Backster Zone of

Comparison format, by that, I mean by that, you compare the relevant issue, the issue you are trying to determine truthfulness with comparison questions similar in nature. It gives you a much more accurate way of evaluating results.

What you look at in polygraph is responses, psychophysiological responses to the questions. If you can have a good comparison, you have a much more accurate reading. We analyzed all of the results using a numerical scoring system developed by the Department of Defense, and it's approved by the American Polygraph Association which gives us more reliability to say what we have here is a more reliable instrument, more reliable result.

We did this on a three-month interval. As you can see, over the period of time, we did, initially had no psychotherapy, no Lupron, we went through that got Lupron and psychotherapy.

One of the things we tried to do was determine their sexual history. By that, we went through and asked them what their sexual history was. By that, we focus mainly on the sexual offending behavior. We are not asking about other things not in the offense behavior, just the behavior. We ask about their victims, we ask them about other pedophilias,

you will see some of this comes out.

Then we ask them three basic questions. These are the three questions. We repeated the questions each time. Then we measure the responses. Have they masturbated to sexual thoughts about anyone under 18? Have they purposely withheld any important sexual information from the therapist? Have they had strong urges to initiate sexual conduct with anyone under 18?

This is a picture of what I see when I look at the polygraph. We don't have, we are using computerized instrumentation now. We don't have the little funny lines you see Robert DiNiro uses a polygraph test on the son-in-law. I don't test son-in-laws, been accused of it but haven't done it yet.

But this is what we see the computerized version, if you look at the screen, if you look at R 5, that is a relevant question that we've asked there. If you come to back to C 4, you can see the person's normal responses. He is responding. If we go down -- I don't have a pointer with me. The top two lines measure the breathing pattern of the person. The thicker line in the middle measures galvanic skin response. The bottom line is the cardio response.

You can see when we ask the question at C 4, there are responses there. But if you come over to R 5, starting with the breathing pattern, you can see there is apnea occurring at that question.

In other words, the person doesn't realize it, they are holding their breath. We ask them that question, they responded, come down to cardio, you can see how significant it goes up. It almost goes off the chart. And it continued to go up. The reason, what we do in this particular test, if you see the next question is an irrelevant question. The reason we ask it there, was because the person is still responding. So we don't want that to go to another question we will compare.

So that is a typical graph you would see with the polygraph, especially someone not being truthful. This is what we call the deceptive response. As you can see it is pretty clear there is something going on there, something more significant than what went on at question four.

We go through all the questions with the individual in the pretest. They are not asked surprise questions. It shouldn't be a surprise. They should understand the questions. They are given a chance -- if they don't like the way a question is

worded, we give them an opportunity to change that. As long as they stay in the parameters we are trying to test. If they try to change the issue, then we won't do that.

Then we do the in-test phase, we attach components to the examinee, and go through the questions. We ask questions while attached three times. Then in post-test we talk to them about their responses.

What we found in doing this in intervals, we have been able to help the therapist in looking at issues they should be going to. We talked about, also demonstrates monitoring their behavior. Believe me, after a while they know if their body is going to respond. If they are not telling the truth, they know that's going to happen. It really does help them. Most of the time now what happens come in the pretest they clarify issues that have been going on in their treatment. So that has been very helpful there. And it also really clearly identifies the issues we need to address.

During the -- we found none of these individuals reported any new offenses nor were any new offenses noted. Things that came out we found the number of victims they self reported initially had

increased dramatically which is very typical. Believe it or not, the average pedophile probably has around 250 victims in their history. Most of them come in with, they are convicted of one or two victims, when, by the time they finish with sexual history it is upwards of 250 victims. So they are very active.

The only thing that comes out in this is cross over paraphilia, we have a number of paraphilia we were able to determine. As you can see from this slide, the victimization, the identification of victims goes up dramatically.

Subject number two had probably the largest increase of victims from a self report to what we verified. Like I said, a number of crossover paraphilia, but the two that were recorded by all of them were exhibitionism and frottage. Frottage means rubbing against somebody for sexual gratification.

Here are the paraphilia we come up with, the list is pretty wide. It always amazes us when we do this to find out how many different activities these individuals engage in. In fact, in my practice in Colorado, we keep increasing this list. Because we keep finding more paraphilias we didn't know about. These are the paraphilias these individuals reported. You can see some of them like we said, exhibitionism,

frottage, they all reported public masturbation, peeping, strip bars, adult bookstores, they all reported that. And it goes down.

Again, the paraphilias reported. This is the first question we ask them every time. Since your last polygraph, have you purposely withheld important sexual information about yourself from your therapists? As you can see here the baseline, they were all deceptive, all withheld information. As they went into the study, it was very interesting they started to, Lupron took effect they became, their responses became more truthful, more non-deceptive.

When we took them off of the Lupron, it went back up again. In parlance what we found. The next question, since the last polygraph have you masturbated to any sexual thoughts of anyone under 18? Baseline, all deceptive. Lupron took effect, you can see from the graph that they became more non-deceptive as they went because the Lupron seemed to have an impact on their urges to do this sort of thing.

And then again when they came off they went back down.

The self reporting before Lupron, you see masturbation frequency with Lupron, verified by the polygraph.

The last question, since your last polygraph, have you had strong urges to initiate sexual contact with anyone under 18? Again, the same thing happened, baseline very deceptive. Went through study they became non-deceptive.

Overall, again, before the Lupron, baseline high deception, went through the study, went through Lupron they became more truthful. Undeceptive, when Lupron was taken away, went back to not quite as bad as they were before but they went back.

I talked about the associated paraphilias. The big thing that we find, this is very true, the number of victims coming in is always minimized. That is where the treatment proves successful. The polygraph also causes them to, you know, they have to verify they are telling us the number is correct. If they can't, they realize this after a while. So that number does go up.

We used "no" responses because they are easier to measure than "yes" questions. As I said, in the beginning, the majority of them were deceptive responses to relevant questions. As we went through the study, the Lupron responses went from deceptive to non-deceptive.

I will turn it over to.

DR. KUHN: The section six is being presented by Peter Byrne, our Ph.D. His expertise is in counseling psychology. I mentioned before he is president and CEO of Behavior Technology Incorporated. And he flew in from Salt Lake City last night. Dr. Earle flew in from Denver, Colorado. I want to introduce our dedicated researcher, Dr. Peter Byrne. Dr. Byrne.

DR. BYRNE: The area I'm going to be discussing relates to penile plethysmography, commonly referred to as sexual arousal measurement. And sexual arousal measurement is extremely important relation to the topic we are studying here simply because I came into the study with a rather large predisposition if we put the guys on Lupron, we would simply knock out sexual responsiveness. That was a presupposition I came into the study with. I think it will be interesting to examine that during this time.

Again, as Dr. Kuhn alluded to earlier, one of the things we are trying to do in the study is objectively verify outcomes. I also manage and supervise an outpatient treatment program for sex offenders. If they taught me one thing, I need to use things like the polygraph, and on testing I use validity scales that give me an idea how defensive or

non-disclosing a person will be.

A couple of things about penile plethysmography. It's recognized as the best physiological measure of sexual arousal. Dependent variable the thing we look at penile tumescence. Men don't generate blood flow to the penis unless they are evaluating a stimulus sexual passion. So that is one of the reasons why it is referred to as a gold standard.

It is actually been used for about almost approximately 40 years in evaluation of treatment of sex offenders, so it has been around for an extremely long time. It has the benefit of having decades of independent research on the methodology itself.

What we really wanted to do, we used a specific form of penile plethysmography called the Monarch PPG standardized stimuli used at 90 sites across the country. One of the strengths I was mentioning, Monarch PPG in general is a gold standard. One of the weaknesses of penile plethysmography is standardization. The instruments we chose to use is the standardized form of penile plethysmography.

Essentially the, just a brief overview is in order. Unlike the polygraph, we don't sit face-to-face with the client or in the same room.

Penile plethysmography is a lab procedure that involves two rooms. The client is seated in a comfortable chair with a TV screen where they can view the various stimuli presented. Always working with Dr. Schober is a challenge and an interest to me, I train people all around the country to do this mainly 99 and two thirds percent mental health professionals. One of the things we do is we always work to respect the client's privacy, and so forth.

So, us mental health professionals typically are not medically trained. Dr. Schober is a urologist. So one of the things when Dr. Schober and I run PPG, there will be a problem I will go in and look at this. That is her job, she's a urologist and medically trained. In our situation most of the time 99 percent of the time, virtually every other time I ever run a PPG, we don't have that luxury. So, we often use another room, and their privacy is respected. I think that is an important part of it.

So, unlike, very similar measure to polygraph but also has got some important differences. Additionally, the stimuli if one thinks of them in a polygraph are the questions that the examiner asks. In this case the stimuli are standardized stimuli that present potentially sexually explicit scenarios

between a male and a target of various ages and genders, that's essentially how a penile plethysmograph is done. Important aspects of the Monarch PPG specifically is that it doesn't use any nude or pornographic type, nude images of children or any pornographic images. It is an extremely important point. Stimuli are designed based on actual offense scenarios.

What we try to do is have my predecessor with 35 years of experience treating this population put together the audio scripts in such a way that we didn't have to have all of the pornographic references in the stimuli themselves. Essentially we are relying on a projected methodology.

We set up the context of the situation where an offender might actually commit an offense. If a person has memories or thoughts or fantasies associated with that, they tend to respond. Individuals who don't have memories, thoughts or masturbatory fantasies associated with behavior, don't respond.

So, the Monarch PPG is utilized in this sense to get around some of the ethical and legal considerations because while PPG has been around for a long time the first 30 years of research utilized nude

visuals of children which caused severe ethical problems. So, Monarch PPG has overcome that and still maintain the same level of reliability and validity.

There are a few things we do during the course of a test. We measure penile tumescence. As Dr. Kuhn alluded to we put penile transducer or gauge. The client can place that on their own penis. Again, that's the benefit of this type of methodology. The client can actually place that on their own penis, don't require somebody else to do it. It allows medical health professionals to do this type of administration.

Simultaneously, very similar to polygraph but for somewhat different reasons, we collect respiration and galvanic skin response data. Our purpose in collecting those is to deter response faking.

What we want to do is some individuals will take the test and simply try to hold their breath and not respond. They will try not to pay attention to stimuli or process them. There's a number of counter measures an individual will use. So we've introduced in Monarch PPG a number of counter measures to stop an individual from faking.

Some of the methodology, each subject

performed self measurements twice for correct sizing of the gauge. It was from that process we gained some earlier information associated with reductions of penile size. Some of the subjects who had difficulty were assisted by a urologist in that measure. To provide accuracy, self measurements needed to be within one centimeter of each other, that increases reliability of validity of the measurement itself. Results of measurements were recorded and compared before, during and after Lupron therapy.

Again, part of the methodology in PPG, is they measure flaccid penis size for the correct placement of the transducer. And then to ensure the penile transducer is operating properly, it's calibrated, a specific form we alluded to called indium-gallium gauge clients were able to place on themselves. Some of those who had difficulty were assisted by the urologist, but that doesn't happen very often. During this time while they are hooked up and while they are observing stimuli, that is when penile tumescence is measured.

Similar to the rest of the outcome measures we took a baseline and psychotherapy while on the Lupron and then just while on receiving only psychotherapy.

In this type of analysis there's, there are a couple of ways to examine the data. The first is we want to look at the raw data which has to do with the dependent variable in the case is the changes in millimeters in circumference of penis in response to various stimuli. So, at baseline what we worked on is obtaining a measure of their responses to the preferred deviant stimuli. We track those over time and analyze them.

Another type of analysis we do is something more along the lines of classification, use slightly different approach with the data. You simply use what is called standard score transformation. What we are doing in this type of situation if you will, in this situation, we are doing classification. So, in this case we are looking at how aroused an individual is to adults as compared to children. That is how you do a classification in this way. Raw score type of thing is we looking at how much less aroused do they get in general.

Kind of two different research questions that require two different ways of looking at the data. What we found over all with raw score data the tumescence, in other words, how aroused they got to deviant stimuli was significantly decreased when on

Lupron. Not surprised if we look at blood testosterone levels earlier but we were able to statistically analyze that found the treatment effect was very strong.

What we also found was the area of interest in the classification using standard scores, Z scores remained unchanged in three of the five subjects.

Again, as alluded to earlier, this is essentially the changes in penile size. We had a consistent decrease in circumference of the penis. Again as Dr. Schober discussed, that is directly relatable, attributable to the effect of the Lupron.

I will skip this one, it doesn't give us as much information.

This graph gives us an idea, an important idea of how the arousal was reduced. This is looking at the group as a whole overall. The red bars indicate off Lupron whereas the blue bars represent on Lupron. And the main thing you can see in terms of this data is that the blue bars, you will see that the arousal was significantly reduced on the blue bars but again as I noted one of my preconceptions was not supported, we did not eliminate sexual arousal responsiveness.

If we look at this within individuals, this

is one of the first subjects, so arousal was extremely high prior to initiation of the Lupron, the blue bars show a consistent decrease through one month, four month, down to a low at seven months then a return at ten months and an interesting thing to examine we mention this anecdotally in our paper, we were using three month injections. At the ten month point we went back looked at the data, we examined, we saw a spike, if you look at the 13 month data, you note the rising and return of responsiveness. We were, we found, you will see this on virtually all subjects, we found we had a spike in our data in between the ten and 13 month period. What is really interesting is we picked this up on PPG but didn't necessarily show up on some of the other measures. We can discuss that, the implications of that in terms of risk later.

So this is the other subject who had a relatively lower arousal pattern. But you see again right at the beginning rather large, the decrease. But then again the rebound at about ten months just from being late with the shot by about two weeks.

This individual didn't evidence as much of a rebound effect but there is a strong treatment effect for the Lupron. I think this one is compelling, when I go and present this data in other context I always

like to say when you do research studies, often times you are combining groups of individuals, but we remember with sex offenders we treat each individual.

Now, this is an individual, if you look at the data conceptually, he may well have gotten worse in terms of the deviance and arousal. Clearly he went down for four months, but at seven months return, ten month spike was above baseline in terms of overall arousal level. So, again at ten months one thing might be this individual is more risky in terms of his sexual arousal pattern than he was at baseline. I don't think the Lupron made him worse necessarily. But what this may speak to is management in the community issues as far as that goes.

DR. KUHN: Multiple baselines.

DR. BYRNE: And it may speak to multiple baselines as Dr. Kuhn was mentioning. It may speak to either of the two things, a research question to be addressed. Nonetheless, the data here on this individual shows some improvement but that ten month spike is rather substantial with this individual.

In conclusion, the Leuprolide reduced the arousal to preferred stimuli. There are two important caveats. It didn't eliminate all significant responding. We also had flares within the data where

the individuals actually had a rebound in their penile responsiveness at approximately 10 and 13 months.

The final comment was there was, as with any medication, I'm not a physician, a Ph.D. psychologist, but there is always individual differences in responses to medications, to any kind of intervention.

So, the take-home message as far as my aspect of the study was you are going to get those individual differences and that supervision and monitoring on Lupron while effective intervention, supervision and monitoring are still critical aspects that need to be undertaken if you try to use this in the community.

And in addition, I wanted to make two other comments if I could when I reviewed the bill. Is that okay, just briefly? I see, I'm kind of getting a sense what it is you are attempting to do. And essentially what I see you are, you are attempting to manage risk as best you can with sexual offenders.

The largest analyses and best research on sexual recidivism are essentially divided into two components. One would be sexual deviance, and that's what we are really focusing on here with this type of measure. Another is antisocial or kind of psychopathic types of tendency of individuals.

You have in your state as a consultant on sex offender management board one of the leading experts in the world on psychopathy who may help you consult. The reason I bring that up, in my opinion the Lupron is most likely to be successful with those who have mainly sexual deviance problems. Those with more and more levels of psychopathy, they are going to be the ones who are less and less likely to be compliant with Lupron. If you put someone who is a pedophilic psychopath, so to speak, on Lupron, that would be type of guy who is much more likely out there to try to find testosterone replacement therapy. Those types of things.

In your procedures that may be something useful to give some consideration to.

Another aspect of risk assessment is, this is the final comment I really had, is that often times in risk assessment we have to use things that are called static predictors. Static predictors are those that don't change. So like genders of the victims, how many victims, the number of victims can change, in general, historical things about an individual that don't change.

One of the useful things about some of the measures being used here in my opinion particularly

that's PPG and polygraph is they are in a different form of a risk factor measure, they are dynamic risk factor measures. Because the one thing you may run into when you are trying to implement a proposal like this is if you are ever going to have someone stop using Lupron and why, how to justify it, on the basis of static risk factors the risk will never change. By definition it can't.

But you can track dynamic changes with things like penile plethysmograph and the polygraph with these individuals, the need may arise to switch medications, do the medical complications, those type of things if you use polygraph and plethysmograph as outcome measures that can be rather useful in terms of establishing some of the rationale for why you may have to make some changes with a given individual.

Additionally, use of these outcome measures will help you in identifying the variability of individual differences in the responsiveness to the medication. Some individuals it will help extremely, some it may not help as much. And having an idea about that would be extremely important. As far as management goes in the community, somebody has to manage people in the community, I slept a lot better once I recognized I had PPG and polygraph

incorporated. To and I don't treat as high a risk individual as I think we are talking about, we are talking about repeat offenders with this.

Thank you for your time. I appreciate it.

DR. SCHOBER: You are looking at the two flares. The first flare occurred one and a half weeks late with injection it was over a holiday trying to get them all in without making them miss the holiday.

What I want you to know is that flare occurred when testosterone levels were still castrate, which means perhaps it takes a very small amount of testosterone in order for there to be urges and fantasies to come back, particularly when the receptors are bared for a period of time. You take away testosterone castrated the receptors are bare for a period of time. It take very, very small amounts of testosterone to bring that back which is perhaps reasons why was so poor as a therapy method over the years such recidivism so little efficacy with Provera.

It didn't take the testosterone level down far enough. It seems there is just a very small area where testosterone came back up to make you very active again. In fact, you need as what I'm saying as things progressed from sort of a three month injection to one year implant, the one year implant wouldn't

allow this to happen, the levels of testosterone give you a nice smooth suppression over time. So, the less number intervals, the less bouncing you have of testosterone levels.

DR. KUHN: Thank you. We will get Dr. Schober up for question and answer. We are in the home stretch, folks. This is the Abel Assessment developed by Gene Abel. Actually 160 slides and a questionnaire. They identify 21 paraphilias, paraphilias called aberrant sexual responses.

I am going to interject this for the ladies in the office, at this age I found out more about sexual paraphilias than I ever thought I would learn in my entire life. That is women have a fantasy about having two men at the same time. However, one is cooking and one is cleaning. I had to do that.

Again, the Abel Assessment was performed the same as the PPG. That was at baseline, every three months. This is a little screen, the gentlemen look at pictures, the computer records the amount of time they look at pictures. Fairly innocuous.

But this system actually works. I did delete the slide that is really an interesting young man. Anyway. What we did was to look at their interest preference and we only looked at the stimulus

that provided highest response visual reaction time how long they looked at the studied subject.

Abel has had I'd say a cumbersome method for interpreting data. What happened when we used the Abel method of thirds, it gave us a large array of different types of people that they are saying this person is responding to. YM, young female, AF, adult female, YM, young male. We looked at the very highest responses.

Interestingly, with the Abel Assessment using the modification, we came up with adult male, adolescent male for subject number one. Self adult male adolescent male made the data cleaner and we were able to actually use it. What we did, after we had the Abel results Monarch results we went through data. Where you see it bolded is where they matched very well. I will just be very brief here and just tell you there is no consistent change in pedophilic interest preference in four of five subjects.

So, this brings us to some of the limitations of the study. One of them was sample size. Actually, we did something called power analysis. We knew we would get 100 percent response rates. Five subjects were ample to give us 80 percent probability of finding statistically significant

results.

Our length of follow-up may be considered one limitation, we are still following some of the men. We did have a few protocol deviation there was drop out and replacement. One set of data was missing. One set of injections was 1.5 weeks late. There was no randomization in this study. They were either all on or all off. Some investigators were not blinded. However, those that were not blinded actually had no direct input in collection of data. Our two subjects restarted on LA.

The other thing is that when a patient came in, we only did what they call one baseline measurement. When you first walked through the door we did one polygraph, one plethysmograph, one Abel, I wish we had them more. What we would later see the results actually did match a lot of the data we got when we took them off LA.

Your traditional legal response sets base prime, is five year mandatory incarceration for each offense, parole and probation and psychotherapy. Relative costs, LA and psychotherapy, $12,500. Incarceration, anywhere 27 to $32,000. Some civil commitments, 16 states, $100 to $120,000 per year. Here are a few future studies. Dr. Schober alluded to

Lupron implant. This will be very helpful. You can implant it, it is there for a year. There is a drug called Zoloft, Zoladex available, Lupron, they are look being at not available yet.

We would also look at young offenders. The men we look at mean age 50 have done their damage. This does not start when a man is 50, this starts when he is very young. We do want to start a new study called 4 Rs, recognition, response, recovery, rehabilitation. The study is set up, we are involving 12 institutions and in different individuals with a variety of background, it addresses both recognizing child, response recovery and rehabilitation of the child as well as the pedophile.

We do have an expert we would like to bring in, he is a specialist in children who are offenders, age five to 12 years old. An incredible problem.

We would like to look at exhibitionists. If you, if you were taking notes, Carol knows, every single pedophile was an exhibitionist first. If Dr. Kovacs were here, this is how things start and generally progress. We would like to look at that in other sex crimes.

Research questions. What effect did LA have on testosterone levels. Significant decrease to

castrate. That is statistically significant decrease.

Pedophilic interest. Generally no consistent change. What did it have on sexual ideation regarding urges, decrease in strong urges to initiate sexual contact with anyone under 18. Confirmed by polygraph. Decrease in masturbation to sexual thoughts of anyone less than 18. Confirmed by polygraph. And withholding important information, not withholding, again confirmed by polygraph.

What is interesting this is some of the very first objective data to show deceptiveness is greatly decreased on LA versus off LA. Another component you have to realize is psychotherapy is ineffective if subjects are deceptive.

Regarding penile responsiveness, tumescence significantly decreased, penile circumference decreased, subject reported decreased masturbatory frequency.

Analogy. If you have severe respiratory infection or cold and you take an antihistamine, all symptoms go away. You still have the cold. The second the antihistamine wears off all the cold symptoms come back. We do feel that people will probably have to be treated for a lifetime. We are working on one of the studies now.

Psychotherapy should be augmented with drugs to reduce recidivism. We found Leuprolide acetate is an effective alternative to current Testosterone suppressant medication such as Provera and we believe we have proven to you that Lupron actually impacts sexual fantasy and urges impacts the masturbation rate. This is from one of the studied subjects. The medication reduced if not eliminated fantasies to all the attractions. There are very few, if any urges toward any young people. The boy could be there, I could acknowledge an immediate attraction but I wouldn't go home and fantasize at all. It's amazing. That is subject number one. He is also the one that said thank you for helping those of us who have been abandoned. So we are open for questions. Thank you for your attention.

HONORABLE ALLAN EGOLF: If we are all set, we will go down the line here and have questions for you. Maybe some answers will generate further questioning. Quite a presentation. I have some questions that probably you covered I maybe missed it.

Since the fact you said all the molesters had been molested, is there also, do you find out, do you know if there is a genetic problem also that makes these people more subject to it? What is the sex

connection, if they are molested that is not genetic, how does that tie in?

DR. SCHOBER: I would have to say that I think it is my opinion the sexual orientation is hard wired. That means you are born is an orientation. And that you are unaware at this point in time whether there is a genetic chromosomal thing which would make you have a certain kind of sexual orientation. In fact though, there is a lot of study going on right now which would suggest homosexuality may be chromosomally related.

In the case of pedophilia, you see this business of people who are pedophiles having had a history of being sexually abused. What may happen, there is a component to orientation which is cultural. There is a component to orientation which is societal, a component that has something to do with the way you are raised. In this case, if someone impacts you sexually, and breaks a generational boundary, we have generational boundaries. Most people would suggest having sex with parents is a boundary you would never break or having sex with a child would be a boundary you wouldn't break. But once that has been broken in your cultural history, it becomes, you fail to recognize it as wrong in the future. I think that may

be where the damage is done in some individuals, why we can see the repetitive pattern cultural boundary that is broken.

HONORABLE ALLAN EGOLF: Thank you.

DR. KUHN: I think we get you down to etiology is very elusive. There are some family settings, a number of subjects where there is possibly low IQ involved that allows for this type of behavior to continue. So, it is something that Dr. Schober will be looking at in the future, she did collect blood specimens or subjects. We will do chromosome studies to find out if there is aberration in the sex chromosome area.

HONORABLE ALLAN EGOLF: Thank you. Another question raised here. You said in Scandinavian countries they are using castration. Is that voluntary or mandatory or --

DR. SCHOBER: Mandated by court. A combination of both things, so I'm sure some people choose castration. I think in fact, the statistics you see from Denmark, Sweden, Norway probably reflect court-mandated castration. That is surgical castration.

HONORABLE ALLAN EGOLF: They are put back out into society?

DR. SCHOBER: Yes.

HONORABLE ALLAN EGOLF: Very low recitivism?

DR. SCHOBER: Very low, about three percent.

HONORABLE ALLAN EGOLF: Okay.

DR. SCHOBER: Those are quite long-term studies. I think 20-year studies.

HONORABLE ALLAN EGOLF: I was wondering about your study. First of all, were any subjects -- did any subjects ask for castration?

DR. SCHOBER: Surgical castration, none of these five asked for surgical castration. Of course, we had issue with those in the past who have. I don't think we had the ability to provide it legally. I think that is, although it appears there has been some cases in the United States where people have provided it, it has been illegal to provide that as a non-therapeutic, non-cancerous therapeutic reason.

HONORABLE ALLAN EGOLF: They could on their own do it?

DR. SCHOBER: They can go to Mexico and have it done.

HONORABLE ALLAN EGOLF: I was wondering

during too, the study when you went on and off Lupron, how did you, I assume subjects maybe had went out and did molest children during that time?

DR. SCHOBER: None.

HONORABLE ALLAN EGOLF: None did?

DR. SCHOBER: None. We had no offenses during that time.

HONORABLE ALLAN EGOLF: Even when they were off?

DR. SCHOBER: Even when they were off.

HONORABLE ALLAN EGOLF: They had fantasies, urges?

DR. SCHOBER: Yes, they had fantasies and urges. And you could see the, track them, see it rising. The ones where it became an issue, fantasies, urges became an issue asked to have their therapy back. After 12 months we provided it back again. We tried to keep them on placebo for 12 months. We wanted to see what would happen. If they came to a point they said it is getting critical for me now, you know, these urges are very disturbing, I'm feeling myself getting back into this pattern, I'm afraid what I might do, we immediately broke the blind and put the Lupron back into play.

Some patients were able to carry out

12-month placebo. I should tell you the second part of the study all were put back on it at 12 months by their request.

HONORABLE ALLAN EGOLF: Are they on it now that you are finished with the study?

DR. SCHOBER: Yes.

HONORABLE ALLAN EGOLF: Are they going to remain?

DR. SCHOBER: They would like to remain, they choose to remain on it.

HONORABLE ALLAN EGOLF: They are on parole, all of them?

DR. BYRNE: No, one of them is not on parole.

HONORABLE ALLAN EGOLF: How are they being,

if they have this now for life, what is the future?

DR. SCHOBER: I think probably two aspects of it. Sometimes after getting Lupron for a very long period time your testosterone level does not rise again. However, we don't have any long-term studies. The people that have been studied on it for the rest of their life have been older men with prostate cancer. So, we don't really, those people who had

prostate cancer were never taken off during their lifetime because prostate cancer would surge if they were off the Lupron. Unless of course they were castrated by having testicles removed.

We don't have data how long it would take to suppress testosterone, we know that is a possibility. These guys would likely, I mean there is because we are able to track so carefully with objective measures, we may be able to carry out our study for a long period of time and take them off see if levels stay down, see how they respond to time off the Leuprolide. We will be able to do that in the future.

However, at this point our patients have asked to remain on Lupron. They feel safer on it. In fact, they get, this has been reported in the literature. People go on Leuprolide, this is their affliction, they get a feeling of euphoria, sort of relaxational control. They don't like the loss of that feeling. So, our guys at this point in time have the drug because the drug is provided by the drug company to us. So we can give it to them, it is a very expensive drug.

There have been instances, it appears now Leuprolide is being recognized as a drug for this purpose, some insurance companies, particularly

medicaid is actually covering it for that type of therapeutic purpose. There may be some hope that in the future that medicine, some type of medical insurance will cover this drug for this therapeutic purpose even though it is not an FDA recognized purpose.

HONORABLE ALLAN EGOLF: Are they also on the Lupron, are they also being, on a polygraph too?

DR. SCHOBER: Yes, all of them. We still have a group who are being followed sort of long-term on Lupron, four years out I think now. Our goal of course is to follow them, Lupron, to sort of see what happens to the bone density. At this point in time we found they have not had significant loss of bone density over a long period of time. Also to look at how they respond.

One of the questions, I recognize this is something that may be over everybody's head, one of the questions is if you bare the receptors of testosterone over a long period of time, is there another hormone body that might be able to attach to the receptor and bring back some sexual, are there other hormones in the body that will act like testosterone in the body to bring back sexual arousal. That is one questions out there. We don't know the

answer to it. We haven't studied somebody objectively for long enough period of time. To answer the question, it would take ten or 20 years on the drug. We are just in the initial stages of that.

HONORABLE ALLAN EGOLF: Is there any indication of any resistance being built up to Lupron?

DR. SCHOBER: Not really.

HONORABLE ALLAN EGOLF: Over a long period of time?

DR. SCHOBER: No.

HONORABLE ALLAN EGOLF: You said lesions or damage to the brain showed up in those scans?

DR. SCHOBER: Right. There is some literature to indicate that there may be brain lesions, you know, brain damage or brain lesions which could lead to compulsive sexual activity. One of the kinds of which could be pedophilia. And/or loss of inhibition.

HONORABLE ALLAN EGOLF: Only some of them had it.

DR. SCHOBER: Only one, only in one person, again there were only five.

HONORABLE ALLAN EGOLF: So, that just happened they, all of them had molestation when they were young.

DR. SCHOBER: All but one.

DR. KUHN: All but one.

DR. SCHOBER: All but one was molested as a juvenile.

HONORABLE ALLAN EGOLF: That has no relationship.

DR. KUHN: Sure there --

DR. SCHOBER: There is a possibility, there have been studies that suggested having been sexually abused early in your lifetime may cause acute stress syndromes, some type of brain damage.

DR. KUHN: Dr. Pithers had done some work, he presented it so clinically it was almost chilling. If a child is physically abused once, sexually once, gets before age 5, there is 75 to 80 percent probability he will become an offender. As we said before, the etiology, the cause of the disease or the disorder is elusive. There may be more than one cause for a person having pedophilic urges. We are only at the stage we can suppress the symptoms. You really have to get to the etiology what is causing it before you can attempt to even think about a cure.

DR. SCHOBER: That is what this whole study is basically showing you. Even though we suppress them to castrate levels, even though they

don't have the urge or desire, libido masturbation activities behaviors, those are caused by the drug, their orientation doesn't change, they still have the same attraction to the same thing. The same category, little boy or little girl. That doesn't change over time. It doesn't change with chemical lowering, testosterone lowering therapy.

They still have the same orientation, it is just that they don't have the same urges and the same behaviors. They don't act on orientation or desire or their, I don't want to say desire, they don't act on who they are attracted to.

DR. KUHN: Other studies have shown there are children who have been molested who do not become molesters themselves, so that area is controversial. Whether it was happenstance or not, we did have four of the five who were molested as children.

HONORABLE ALLAN EGOLF: One final question right now. The individual who I think the state worker who his family had been through this for generations, what incentive, why did he want to go into this program, if he was, sounds like it was acceptable to them and their family, no shame, whatever.

DR. SCHOBER: I know that is a very good

question. I spent much, much time in therapy with that individual. He is, he was one of the state workers, you would be correct, with a licensing bureau, auto licensing bureau. He was the person who molested his own children from the time they were infants. His two children were taken away from him. At that point in time, when the Children and Youth Services took the two children away, they made him go into counseling. So he was in a counseling group down state from us. The counseling group down state from us I think recognized what a difficult individual he was with simple psychotherapy. They thought perhaps with some sort of augmentation simple psychotherapy it would help.

But I think the other thing that kept him in this program was fear. I think he had a terrible fear that he was going to commit again and be arrested. He is kind of a very, well, he's -- very, I don't want to say weepy kind of guy. Kind of a fragile guy. He would be the first person, one of the first people I would expect might commit suicide if they ended up being arrested. He just has no ability to deal with any sort of, with that sort of situation. He is very frightened of being arrested.

HONORABLE ALLAN EGOLF: Thank you.

MR. THOMAS: Again thank you guys very much for traveling here today for the testimony. It was very, very informative, definitely you can have our word this information will be taken back by myself and the rest of the staff here today to the members of the committee and shared with them and talked about.

A couple questions that I have. One is, I don't know if any of you will know this, do any of you, did you look at prior to doing the study in Pennsylvania specifically how sex offenders were being treated maybe while incarcerated currently, are they getting psychotherapy at all with any medication or did you have an opportunity to look at that?

DR. SCHOBER: Yes, we did have actually an opportunity for years before we started the study, we traveled. We were trying to think of via the judges and District Attorney's office how we would just fit in with probation, parole, prison, how the study would fit. Would we be able to do the study on people in prison, what were the laws that governed research on prisoners and also what people were coming out with, what they had in prison and how they came out on probation.

It appears to me in Pennsylvania we have a very, we have a detailed mechanism for sex offender

counseling in prison. We have a very good built up program for that happening in prison. But, once again, I would suggest to you that I think psychotherapy once it ends, which is quite often, if they get out of prison, if they complete the prison sentence, they leave and have nothing, right. So the recidivism goes right back up to 80 percent because they no longer have psychotherapy.

The ones that come out of prison and are within the probationary sector have, usually have some sort of ongoing probation and counseling. They have infrequent counseling, probation, it would be almost impossible to track the guys. It is such an odd thing, happening on thing, frequent it is difficult for probationary officers to follow them.

Psychotherapy on its own is not very effective. I think everything you see from the Catholic Church has shown that. The priests, they have gone through psychotherapy and whenever it has pronounced them cured, they come out, they have done their deal again and again and again. That is a historical observation.

So, I would say to you that there are psychotherapy programs both in prison and when people come out on probation. I will say to you I don't know

of any within the prison medical programs like drug giving programs. I'm not so sure, I think it is hit and miss whether they might give some sort of drug therapy when they are out. But I think very few people because it would necessitate the involvement, most of these people come out counseled by psychotherapists or psychologists. Very rarely is there the intervention of the psychiatrist. You need to have intervention of the psychiatrist to give the drug. So it seems to me drug therapy is reserved for those people very extreme. Perhaps had connective psychopathy. Those are the ones that don't work the best with it any ways. So, I think we are missing the very categoric people that would be most treatable as they come out of prison.

MR. THOMAS: I think about sex offenders that are coming out that are either being paroled out of the system now or maxing out, it sounds to me from things you are saying, sex offenders are made aware of the medication that it is available right now, the success you guys found with your study, they would have a difficult time, would they be able to go to a psychiatrist and get a prescription or insurance, the problem now maybe the insurance industry needs to be educated on the necessity of maybe recognizing this

with some of their coverages?

DR. SCHOBER: You hit the very point. You hit the absolute crucial point. Coming out of prison it would be very hard for them to access the system to get this kind of therapy. It would be almost impossible. That's very much a shame, isn't it?

MR. THOMAS: Yes. What about it sounds like for purposes of your subject you had five subjects that went into this voluntarily. What are your thoughts on House Bill 1992 is not mandatory in one sense I would say it is, in another in order to get out you have to submit to this type of testosterone lowering treatment. Any idea on the effect the voluntary attitude would have on it rather than somebody being mandated to get into the testosterone lowering treatment?

DR. SCHOBER: I suppose what I would say, anyone who enters a therapy program voluntarily would immediately expect a better outcome, better participation with therapy, particularly psychotherapy. However, we know the efficacy of the drug. The efficacy of the drug is very good. Perhaps once a person starts on a drug like this, I would suggest to you that they would be very more likely to

participate in psychotherapy, because they would instead of having the constant compulsion aspect of their orientation, if that were suppressed, mainly by psychotherapy and incorporate psychotherapy much better. It is always, you know, something that can be reversed. Say someone entered a program like this, they still have free will.

I was looking at your Bill. If they didn't like what it was like on this type of therapy, they would have the right to stop it and go back into prison, and probably be considered through another type of appeal, isn't that true? I don't know. I think they have the right to go back into prison and perhaps state their case to a probation board yet again and have the right to have consideration for at, at least max out. They have the right to choose maxing out and coming away with nothing. Is that right? I might not have it right.

MR. THOMAS: Well --

HONORABLE ALLAN EGOLF: If they go off treatment, they will go back into prison whether they would --

DR. SCHOBER: They go back to prison.

MR. THOMAS: There is definitely some things in the bill I think need cleaned up.

Particularly, there is some confusion on the sentencing scheme, it appears, I didn't draft it, so I don't know for sure. My read of the bill looks like it requires some type of sentence of life imprisonment, give you a mandatory minimum at some point you are eligible for parole, but for the remainder of your life you will be on parole.

I'm -- I talked to the District Attorney Association about the bill and Janet is here today, assuming she can help us with that. Their take on how that is going to work if the offender does reject going into the testosterone lowering treatment.

DR. KUHN: I think the point brought up was who would go into this. Our psychotherapist did ask his group of offenders if anyone would volunteer for the program. I can't remember how many men were in the group, ten or 15, not a single one wanted to go in.

I do think because we have had such success with some of these men and they are begging to stay on it, there may be an opportunity for people who have been treated to actually go into the prison system, I wouldn't say promote, to tell them how it is, how they feel. I just received a letter from a gentleman in prison, dear Ms. Kuhn I wrote you some time ago

November of 1999 asking about your project relating to sex offenders. You're only dealing with a few men who are child molesters was unable to help me at that time. You forwarded my letter to Stanley Sayer, do you remember. Anyway, I have been in therapy for around 15 years now I have been in prison for 27 years this September. I will come up for parole in December this year and if I may get my make it my time will be up in March of 2005. The reason I'm writing is that I'm trying to get a group started upon release, potential re-ffender intervention group. What he is hoping for is to help others.

But it is an interesting letter in concept. I think it is a challenge of offering this type of therapy that is going to be addressed and overcome. That may be a way to do it. I would point out too, do you remember the figures we showed you the initiation of the abuse cycle isolation, depression, when these men come out of prison, think of what we do to them. They are labeled as sex offenders, some violent sex offenders. You talk about isolation, you talk about depression.

So my thought is, the way we are managing them now, we are setting them up for relapse. The ones that don't relapse, it's a minor miracle. We are

setting them up for relapse. As Peter pointed out with the bill we currently have, there is no mention of plethysmography, a means of monitoring after they are released from prison. If the bill is readjusted, the problem that probably should be looked at. Assessing them a baseline with multiple measures with the Abel, the plethysmography. Thank you.

MR. THOMAS: That was, you actually led me into my next question dealing with Megan's Law.

DR. BYRNE: You asked about voluntariness, your question really fits in well with what I talk about. The two factor model recidivism sexual deviant versus psychopathy. You have individuals motivated by sexual deviance, those masturbating, fantasizing, one general class. That is what we had in our study. There is another class of individuals equally as risky more personal traits, psychopathy. Regardless whether they would come in, one of the things we are trying to do is manage risk. If we put these individuals psychopaths in the literature, now psychopaths, there isn't any treatment that helps them in any way we have been able to identify.

Now we are identifying more, you heard earlier in the presentation there are civil commitment programs with sex offenders, beginning to be able to

identify psychopaths and design specific treatment programs for them. But, until those are more clearly identified, it would be wise to do as best you could to screen those individuals out of the loop on eligibility if possible. Simply because those are the ones who are extremely manipulative, extremely deceptive even with polygraph while we detect deception, they are going to be deceptive. They have a long history of it. They can be identified pretty reliably with some of the assessment measures. So, I think the voluntary issue is good for those more sexually deviant that also help them maximize from the psychotherapy portion of the overall treatment portion. The psychopath won benefit from psychotherapy regardless of Lupron. Maze helps with sexual deviant issues they have. They will be much more likely to fail out to do poorly in psychotherapy just in general with or without the Lupron. Identifying those individuals might help in a management sense. They can be reliably identified pretty easily.

MR. THOMAS: That is interesting, as I was listening to you talk about that, the two classes, a thought went through my mind, talking about Megan's Law I don't know if you are familiar with our Megan's

Law, you go before a sexual offender assessment board, do you know, are you familiar with this sexual offender assessment board?

DR. BYRNE: Vaguely.

MR. THOMAS: My question wondering whether somebody is convicted of an offense they go before the board. Is that something the board could also look at to determine eligibility for first they assess whether SVP, could they look if somebody might benefit under this program say you won't, you will, classify them that way?

DR. BYRNE: I would be, the expert on the board a consultant Adele Forth, she is one of the worldwide leaders in psychopathy assessment. I would be willing to bet very strongly as part of that the SVP consideration they are doing psychopathy evaluation for everyone that comes before the board. I don't know for a fact given what you describe it is highly like likely they are doing that. That would be useful.

MR. THOMAS: Two other things trying to make this quick. Your study dealt with pedofilia. Are there other sexual offenses such as rapists, I'm not an expert, forgive me if I have this wrong, adult on adult rape situation, do you foresee if this, a

drug like this will help in that manner at all?

DR. SCHOBER: Well, I have to say to you this, I think it is a mixed bag, none of the studies have shown rapist responded well to drug therapy. However, what one does have to recognize there is probably a relationship between testosterone and aggression. There is the possibility manipulation of testosterone may suppress aggression. That is something that has been high in the literature now, beginning to emerge.

DR. BYRNE: Rape would tend to have more antisocial psychopath type of motivation in general. Not completely. Tending more in that direction.

DR. KUHN: Our current challenge is finding funding to continue this study and also to expand it. To the other types of paraphilia the younger and younger populations.

MR. THOMAS: Finally the last question I have. We have another bill pending before the House Judiciary Committee now. I'm sure MOST of you have heard about it, other states are starting to deal with, Tennessee was the latest. Sexual offenders what they do is GPS for tracking sexual offenders once paroled out of prison or maxing out. From what I've heard from you all today is that merely tracking the

offender through GPS device probably isn't going to do very much. What are your thoughts about what a GPS tracking system working in conjunction with psychotherapy testosterone lowering treatment be something that might even make this better?

DR. SCHOBER: Well, you know, I think most offenders if you start looking out there in cycles, offend in their immediate locale. I don't think GPS will make a huge impact. What GPS does, those offenders who go across state lines, offenses are in two different states perhaps not recognized as being subsequent offenses, it may knot stop that. I don't think -- would you say that Peter most sex offenders are in the place most familiar with, in their own home or their own car or --

DR. BYRNE: Significant limitations they will offend anywhere.

DR. EARLE: We use GPS with some of my clients, in Colorado. We identify areas you are not supposed to go. If they cross over boundaries, immediately sets off an alarm. It does work with these people. It keeps them from going. They go every place. You can't sit down say they offend in their home. It is a very effective tool.

MR. THOMAS: It is effective but probably

effective aid law enforcement to help them with their job. But do you see it is also effective as far as recidivism goes?

DR. EARLE: I think it is. Clients I'm talking about are in treatment. Not law enforcement doing this, treatment providers. Talking about community correction facility they use GPS. It really does.

MR. THOMAS: GPS used in conjunction with treatment?

DR. EARLE: Sure, it would work. Putting GPS on wouldn't work.

DR. BYRNE: I would like to comment on it. A couple things, obviously, when I'm running group and treating individuals, I commonly tell them the best way to, for child molester, the most surefire way in the community to stop recidivism, no contact. If you don't have access to children, you can't offend. A necessary ingredient. I think with individuals who aren't on Lupron, that may be a useful thing, the motive for outlet is still there. How effective it would be with Lupron is an interesting question. What our data is showing they wouldn't be motivated to seek at the same level, theoretical at least, it wouldn't be as motivated to seek out the child for sexual

activity. I will say with GPS you heard us allude to civil commitment programs for adults in 16 states. Of those 16 states, 15 are all inpatient meaning quasi prison essential. They are not inmates, residents, for all intents purposes it is a prison. The only one that has an outpatient program is the state of Texas. GPS is absolutely part of the program. It is very similar. The population you are talking about, these are high risk individuals in this bill you are talking about recidivism, talking about sub population of sex offenders in general. So, in terms of risk management, of the entire population with high risk individuals, they are not using Lupron though. Again you have the notion of which types of interventions are best, depends on the treatment and supervision being offered depending how that is going. I would be interested in, I like using GPS, I think it would be very effective. Would be more effective with individuals who aren't on Lupron. That is my comment.

DR. KUHN: I think what is interesting when we started this our psychotherapist.

HONORABLE ALLAN EGOLF: Take the microphone, please.

DR. KUHN: Our psychotherapist, thought all was needed was psychotherapy. I was of the

opinion all we needed was Lupron. I know Dr. Earle was strongly in favor of showing polygraph deters from this acting. All these things are necessary. As you add different layers on your adding different layers of safety net, the more you add on, the stronger and stronger net to protect the child from the molester. So, if you got polygraph, you got Lupron, you got psychotherapy, and you've got GPS, you've got a very strong program.

No one can actually tell you about the efficacy of GPS, here comes a scientist unless you do a control blinded study. Somehow to tag these men not less them know they are tagged, follow their movements tell them they are tagged and follow their movement. These gentlemen have practical hard core experience shouldn't use hard core, practical everyday experience, they are saying this is efficacious, this is why bringing these individuals together is so informative and helpful.

MR. THOMAS: Again, I thank you guys for coming here. I want to put you on notice. Often subjects like this start to get recognition start out in subcommittees then when I go back the rest of the staff go back to talk to our chairman and other members of the committee, this could be something we

may be calling you all back to Harrisburg at some point to take this before the full committee. Right now there is ongoing meetings with the four caucuses in the governor's office on Megan's Law. We are looking at doing amendments to Megan's Law statute. We have had recent opinions from the Supreme Court on Megan's Law. I note one of the justices keeps talking about need for some type of subsequent review of offenders where you have these are offenders are determined SVP register for life subject to community notification. We can get away with that because it is rehabilitative rather than punitive. One of the justices in the Supreme Court continues to say it is possible problem with the statute there is no subsequent review provisions.

To look at an offender to determine whether or not certain time he might be rehabilitated, maybe no longer needs community notification or door knocking as it is called. That ties in with that for some of the sexual offenders, unless they are on something with treatment with the medication maybe that may be a way of rehabilitated to the point the door knocking community informing may not be necessary as long as they continue treatment and medication. I raise that as a point we can take back to the

committee. Thank you.

MR. FINK: One of the things I heard over and again was the issue that this kind of program seems like you are getting a lot of very valuable information that has enormous implications to be very constructive in guiding public policy and treatment of these individuals who are offenders, of young children. I was wondering if you can give us any idea as to whether or not there are any other states, any other initiatives that have, are in place? It seems like such an important task and yet the dollar seems so limited, and the need so great. Can you give us some sense as to what else might be going on in this country, federal initiative, private foundations, etc., etc.?

DR. SCHOBER: It is a very hard question. I think several states have considered this in the same way we have. You know what I really think is the limitation? I think that the limitation for implementing a system like this is the lack of objective information. Up until this time in the literature, up until this study, there has been very little objective information. It has all been based on subjective interview.

We have shown you how likely just baseline

objective interview is to be truthful. So I think the lack of objective data, the lack of an ability to follow someone up in an objective way has hampered the use of this kind of drug. Look at every other drug we use in the industry as physicians. It has been rigorously tested by the FDA to know whether it works and to look at the side effect profile whether it is dangerous, how long you can use it, what kind of long-term problems it has, what kind of interactions it has with other drugs. But this use, this drug has never been looked at in that way. It has been looked at, not objectively.

DR. KUHN: It -- this particular drug that Dr. Schober is talking about is kind of interesting, because the other part which she didn't quite get to, was that another thing the drug companies do is look at different applications for the same drug. This particular drug has been used for years and years and years to treat prostate cancer. So there is lot of safety efficacy data on it. But it has not been used for this particular application Dr. Schober is using it for.

DR. SCHOBER: What we are saying so we don't have objective information on efficacy. It is difficult to put something into law or make it a

therapeutic principle unless you have objective information about efficacy. That is why we have not seen this type of a program come into standardized usage. We don't have that information. Part of the reason we don't have this information is the kind of people that pedophiles come into contact with as a therapeutic principle.

Pedophilia is always classified as a psychiatric disease. But when you really look at it, you think, is it really a psychiatric disease or just an orientation disorder. And how many years, how many hundreds of years was homosexuality looked at as a psychiatric disease that people were imprisoned for. After a period of time people began to recognize, it is not really a psychiatric disease, it is just a disorder, not even a disorder, it's just an altered orientation, different orientation.

When it comes to adults, it is not, we can't find a reason to make that illegal. But when it comes to children, when you are doing something, when your orientation is towards someone who is not legal age to make the decision you can have that interaction with them, it is a whole other thing. All of a sudden the orientation disorder can also be a crime.

But the people that have been looking at

these people pedophiles providing therapy have been only psychotherapists, psychiatrists, psychologists. They have never been looked at as a sort of a disorder that might be treated medically. Never looked at in that way. So you don't really have the kind of objective person to make the qualification drug therapy works.

In fact, it would be very difficult for a person just a medical doctor even a specialized type of medical doctor to make that determination. It takes a panel of people who see it in different ways to make the determination if something works.

I have to say to you on my own, would I carry out this kind of research to look at all the different facets of pedophilia, all the testing it takes in order to make objective decision? No. No. As educated as I am, all the years I have in sexual medicine, I don't have the qualifications or the background to look at it in every facet that it needs to be looked at. It needs to be looked at in a multi specialty group the way this group has been chosen and formed.

It takes into consideration all of the aspects of the parameters of pedophilia, and by all the expert people who look at it. Even now, even with

what we have together as a multi specialty group. We probably would be, we probably could be enhanced even more. We could have a psycho-endocrinologist or endocrinologist on the panel and that might enhance our outcomes even further. But this is the kind of examination, this is the kind of nidus, the kind of stark action that needs to be taken to make objective determinations that would create a basis for a psychotherapeutic model. A medical model. For outcomes. Outcomes have to be objectified in some way in order for us to say is this successful or not successful.

How can we put, unless we say that objectively, how can we advocate it yet to take place all across the United States in the same type of model unless we can show objective outcomes that are positive. And I believe we have shown you objective outcomes that are positive. Up until this time that has not been in existence, never been a program like this.

DR. KUHN: I think that California is leading the states in their different types of programs they have for pedophiles and years ago it was California.

DR. EARLE: California?

DR. KUHN: Yes.

DR. SCHOBER: Tried it not thoughtfully.

DR. EARLE: California has no standards. Nothing.

DR. KUHN: They will be offering --

DR. BYRNE: If I may respond. I kind of was hearing a policy issue in your question. And I think what we are talking about with our study is a subgroup of the population of sex offenders who are high risk. And when those individuals come to the attention of the state, it is the state's responsibility to manage that in two facets: Community safety risk manage. Financial issue, if you incarcerate them, you take the financial responsibility to do so, you do a civil commitment, you take the responsibility to do so.

One way to conceptualize this issue is risk management on the part of the state. This study suggests that with a subgroup of high risk individuals, you may have a useful intervention to utilize. In my experience I train people every month from all over the country, they come to Salt Lake to learn plethysmography. In Salt Lake -- in Utah we have indeterminate sentencing so we use psychotherapy as the care. So, if they get through it rather

rigorous program while in prison, they have an opportunity to get out earlier. I just went to Tennessee and did some training there. And the treatment is offered while incarcerated. But no one gets out until they serve the entire prison term, no such thing as parole.

Depending how one wants to implement that motivationally will be extremely critical. It is about managing the financial risk and balancing with community risk as best one can. What we see here is there is a subgroup of these higher risk individuals who account for the most recidivism that are responsible to medical intervention. It does lower their risk. In that sense it has some very salient public policy implications both financially and community safety wise.

HONORABLE ALLAN EGOLF: I think you had some figures earlier about the cost, the cost of incarceration. What is the cost per year for this program through continuous psychotherapy, and polygraph, and Lupron treatment.

DR. KUHN: 12,500 per subject.

HONORABLE ALLAN EGOLF: The whole thing, $12,500 --

DR. SCHOBER: There is a lot of testing

that will not be absolutely necessary.

DR. KUHN: Correct.

DR. SCHOBER: The therapeutic model part of a research model.

HONORABLE ALLAN EGOLF: Less than that.

DR. SCHOBER: Exactly. Less than that. In comparison to incarceration which is 27 to 32. And civil commitment can be well over 100,000.

DR. KUHN: Lupron is one three month injection about $1,500. Kind of interesting a lot of the drug companies that sponsored us, they have been very supportive but they are also, it is interesting they are very conservative. Some drug companies don't want their names associated with treatment of pedophilia. They don't want Lupron labeled for this type of treatment.

But had they labeled it differently, Dr. Sherman and I went through this at Bayer, if it had been labeled testosterone lowering agent, then insurance companies would pay for it, it would be appropriately labeled. Bayer does have a Lupron implant for a year, but it's not available yet. We would have been, I wouldn't say home free, basically home free, but because labeled for treatment of prostate cancer, that kind of left us out in the cold.

Very minor things you have to --

HONORABLE ALLAN EGOLF: If you had implant it probably would even lower the cost more.

DR. KUHN: Yes.

HONORABLE ALLAN EGOLF: I want to clarify one thing we talked about the getting parole maybe a person, psychopath, in the legislation there are, as far as restrictions on parole, it is not automatic. No parole or other release shall be authorized by subchapter if at the time of request for such parole or release there are other reasonable grounds for denying parole. It is not automatic at all. They have to go through a process, regulations set up under the legislation.

So I think -- I think that -- any more questions? Certainly thank you for your presentation. I guess one last question, do you have any suggestions on parts of the legislation you think should be changed, anything that comes to mind? We will get input from a legal standpoint too next. I just wondered from your aspect whether there is anything.

DR. BYRNE: Page two bottom of the page testosterone. I would just the thing that says quote testosterone lowering treatment. I would just suggest at least from my reading of it, rewriting because of

the way it is written it says testosterone lowering treatment Leuprolide acetate reduces capacity serial child molester to commit sexual offense -- child under 13 years of age or the use of any other drug for this purpose. The issue I guess just clarifying, the use of testosterone for this purpose meaning testosterone lowering agents, I guess. When I read this it was unclear. It goes on to say that the department in consultation with the Department of Health determines equivalent to or more effective Lupron acetate at doing what?

We are talking about management of sex offenders clearly but a very specific kind which is testosterone lowering. Just as an example, there are some anecdotal evidence about another class of medication that might be useful at treating sexual compulsions. That is a different mechanism they are targeting rather than testosterone lowering. When I read that, it was somewhat unclear, at least to me. It's just something making sure about testosterone lowering therapies as opposed to something like antidepressants, or other classes of medications.

DR. KUHN: Which can reduce libido but they don't decrease testosterone.

DR. BYRNE: Exactly, they work by a

different mechanism. I can see somebody reading this Zoloft is only $50 a month for prescription, but you got to pay $1,000 for Lupron. Maybe we can make that, I'm saying someone may try to do that.

DR. KUHN: The other thing is, as Dr. Byrne pointed out, it would be nice to incorporate plethysmography in the -- the other thing, the baseline, you are going to want Abel and plethysmography and polygraph. There has to be a testing baseline.

HONORABLE ALLAN EGOLF: Just so I understand, you are back to this goes to say, maybe I'm misunderstanding your concern. It does say that the use of Leuprolide acetate, goes on to say, any other drug for this purpose that in consultation with the Department of Health determines is equivalent to or more effective than Leuprolide acetate. So would that take care of it?

DR. BYRNE: Put before the period, "in lowering testosterone." In lowering testosterone. That would help you. It keeps you in the same class. There are alternative drugs people are conceptualizing like SSRI, some of the inhibitors that reduce libido operate differently than testosterone lowering agents.

DR. SCHOBER: I like the way that was

worded in a way it allows you to modify as drugs come out, designer drugs that perhaps will be more specific for very specific functions, very specific receptors. I think it is important to have that language in there "other drugs." I think that is an important piece of language to keep.

HONORABLE ALLAN EGOLF: We can work with you on that.

DR. BYRNE: I have one other one on page nine. Section E, voluntary surgical castration. A serial child molester may voluntarily choose to undergo surgical castration as an alternative to testosterone lowering, provided that the serial child molester satisfies the psychotherapy and polygraph.

What I was thinking is, you still may end up with those somewhat manipulative. I thought the issue of D, criterion D just before this one should be included in addition to the psychotherapy and polygraph, they should also be subject to random testosterone levels because one could still reverse the effects of surgical castration with the testosterone supplement. If they are in the community, we already know they're high risk, have been surgically castrated, the notion of having them subject to random testosterone blood levels would be

extremely useful. You would then be able to, we would probably catch it with the polygraph, I say probably may be able to incorporate it that way. Not a bad threat or deterrent to have in terms of random blood testing for that purpose, just in case, just in case it is not monitored in that way with the polygraph. That might be a useful consideration as well.

HONORABLE ALLAN EGOLF: It does say that in D.

DR. BYRNE: It says it in D. E by itself just said, E specifically identifies psychotherapy and polygraph.

HONORABLE ALLAN EGOLF: Okay. Got you. Very good, thank you very much. I certainly appreciate that. We have one more.

You certainly are welcome to stay and comment on this. We have Janet Necessary, Assistant District Attorney from the District Attorney's office in Allegheny County. If you would like to do your presentation now or questions. Do you have questions for any of the members here? Just strictly on the legislation.

MS. NECESSARY: Well, I did have one comment Dr. Byrne answered, my comments, most of my colleagues when I told them, showed them the Bill

asked them what they thought about it, most of them were highly skeptical of chemical castration. We have all been taught that rape is a crime of power, not a crime of sex. So, we of course are referring to the psychopaths that we deal with who derive pleasure, you know, satisfaction from hurting an adult or child and may not use their penis at all in the crime. They may you know, insert an object in the victim. They may torture the victim, do something else. I think it is very important that it is made clear that not all sexual offenders are going to be, society is not going to be protected against all sexual offenders simply by castrating them surgically or chemically.

That point has been made clearly the psychopaths, those I assume suffering from antisocial personality disorder which we see very, very often in our cases are not the people that are going to be helped by this. I think this presentation enlightened me as to the difference between the two. I think that is very important too. My question was answered.

I will not keep everybody from their lunch too long. I have a few things, comments on the Bill. First of all, my name is Janet Necessary, Deputy District Attorney for Allegheny County, I work for Stephen Zapalla, Jr., District Attorney of Allegheny

County. I have been with the District Attorney's office since 1978. I have prosecuted sexual assaults both adults and children since about 1980.

Currently on the supervisor of the Crimes Against Person's unit which we handle strictly adult offenses. Our unit recently a couple years ago divided into two different parts. We have a group of four prosecutors who handle all of the child abuse, physical and sexual cases, and my unit is left with the adult cases. I'm very familiar both with adult and child sexual assaults.

I would like to point out a few things about the legislation from the standpoint of a prosecutor. I would like to make the point these cases are very, very difficult to prosecute. I would say the majority of the cases that we have we do not have any physical evidence either in the way of DNA evidence or even in the way of physical trauma to the child or the adult at all. Most of our cases rely purely on the testimony of the child speaking specifically of children because most of these cases the children do not report immediately. They are more likely to be threatened and shamed into silence. They don't tell.

So we very rarely get DNA. You may have read the paper, the local papers in the last week, we

had sentencing of a child molester, child rapist who was a former head of the school board, fairly respected member of the community raped a seven-year-old child who was being baby sat by his wife or his girlfriend. And vehemently denied the charge when he was first arrested.

Apparently, the child even was subject to some, family subject to some harassment by members of the community or his family who didn't believe that this child made these things up. It was only after DNA was amazingly recovered because the child did tell someone right away. It was identified as his DNA did he give it up and admit finally pleading guilty, admitting he committed this crime. I think about those cases but for the happenstance this child told someone there was DNA to back up her story she would be forced to go to trial, she would be subjected to withering cross-examination, would be extremely difficult for her and difficult for the commonwealth to get a conviction on the case.

We need to keep in mind that not all of these cases are going to result in convictions, especially if the stakes are so high as far as the person facing a life sentence, he is going to go to trial, he will go to jury trial and fight this with

every resource that he has. So, I would urge the committee to keep the prosecutor's ability to be flexible in mind.

Sometimes we do have to offer plea agreements, work out bargains for the good of our victims and for the protection of society. Not everything works out well we have overwhelming evidence.

With that said, I would like to point out the Pennsylvania District Attorney's Association which I'm here today representing asked me to appear this week and they wanted to say that they have no formal position on the Bill at this time.

Apparently, the members were, have not had a chance to review it, however, we are interested in learning more about the issues raised in the Bill and would like to develop a position on that once we have a chance to review it.

I have a couple of specific questions about the Bill. And someone mentioned that there were, was some language to clean up, a little confused, everyone that looked at what exactly the sentences were for the sexual recidivist, sexual offenders. I notice the first section that it said mandated life sentence for somebody previously convicted. Then it went down

below to say well, for certain offenders, there is 15 years, so, that was my question.

Normally, if you are talking about first degree murder, you talk about shall be sentenced to a term of life imprisonment. That is what it says. As this does in first section. So it is a little confusing.

I think I know what you are saying, trying to allow maximum of life imprisonment with these other mandated minimums. So that's something that probably needs to be clarified a little bit.

Another comment I would have about the Bill is I notice that the definition of sexual offenders encompasses a broad range of conduct, a broad range of crimes. From actual penile penetration all the way down to fondling or touching. I don't know, I think you should consider whether or not it is useful to treat say a multiple rapist who penetrates children or commits other felony sexual offenses the same way that you would treat someone who perhaps is a multiple toucher. One of my colleagues said you are treating someone who actually rapes the child the same as someone who might pinch them on the butt or touch the children. We have people who go to swimming pools. They try to touch the children maybe on their breasts

or on their thighs or buttocks. I think I have known children who have been just as affected by that as someone actually penetrated but for the most part I think that the actual penetration and those kind of offenses are much more serious in their effects on the children.

So I think a little delineation. I would like to see one of my colleagues raised this, we have people who are multiple offenders, repeat offenders, and that is their only crime is fondling. It would be nice perhaps to have a repeat fondler be committing a felony as opposed to a misdemeanor which is what it is now, doesn't matter how many times somebody fondles a child, still a misdemeanor. A person under 13, victim under 13 a misdemeanor of the first degree. It would be nice to see that raised in grade or seriousness a little bit.

It really is a broad range of conduct. I would point out that expert testimony is obvious here today is something that really raises people's consciousness about these crimes, really opens their eyes. I have certainly learned a lot today by listening to this. I would point out one of the ironic things when we are prosecuting child abuse cases, we are not permitted to present expert

testimony at all to explain the dynamics of child abuse or why children behave the way they are, the way they do, why they don't tell. That is based on Supreme Court case law from actually many years ago. I don't know it would ever be possible to change the law in that direction. That is certainly something that the public does not know about, the public does not understand child abuse or dynamics of child abuse.

I have one more point as far as the therapy which I think most of our sex offenders are not going to be in jail, if they are in jail, they will not be in jail that long. Everybody gets out, most everybody gets out.

I think this type of therapy, and the chemical component of it can be very useful. My question would be how useful it is, maybe the panel can say something about this, for someone who is in denial. An awful lot of our offenders, they may be placed on probation either because of a plea or what the sentence is for this kind of crime. And the probation officers tell us they have a very hard time getting them to go through therapy because they won't admit what they've done. Even to their therapist. So I think we do have that as a problem. People whose cases are not serious enough they will go to jail for

a long time but they are also very resistant to therapy. I think those people are going to be more likely to go out and offend. What do you do, someone?

DR. KUHN: In Colorado they have six months to get out of denial. If not in denial in six months, they go back to court. And that is very effective.

MS. NECESSARY: As a probation violation type of thing. I think that is important thing you have the stick, you need the carrot and you need the stick. I open it up for questions anything someone might have.

HONORABLE ALLAN EGOLF: This is a round table discussion. So, reaction there to her questions and comments?

DR. KUHN: I just have one comment.

HONORABLE ALLAN EGOLF: Do you want to take the microphone?

DR. KUHN: If we had more time, I would tell you stories about the different psychotherapists that we tried to maintain on the project and what happened. One had an excellent idea, I thought. He said the more punishment you heap on the people, the deeper and deeper they tunnel, the less likely they are to emerge for treatment of their problem.

One of the things he was entertaining was actually like pedophile anonymous, someplace they could go for treatment where they wouldn't be punished. We know too a lot of families don't want the aunt or uncle most likely punished, they want them treated. That is another aspect of something that could be looked at. The voluntary programs they are not punitive, they are therapeutic.

HONORABLE ALLAN EGOLF: Seemed like I got from your testimony though today that so many of them, most of them are in denial they wouldn't go for therapy unless there is some stick, punishment, incarceration.

DR. KUHN: It was kind of interesting it does seem to be an ambiguity between Dr. Kovacs the group he treated the five people that walked in off the street, the sixth one, I think there is a population out there that would come in. Because we have seen them.

DR. BYRNE: I wanted to comment on the issue of the fondling verses intercourse issue. More and more penetration types of things. An individual I guess based on my experience also with what I know of recidivism research, there is very little research finding, research findings on recidivism that suggest

the intercourse is, results in less risk later on.

So the classification of those fondling, particularly fondling of the genital or private areas, those I would be somewhat concerned about differentiated in terms of risk still sexual offense still loads over on risk for recidivism another left unchecked, I would be very concerned. We already saw in our study these individuals started out with hands off offenses, exhibitionism, all of them did. And then there is the normal kind of progression almost like drugs you have to go to something more intense.

I think stopping and addressing the fondling issue, starting to step over the line of violating the child's extremely private and personal space, I think in general from what I see in risk recidivism has an impact both are likely to be very impactful to the victim.

Risk wise I'm not sure there is a difference only one study I have seen says invasiveness resulted in elevated risk. Once it crosses the hands-on threshold. That was just one comment I wanted to make.

MS. NECESSARY: I agree that fondling often escalated talking about one victim the offender will start with the victim fondling and then progress

to other things. My concern would be if you are going to say that, say a two-time fondler will get a life sentence, a lot of judges might be reluctant in that case to actually sentence somebody to that. But I agree. I have had victims who have been terribly traumatized by fondling that never progressed any farther. I agree, those people go out and continue to do it.

DR. EARLE: We have to be careful of the impact of the victim, fondling seems to be more impactful on the victim than actual penetration. You have to be real careful with --

HONORABLE ALLAN EGOLF: That's one of the things we wrestled with when we made this life sentence, I know it is drastic. We felt that it had to be certainly after two offenses at least, two convictions rather. So the first -- time around authors in convicting the person. Secondly, by the second time, the individual should have known from the first incarceration whatever conviction it is serious. They didn't stop. They did it again. So maybe we need to change it. But we felt life sentence because we know once they are into this, research has shown they will keep doing it. We made it life sentence but giving them the option of this parole if they are

willing to go into the program. Maybe that sounds certainly severe. It gives them the out. We know the whole thing is serious, it is a serious crime. In fact, it is one, a different type of crime.

I think it is horrendous, not like ones that have a victim you rob them it is traumatic, but it is finished. They are victims for the rest of their life the way I feel. So I felt very strongly we need to do something very serious. But maybe if, maybe we need to look at that. Maybe too severe. Maybe we won't get it through because of that. We wanted to find that out today.

We certainly have had tremendous input here testimony from all of you and your experiences and research. And I can say that you should know, some of you know, I'm retiring not running again, but I will be down there lobbying, I will find somebody to take this. We have almost 50 could sponsors on this legislation. We have somebody to shepherd this through the next term I will be down there lobbying. I think it is a serious effort. But we do want your input, if you think there are parts of it too lenient and severe need changing for clarification that is what we wanted to hear today.

DR. KUHN: Can I make one comment?

HONORABLE ALLAN EGOLF: Certainly, thank you.

DR. KUHN: I think it is a concern, and Dr. Schober and our researchers have seen this. We did have pedophile say well, you know, so many strikes you are out. If it happens again, he would kill the child because the punishment is so severe, they want to stay out of prison. So for every action there is an equal and just as violent reaction. Dr. Schober what do you think.

HONORABLE ALLAN EGOLF: Do you think that was a sincere threat?

DR. KUHN: Oh, yes.

HONORABLE ALLAN EGOLF: Because how do they figure they will get away with that.

DR. SCHOBER: This idea of lifetime. This is why I like this bill. This bill is set up so it is a very specific set of offenders. It is a set, you made it very clear, they are serial offenders. That they have had more than one situation. But the nice thing about the Bill is this, if in fact it has been the only option after a certain number of convictions, one goes on to a life sentence, this bill gives the opportunity for an alternative. And perhaps that is the out someone needs.

If in fact what they said was I can either go to prison for the rest of my life or I can kill this child, maybe in their head they finally can say well, maybe I can go to prison for the rest of my life, or maybe I will finally get some help for this. That therapeutic option was never really a possibility in the past. I always wonder whenever I talk to these men, I always wonder if they haven't really been seeking it all their lives, seeking some, the minute they recognize they had a different orientation, the minute they recognize they were different. They still do have some conscience.

Although it takes a lot of rationalization to do what they do, many of them recognize doing something that isn't right. They don't really have any way to control it, they don't have any way to stop it. Perhaps that is the missing piece all along.

HONORABLE ALLAN EGOLF: Do you think 15 years is too long before they can get into therapy, do you think that needs to be decreased possibly?

DR. SCHOBER: I think that is something to definitely consider.

HONORABLE ALLAN EGOLF: That was very --

DR. SCHOBER: To offer the therapy up front.

HONORABLE ALLAN EGOLF: Maybe after ten years. We felt thought there should be some punishment.

DR. SCHOBER: Absolutely. So do I. Because there are laws. If one breaks the law one has the punishment aspect of it to consider. I do think too, maybe it would be a better thing to offer therapy sooner than 15 years.

HONORABLE ALLAN EGOLF: We thought of ten years.

DR. SCHOBER: You know, when you look at it, what is the outcome of incarceration with sex offenders? No benefit.

MR. THOMAS: We have a bill right now different dealing with drug and alcohol offenders, trying to get alternative sentencing schemes like state intermediate punishment you can get drug and alcohol offenders into treatment. We have a requirement of the Bill some institutional therapeutic action where institutionalized but undergoing treatment. I think that is something that may work with this type of thing while institutionalized in prison they should get started on the treatment. That will give the institutional physicians overseeing the treatment the opportunity to see how they respond to

the treatment.

They may have people that respond very well to it, that will help with the decision when they come up for parole or maxing out. That would be something they could do.

DR. SCHOBER: That is very enlightened.

HONORABLE ALLAN EGOLF: Okay, thank you all very much for being here. We really appreciate it. Unfortunately, we're very sorry we didn't have more legislative members here. We have staff, that is key. We have staff here.

(**WHEREUPON**, Hearing ended at 1:29 p.m.)

CAPTION

The Hearing was held in the matter, on the date, and at the time and place set out on the title page hereof.

It was requested that the Hearing be taken by the reporter and that the same be reduced to typewritten form.

COMMONWEALTH OF PENNSYLVANIA

COUNTY OF ALLEGHENY

I, William E. Weber, a Registered Diplomate Reporter and a Notary Public in and for the Commonwealth of Pennsylvania, the hearing was recorded stenographically by me and then reduced to typewriting under my direction, and constitutes a true record of the testimony given by said witness, all to the best of my skill and ability.

I further certify that I am not a relative, an employee of either counsel, and that I am in no way interested, directly or indirectly, in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my signature of office this 1st day of October, 2004.

William E. Weber, RDR
Registered Diplomate Reporter