To Catch A Predator, and Then Commit Him for Life

Sexual Offender Risk Assessment — Part Two

There are various issues, such as the assessment of psychiatric diagnoses, that a practicing attorney should be knowledgeable about in civil commitment cases. Part One discussed the legal constructs of the Adam Walsh Act, with a particular emphasis on the civil commitment of sexually dangerous persons. Part Two has a clinical focus, with an emphasis on the fields of forensic psychology and psychiatry and how they function within the psycholegal landscape of sex offender risk assessment in civil commitment cases. Included is a discussion of factors predicting the selection of sexually violent predators for state civil commitment.

This article offers recommendations for lawyers and expert witnesses to consider when assessing the federal sex offender. Some of these offenders will be hands-off (non-contact) offenders who have a history of solicitation and pornography possession-type sexual crimes. They are somewhat distinct from traditional child molesters and rapists who often flood the state court systems. An offender being considered for civil commitment proceedings must be competent to stand trial, and the attorney representing him must contend that the client is able to understand the nature and objectives of the proceeding and is able of rationally assisting in his behalf.

Factors Predicting Civil Commitment of Sexually Violent Predators

Nearly 20 states have laws addressing the civil commitment of sexually violent predators. What is the difference between sexually violent predators (SVPs) appropriate for indefinite civil commitment versus the dangerous but typical recidivist relevant to the holdings in *Kansas v. Hendricks* and *Kansas v. Crane*?[1]

Researchers in Florida found that offenders who were of non-minority race carried diagnoses and/or assessments of pedophilia and paraphilia not otherwise specified (NOS), had significant evidence of psychopathy (severe criminal personality), and had high actuarial risk assessment scores. They also offended against a younger victim, had more total victims, offended against victims of both genders, and were more likely to be civilly committed under Florida's Jimmy Ryce Act.[2]

Another study examined common factors amongst civilly committed sex offenders in Arizona, revealing that offenders averaged 2.6 sex offense convictions and 85 percent had prior non-sexual offenses.[3] Most of the offenders abused children sexually, some abused both children and adults, and a small number sexually offended against adults. About 90 percent of the Arizona sample had a history of alcohol abuse, 68 percent marijuana abuse, and 42 percent cocaine abuse. Approximately 63 percent had a diagnosis of pedophilia, 56 percent para-

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philia not otherwise specified, 14 percent exhibitionism, 13 percent voyeurism, and 40 percent antisocial personality disorder.

To date, the Bureau of Prisons (BOP) has filed certificates on prisoners to be considered for civil commitment who have diagnoses with pedophilia, paraphilia, antisocial personality disorder, or a combination of those three diagnoses.[4] Many have had sexual paraphilia diagnoses including exhibitionism, voyeurism, fetishism, sexual sadism, and frotterism, while others have had non-sexual disorder diagnoses including bipolar disorder, borderline, depressive, or histrionic personality disorders. The offenders are likely to have a history of prior contact or attempted contact offenses (regardless of whether they were state or federal convictions) and admissions to deviant sexual behavior and/or fantasies.

Measuring 'Difficulty Refraining' and Volitional Impairment

Under the Adam Walsh Act (AWA), a "sexually dangerous person" means that the defendant has engaged or attempted to engage in sexually violent conduct or child molestation and is sexually dangerous to others.[5] The phrase "sexually dangerous to others" means that the person suffers from a serious mental illness, abnormality, or disorder as a result of which he would have *serious difficulty refraining* from sexually violent conduct or child molestation if released.[6] The statute offers ambiguous language and does not define any of these terms.

Most states that entertain civil commitment statutes for sex offenders have similar statutory guidelines including requirements of a mental abnormality or disorder, a history of sex offending, and a determination that the offender will likely reoffend in the future. The AWA, in contrast, requires the first two elements, but instead of simply requiring a "likelihood" finding, the statute mandates a determination of an offender's volitional impairment over his sexual offending behaviors.

The statute does not mention the term "likely," and even though experts will incorporate actuarial risk assessment methods into their evaluations to assess likelihood, the statute may not require this. Actuarial risk assessment instruments are mechanical and overlook the clinically complex elements of assessing volitional abilities in relationship to the offender's mental abnormality.[7] Simply put, one cannot equate high scores on actuarial risk assessment instruments with one's ability to control or not control behavior.

When considering diagnostic issues, it has been argued in Florida[8] that no diagnosis by itself meets the legal threshold for commitment because it must also be demonstrated that the individual is likely to commit future acts of sexual violence.

Relevant to the AWA, the terms "mental illness," "abnormality," or "disorder" are legal definitions written into the law as a condition required for commitment. The mere presence of any of these terms is not legally sufficient to commit someone, rather the condition must predispose the offender to past and future sexual violence. Critically, one's clinical psychiatric diagnoses must not only predispose him to reoffending, but overpower his volitional capacities not to reoffend. If an offender simply chooses to continue to reoffend, then he should not qualify for commitment.

The Bureau of Prisons provides some guidelines[9] for an expert to consider when assessing "serious difficulty refraining" from sexually violent conduct or molestation. Experts can consider, but are not limited to, evidence:

A. Of the person's repeated contact, or attempted contact, with one or more victims;

B. Of the person's denial of or inability to appreciate the wrongfulness, harmfulness, or likely consequences of engaging in sexually violent conduct or child molestation;

C. Established through interviewing, and testing of the person, or other risk assessment tools, that are relied upon by mental health professionals;

D. Established by forensic indicators of inability to control conduct, such as:

   1. offending while under supervision
   2. engaging in offenses when likely to get caught
   3. statements of intent to reoffend, or
   4. admission of inability of difficulty to control behavior; or

E. Indicating successful completion of, or failure to complete, a sex offender treatment program.

Volitional Diagnostic Dilemmas

Paraphilias, Antisocial Personality Disorder And Psychopathy

The American Bar Association addressed the volitional prong of the ALI relevant to legal definitions of insanity and criticized[10] volitional tests by noting there is no valid or reliable basis for measuring incapacity for self-control.[11]

Similarly, the fields of psychology and psychiatry do not have a valid or reliable means to describe and evaluate a patient's volitional capacity because no uniform clinical definition exists at this time.[12] Experts in SVP proceedings will attempt to link psychiatric diagnoses to volitional impairments.

The issue of inability to control and the choice not to control or lacking the will to control, similar to an irresistible impulse and an impulse not resisted, will often lie within and be explained by the various diagnoses an offender has. It cannot be understated in commitment cases that diagnoses are not enough for commitment and research does not support that paraphilias intrinsically impair self-control.[13] The person's hypersexuality — fueled from his sexual deviance and leaving him unable to exercise choice over his behaviors — is the key, rather than just a diagnostic label.

The issue of volitional impairment is a very complex one, as it encompasses a consideration of the offender's pat-

Common Diagnoses/ Constructs Relevant to AWA Proceedings

- ❖ Pedophilia
- ❖ Paraphilia not otherwise specified (non-consenting) subtype
- ❖ Antisocial Personality Disorder (APD)
- ❖ Psychopathy (severe criminal personality)
- ❖ Exhibitionism
- ❖ Substance abuse, dependency and intoxicated states

tern of sexual offending and a multitude of various psychiatric diagnoses that characterize one's behaviors. Many experts will differ in their beliefs about the biopsychosocial makeup of a particular sex offender, and many will debate a particular offender's inability to control his behavior versus his unwillingness to control his actions. An offender's choice to repeatedly act on aberrant desires does not provide evidence of volitional impairment.[14]

Some argue that sex offenders who are diagnosed with paraphilias (sexual deviancy disorders), which are often viewed similarly to obsessive compulsive disorders, are more likely to lack control of their sexually deviant impulses. Others hold to the belief that *only* offenders who carry paraphilia diagnoses should be committed, as it indicates a deviant sexual preference, whereas antisocial personality disorder is indicative of general criminality and willful behavior.[15]

Antisocial Personality Disorder And Psychopathy

Given the ambiguity of the holding in *Crane* relevant to volitional impairment and its allowance for a sex offender to be committed based on an emotional disorder or personality disorder, there has been heightened scholarly debate as to whether a personality disorder, namely APD, is enough to commit someone indefinitely.[16] Many of these antisocial personality disordered sex offenders may not carry paraphilia diagnoses, and their sex offending may be one of the many antisocial behaviors in which they engage.

For example, consider a middle-aged career criminal who has APD, a juvenile and adult history of violent and non-violent offenses, and no history of sex offending. He enters a house, and during the burglary he commits an opportunistic rape against a stranger female occupant (offender takes goods of value and sex from the victim). This sex offender will score high on some actuarial risk assessment measures in major part due to his non-sexual criminal history despite only one detected sex offense on record.

In contrast, consider a young adult offender with prior juvenile and adult criminal offenses who has APD and one sex crime (instant offense). This offender burglarizes a home with the specific intent of finding a woman to rape. He collects her underwear and experiences sexual gratification and pleasure in raping, ultimately demonstrating some symptoms of paraphilic behavior. This offender may have a similar moderate to high actuarial risk score as the offender in the previous example, but yet be driven to rape by different causative pathways.

The question in AWA proceedings will be whether these types of offenders experience serious difficulty refraining from their sexually violent acts. It will be difficult to prove that either one of these offenders has serious difficulty in refraining with a record of only one sex offense in each case, yet a finding of likelihood of reoffending based on actuarial estimates of probability may occur. However, both the condition of APD and actuarial instrument data again should not speak to volitional impairments and one's inability to control behavior.

Many offenders with APD are not sex offenders, and the APD diagnosis does not require sex offending behavior. In fact, about 50 to 80 percent of all prisoners incarcerated in the United States qualify for APD, and many of them are not sex offenders.[17] These offenders may be viewed as having an ability to exercise a choice more so than the sex offender who has a paraphilic sexual deviancy disorder. It can be argued that APD is a catchall diagnosis for individuals with socially problematic behavior rather than mental illness and paraphilias, and since it does little to distinguish offenders, its validity is questioned.

The construct of psychopathy and being labeled as a psychopath[18] (affective, interpersonal, and behavioral components of a severe criminal personality), similar but yet distinct from APD, is relevant to SVP proceedings. Psychopathy has been known to be correlated with outcomes of general criminal, violent, and to a lesser degree, sexually violent behavior.[19] The use of the instrument to assess psychopathic traits, (Psychopathy Checklist-Revised: PCL-R) is embraced by many experts. Notably, the highest risk offenders may be the ones with paraphilia and antisocial personality disorder diagnoses and presence of significant psychopathic traits. The construct of psychopathy, however, has not been empirically linked to one's volitional impairments. Instead, psychopaths are assessed as having choice and freewill relevant to their antisocial behaviors. Accordingly, the expert witness in AWA proceedings should not equate psychopathy with an inability to refrain from one's sexual behaviors.

The question remains whether a personality disorder diagnosis alone or the presence of psychopathy qualifies a sex offender to have a serious difficulty refraining from future sexual conduct.[20] Despite the holding in *Crane,* antisocial personality disorder and psychopathy are not disorders that fit into the traditional medical model of involuntary civil commitment that provides protection of the community and treatment. Furthermore, offenders with APD and psychopathy have control over most, if not all, of their behaviors and are unwilling to restrain their impulses.

While some believe that antisocial personality disorder indicates the presence of general criminality, and those who have the most serious difficulty controlling their sexual desires have paraphilia diagnoses, the law provides the answer as the AWA includes the term "disorder" under its definition for "sexually dangerous to others" requirement. The *Crane* Court opined that an antisocial personality disorder is a disorder that affects emotional capacity in a manner that predisposes an offender to commit acts of sexual violence. Additionally, courts will likely recognize the construct of psychopathy as a disorder under the AWA and will find that it leads to difficulty in controlling sexual behaviors.

Paraphilia Disorder Not Otherwise Specified, Non-Consenting

To make matters even more complex, a critical debate in SVP proceedings has ensued as to whether the diagnosis Paraphilia Not Otherwise Specified-Nonconsent (rape subtype) even exists. Numerous examiners utilize this diagnosis to indicate that an offender has an affinity to rape, enjoys raping, and obtains sexual arousal from raping, yet does not enjoy the repetitive inflicting of suffering on the victim that would indicate features of sexual sadism.

The DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) indicates in the definition of paraphilia "children or other non-consenting persons,"[21] yet the manual does not specifically endorse a rape subtype relevant to non-consenting adults who are raped. Subsequently, many clinicians assume that: (1) an adult rape victim is a non-consenting person, and (2) if the perpetrator has a pattern of this behavior, he would qualify for the diagnosis of paraphilia non-consent type.

Others believe the diagnosis is too broad, unreliable, imprecisely defined, and in essence, a "wastebasket" diagnosis.[22] Utilizing the diagnosis may be inappropriate. It does not appear to fit with

the intentions of the authors of DSM-IV or DSM-IV-TR,[23] and there is no research conducted to establish the validity of this diagnosis.[24]

A Paraphilia Subcommittee was formed in the 1980s to make recommendations to the DSM-III-R. The subcommittee voted against a "paraphilic coercive disorder" due to the small amount of offenders who would qualify for sexual arousal to a coercive assault.[25] Additionally, the American Psychiatric Association (APA) task force noted that the DSM-IV has not classified paraphilic rapism as a mental disorder.

In contrast, others believe that a small group of rapists have diagnostic features similar to those with other paraphilias due to their arousal patterns to violent non-consenting sex. Yet, the ability to make the diagnosis with a sufficient degree of validity and reliability remains problematic. In addition, other research has shown that many rapes are not the product of primary sexual interest, but rather represent an exercise of power and control.[26] Fittingly, rape is often viewed as an aggressive and violent act having its roots both with APD and sexual deviance.

If an expert witness does utilize the "paraphilia not otherwise specified (non-consent)" diagnosis when assessing a rapist, there are several factors about which the expert should think carefully.

- ❖ Whether the offender experiences sexual arousal and enjoyment to the non-consenting interaction in and of itself and one act is not sufficient, rather a pattern of similar acts is indicated.
- ❖ If the rapist is sexually aroused to the terror and suffering of the victim that exceeds beyond consent, a diagnosis of sexual sadism is likely indicated.
- ❖ Consider the offender's sexual fantasies involving arousal towards non-consenting sexual interactions (rape fantasies).
- ❖ Consider the offender's deviant masturbation practices. Does he need rape fantasies in order to climax?
- ❖ Does the offender experience distress and anxiety when not acting on his rape fantasies and impulses?
- ❖ Consider the nature of the sex offenses and their patterns. Does the offender display a pattern of repetitive sexual assaults within a short period of time?
- ❖ Does the offender possess pornography with non-consensual stimuli?
- ❖ Consider reports from former consensual sexual partners who report on the offender's desire to have non-consensual interactions.
- ❖ Consider plethysmographic results using rape-related stimuli.
- ❖ Consider the offender experiencing less sexual arousal to consensual sexual relations.
- ❖ Do not rely only on police reports about prior sex offenses. The expert must consider other information indicating that the offender is sexually aroused to non-consenting sexual interactions.

Despite the legal answer that courts will consider any and all mental conditions, abnormalities, and disorders in AWA proceedings, expert witnesses must stay true to their knowledge of the distinctions between disorders and their requisite symptoms of behaviors. The expert must remember that diagnostic labels should not be considered dispositive of a legal issue.[27]

The reliability of diagnoses by clinicians is quite poor in SVP proceedings.[28] Considering the aforementioned list representing paraphilia non-consent type, it will be difficult for the expert to gather this information and the reliability of the diagnosis will be seriously challenged.

The expert witness must be mindful of the DSM-IV, which states that the inclusion of diagnostic categories such as pedophilia does not imply that the conduct meets legal criteria for what constitutes mental disease and "may not be wholly relevant to legal determinations."[29] There is an imperfect fit between the questions of ultimate concern to the law and the information obtained in the clinical diagnosis. The DSM states, "In determining whether an individual meets a specified legal standard … additional information is usually required beyond that contained in the DSM-IV diagnosis. This might include information about the individual's functional impairments and how these impairments affect the particular abilities in question."[30] When applying diagnoses such as pedophilia to questions of volition, the DSM-IV states, "Even when diminished control over one's behaviors is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time."[31]

The expert witness and the attorney must recognize the expert's role, which includes applying his specialized knowledge and skills in the diagnostic process. Here, the expert should offer descriptive and explanatory testimony associated with the offender's diagnoses and his history of sexual crimes, along with his volitional impairments in controlling these sexual offending behaviors. Finally, when opining about a diagnosis, the ethics code for psychologists states that "psychologists provide opinions of the psychological characteristics of individuals only after they have conducted an examination of the individuals adequate to support their statements or conclusions."[32]

Many prosecutorial experts render diagnostic opinions without ever setting their eyes on an offender. When performing a risk assessment, an expert who only considers record reviews of an offender without formally evaluating him in person will be limited when addressing various issues including psychopathic traits, sexual fantasies, and sexual offending behavioral patterns.

Courts and Volition

While the AWA and the U.S. Supreme Court failed to define volitional impairment, some courts have attempted to do so. In *In re Patterson*, the Minnesota Court of Appeals rejected an expert's notion that lack of control applies to extreme cases in which the offender suffers from serious mental disorder such as mental retardation, dementia, or organic brain damage.[33] In *Linehan I* and *In re Shweninger*, Minnesota courts have held that evidence of planning and grooming are not indicative of lack of control.[34] Conversely, Minnesota courts have held that evidence of planning and deliberateness have demonstrated an offender's lack of control.[35] In *Westerheide v. Florida*, the court defined volition relevant to a SVP commitment hearing as an "act of will or choosing the act of deciding or the exercise of will."[36] Also, *In re Crocker*[37] considered evidence of lack of control in a case involving an offender who engaged in criminal behavior when it was very foreseeable he would get caught.

Unfortunately for the attorney representing the federal offender, both the U.S. Supreme Court and Arizona Supreme Court agreed that the government needs to only connect causally the likelihood of serious violence to mental disorder and a jury will necessarily infer the presence of a serious difficulty and attribute the person's dangerousness to volitional impairments.[38] Ultimately, no satisfactory legal definition exits for lack of volitional control.

Courts do not need extensive expert testimony stating the obvious that an offender could not control himself from committing crimes. Experts must communicate why an offender is "beyond control" in a manner that makes him prominent from other sex offenders.[39] Further, the expert must not equate the prediction of future sex offenses with serious difficulty in controlling behavior.

Assessing Volition

The expert witness should consider the following elements (not in isolation) relevant to volitional impairment:

- Historically and currently meets criteria for a paraphilia diagnosis and preferably multiple paraphilias;
- History of frequent sex crimes in the community indicating sexual preoccupation and hypersexuality;
- Frequent acts of sexual violence within a closely proximate period of time when at risk in the community (while on supervision or while participating in outpatient sex offender treatment programming);
- Offender engages in behavior when he is aware of a high probability of getting apprehended;
- Offender lacks insight and understanding into his offending behavior;
- Offender lacks control of his behavior when it is unreasonable to expect him to engage or not engage in a certain act under his particular circumstances (considering context of offender's offending patterns);[40]
- Offender sexually acts out to relieve overwhelming anxiety and distress; and
- Offender's strength of sexual desire interferes with his ability to consider alternative courses of action, and decision/ability not to reoffend.

Legal precedent involving the AWA, empirical research, practice guidelines, and experienced clinicians have no clear operationalized definitions or proven reliable methods as related to the criteria to assess volitional impairment. Further, diagnostic labels alone do not fully explain a person's inability to control his sexual urges. Rather, they speak to the presence but not intensity of such urges.

Methods of Risk Assessment

Forensic psychologists and psychiatrists involved in Adam Walsh Act civil commitment cases will be asked to assess the statute's ambiguous language, "serious difficulty refraining from sexually violent conduct or child molestation if released." While they will consider the aforementioned psychiatric diagnoses relevant to this difficulty in refraining and controlling behavior, they may be asked to consider and provide a firm answer as to the offender's likelihood of future sex offending if released into the community. The issue of whether *serious difficulty in refraining* is equated with the likelihood of one's offending will have to be decided through case law.

The question of likelihood of sexual recidivism will necessitate a risk assessment within the BOP and will be conducted by a BOP employee and/or an

independent expert witness. There are various pathways to assessing one's risk,[41] including: (1) unguided/unstructured clinical judgment, (2) structured/guided clinical judgment, (3) clinical judgment based on anamnestic data (assessing the offender's previous patterns of offending behaviors), (4) research-guided clinical judgment, (5) clinically/research guided adjusted actuarial assessment, and (6) purely actuarial assessment.

Two types of risk assessment methods have dominated the literature for many years. One is based on subjective clinical judgment (unstructured clinical decision making). The other includes actuarial techniques that calculate risk and rely on a set number of weighted risk factors that apply to an isolated norm group of offenders who have various probabilities of reoffending over a specific follow-up period.

Prior to 1981, data indicated that psychologists and psychiatrists were accurate in no more than one-third of their predictions of violent behavior over a period of several years when utilizing clinical judgment.[42] In fact, a recent study found a very small (non-significant) correlation between clinical judgments and recidivism and stronger association between actuarial assessments and recidivism.[43]

The reasons for this trend include the fact that the literature has seemingly shifted to actuarial dominance due to its predictive accuracy and the tendency of experts to base their decisions on the presence or absence of information that is weakly related or unrelated to the criterion. For example, experts have a tendency to assign incorrect weights to information, a failure to consider offending base rates (the actual rate of offending within a certain population such as sex offenders), a natural bias toward conservative judgments of violence, a confirmatory bias looking for evidence that supports the hypothesis, or a bias to the party who hires them.

Actuarial risk assessment instruments seemingly eliminate the error in human judgment. Furthermore, they have been used in other sciences and medicine. Consider, for example, the data a cardiologist might have relevant to one's risk for an undesired outcome of heart disease including well-founded risk factors such as the individual's diet, weight, current status and history of smoking, and family history of heart disease. Ignoring group data could be quite costly. Simply put, some research indicates that there is a poor record of clinical judgment in the prediction of human behavior,[44] and the predictive accuracy and validity of actuarial risk assessment instruments are becoming more recognized by experts and the courts.[45]

Although the development of actuarial risk assessment should be considered in an assessment, these instruments have weaknesses. First, they rely solely on static factors that are unchangeable (number of prior sex offenses committed, history of stranger and unrelated victims, number of prior sentencing dates), while failing to consider dynamic factors that led to the offenses (sexual preoccupation, use of pornography and engagement in deviant masturbatory practices, and use of substances to trigger sex offending behaviors).

Secondly, actuarial tools have problems with accuracy of prediction. They incorrectly and falsely predict that an offender will recidivate, which is an enormous consequence on liberty restraints relevant to indefinite civil commitment.

Modification of actuarial data is based on clinician experience and knowledge of risk factors. The ABA's *Benchbook* has recognized a growing consensus that the abilities of clinicians to identify risk factors associated with future violence is improving.[46] Despite this recognition, the *Benchbook* states that although recent studies suggest that clinicians can identify risk factors for providing definitive predictions of dangerousness, courts are reluctant to exclude clinical opinion due to its value.

The expert witness does not formally add or subtract from the actuarials. Rather, the expert contextualizes his risk assessment with empirical risk factors cited in the literature, primarily dynamic and changeable factors that the actuarials fail to measure, as well as other professional and legal considerations. The actuarials need to be presented as they are because if they are formally modified with an expert's subjective judgments, their validity and reliability are damaged. Actuarials are important to consider, but they have significant limitations. They are representative of an assessment of the probability of risk, but are certainly not dispositive of the ultimate legal issue of volitional impairment in AWA cases.[47]

Types of Actuarial Instruments

Within the last 10 years, actuarial risk assessment instruments utilized to assess risk of future sexual violence have included Static-99, Rapid Risk Assessment for Sexual Offender Recidivism (RRASOR), Minnesota Sex Offender Screening Tool-Revised (MnSOST-R), and the Sex Offender Risk Appraisal Guide (SORAG).

Actuarial instruments such as the Static-99[48] utilize statistical analyses of groups of released sex offenders with known outcomes (arrest or reconviction of a sex offense or not identified as having committed a new sex offense) during a specified follow-up period. They simply inform the examiner of a statistically measured rate of reoffending among a group of sex offenders who share certain characteristics with the individual being assessed.

The Static-99 may be the gold standard and includes risk factors based on four normative samples of sex offenders that tap static factors related to sexual deviance, range of potential victims, persistence of sex offending, and antisociality.[49] Weaknesses of the instrument include that the estimate of sexual reoffending is obtained through the offender's criminal record or rap sheet, and is based on formal charges and convictions rather than true rates of reoffending. When considering some hands-off sex offenders with histories surrounding solicitation and child pornography possession, which includes many federal sex offenders, the instrument is likely less valid and should not be used.

Additionally, actuarials are limited to long-term probability estimates rather than assessments of immediate or imminent sexual reoffending. Critical to civil commitment cases, actuarial instruments are limited to providing probabilistic estimates to specific time periods, i.e., up to 15 years, but do not provide long-term lifetime estimates that would be more useful in civil commitment proceedings requiring estimates that look further into the future.

Admissibility in the Courtroom

Risk assessment testimony in commitment proceedings is evaluated for admissibility relevant to three factors — fit, prejudice, and reliability.[50] Once these three elements are satisfied, the judge must consider its legal sufficiency and whether the data satisfies the legal criteria for commitment. Are the reliability and validity of the instruments sufficient for a liberty-restraint? Moreover, the trier of fact must consider the weight of such expert testimony and to what extent it should play in the ultimate issue.

When considering admissibility of expert testimony in AWA civil commitment proceedings, the federal courts will consider the holding in *Daubert et al. v. Merrell-Dow Pharmaceuticals.* The Court

interpreted the Federal Rules of Evidence and mandated the trial court's gatekeeping of evidence responsibilities. The Court determined the admissibility threshold to rest on whether the evidence underling the testimony is scientifically valid, whether it can be applied to the facts at issue, and whether it will aid the trier of act in resolving factual disputes.[51] The Court considered, in dicta, four factors: whether the method being employed is testable; whether there are peer review studies supporting the expert's testimony; the known or potential known error rate; and whether the procedure or theory was generally accepted by the scientific community.[52]

There is a heightened standard of reliability and validity in risk assessment evidence given the consequences of loss of liberty and protection of the community from potential sexual violence.[53] However, state courts hearing sexually violent predator (SVP) cases have consistently admitted clinical judgment testimony establishing low levels of reliability in the courtroom.[54]

The major questions courts have considered regarding admissibility are the reliability and accuracy of the instruments as products of science and the importance of examiners and courts using them properly. Courts, such as the one in *In re R.S.*,[55] have upheld the reliability of actuarial risk assessment instruments as an aid in predicting recidivism.[56] However, they do not rely on them as litmus tests, rather they are interpreted as one piece of a broader clinical evaluation.

State appellate courts have considered the issues of evidentiary reliability of these instruments. Two admitted actuarials[57] and one denied their use,[58] yet all three courts accepted clinical judgment. The admissibility question surrounded not how accurate the instruments are to justify liberty infringements, but rather how accurate must they be to avoid potential prejudice arising from labeling actuarial prediction a science.[59] One court established that scientific reliability was contextual and depended upon the complexity of the testimony and the likely impact of the testimony on the fact-finding process.[60]

In *People v. Taylor,*[61] the court rejected the use of actuarial instruments, questioned the youthfulness of the instruments, and opined that the validity of the instruments has not been established. Trial judges in Arizona and Missouri state commitment cases held that the exclusion of actuarial risk testimony did not prevent the introduction of clinical judgment risk assessments.[62]

In the case *In re Valdez*, a trial court in Florida granted an order to exclude actuarials. The court opined that actuarials may define sexual violence differently from the statute that is the basis of the legal proceedings, and they fail to address the causal nexus issue. The court also said actuarials have potential for prejudice as they give a false impression that they provide an accurate and reliable estimate about the ultimate legal issue of risk assessment. The court went on to say they lack general acceptance and probative value, and none of the tests included whether an offender has been treated or is on supervision. The court stressed the instrument's sole reliance on static factors.[63]

Overall, the instruments must be evaluated for "fit" (their association to the pertinent legal inquiry). The prejudicial impact of actuarial risk assessment instruments might be the most significant issue challenging their reliability. The legal inquiry in AWA cases addresses the issue of "serious difficulty refraining," and it is doubtful that the foundations and objectives of the instruments satisfy the legal fit issue for admissibility. One may consider that a high score indicates that an offender is high risk and therefore has a serious difficulty refraining, yet the actuarial instrument is a better fit with the ambiguous term "likely" than the AWA volitional language.

Although actuarials are likely not relevant to AWA statutory language, they will likely continue to be admitted into federal courts due to their proclaimed accuracy and utility as they tout interrater reliability, measurement error, and predictive validity with future sexual violence. In addition, they have been tested and published in peer review literature. [64] Judges will continue to perceive that they are probative to legal questions and will consider them as support for the clinical opinions of experts.

Most experts who are asked to assess for future sexual violence utilize these instruments in their risk assessments. However, experts, attorneys, and judges in these cases must be aware of the strengths, weaknesses, and limitations of these instruments and challenge their use when applying them to the statutory language "serious difficulty refraining" in AWA cases. Finally, too much emphasis on the statistical foundations of these instruments will undoubtedly confuse and alienate the trier of fact.

Risk Factors

Static Risk Factors

Criminal defense attorneys have to accept their defendants as they find them. Some sex offenders have prior sex offenses, including allegations, arrests, charges, and/or convictions. Obviously, charges and convictions are considered more seriously due to their definitive nature. Static factors that are associated with future sex offending place the offender at a serious disadvantage as they are unchangeable and are bound to history. Empirical studies have examined static risk factors related to groups of sex offenders who have reoffended in the community.[65]

1. Number of prior sexual offenses
2. Prior violent offenses, prior non-violent offenses
3. Beginning sex offending at a young age (25 years of age or younger)
4. Deviant victim choices (unrelated and stranger victims, male victims)
5. Antisocial personality disorder/psychopathy
6. Early termination from sex offender treatment
7. Sexual deviancy indicated by types of offending, diagnosis, and plethysmographic assessment
8. Substance abuse problems and intoxicated state during the sexual offense
9. Single marital status
10. Violation of community supervision
11. History of strong sexual drive (hypersexuality)
12. History of offense planning

These risk factors are incremental in nature. The more there are, the higher the risk level for the individual offender. Many of the static factors are not resistant to change and they cannot be treated or rehabilitated. Many court hearings are based primarily on the defendant's prior sex offense history, which obviously is a main factor to consider as past behavior is often predictive of future behavior. However, the expert witness must assess each prior sex offense and consider certain questions. How long ago did the offense occur? What type of victim (male, female, child, adult) was involved? Was alcohol involved? Was the offender on supervision? What life stressors was the individual experiencing at the time (divorce, unemployment)? The offender's past offense history (frequency, severity, diversity of sexual offending) must be established. Each prior sex offense has its own facts and needs to be examined in context of the defendant's history and sexual offending patterns.

Dynamic Risk Factors

Dynamic factors are risk factors that are changeable and may be amenable to treatment, intervention, supervision, and risk management. The risk assessment process must not avoid the importance of the dynamic offending process and overemphasize static factors. While static factors are more pronounced in determining long-term risk predictions, dynamic factors have been associated with short-term immediate risk assessments. Here are 13 dynamic factors that play a critical role in the etiology and onset of a sex offense.

1. Negative affective mood states (depression, anger, frustration, hostility)
2. General self-regulation and sexual regulation problems
3. Non-compliance with supervision
4. Alcohol and drug use
5. Association with criminal lifestyle and criminal peers
6. Attitudes supporting and condoning sexual interest in children
7. Current younger age
8. Living alone
9. Sexual preoccupations (excessive use of pornography, excessive masturbation)
10. Sexual interest in children, emotional identification with children, child-oriented lifestyle
11. Intimacy deficits
12. Conflicts or absence of intimate partners
13. Rape myths supporting sexual violence towards women

Sexual recidivists are more likely to experience poor social supports and attitudes tolerating sexual assault, antisocial lifestyles, poor self and sexual management strategies, and problems following community supervision demands.[66] Higher risk offenders are more likely to have poor coping skills to deal with changing emotional states such as depression, anger, loneliness, and fears of intimacy. They are more likely to deal with these states through sexual preoccupation, hypersexual behaviors, deviant sexual fantasy and masturbatory practices.[67]

How Often Do Sex Offenders Reoffend?

Base rates are defined as the true prevalence of the defined behavior within the defined population, i.e., frequency of sex offending amongst child molesters and rapists. The estimated base rates reported in a popular study assessing about 24,000 sex offenders was 13.4 percent over 4 to 5 years,[68] and the rate in another study assessing a 31,000 sample of sex offenders was 13.7 percent over 5 to 6 years.[69] True offending rates are unknown since there are many actual offenses that occur but are never reported, and the legal detection of these crimes are measured in arrests, changes, and reconvictions.

Base rate data vary significantly since there are various types of sex offenders (rapists, child molesters, pornography offenders, etc.). Research available through the U.S. Department of Justice Bureau of Justice Statistics[70] reported 5.3 percent of released sex offenders sexually recidivated within the first three years following their prison release (rapists — 5.3 percent rearrested for any new sex crime and 3.5 percent reconvicted for any new sex crime; child molesters — 5.1 percent rearrested for any new sex crime and 3.5 percent reconvicted for any new sex crime).

Important for AWA cases, there has been scant research related to federal sex offender recidivism rates including recidivism rates for solicitation and pornography possession offenders. Interestingly, Andres Hernandez, director of the Sex Offender Treatment Program (Federal Correctional Institution Butner-North Carolina) has reported a significant number of self-disclosures of non-detected sex crimes from federal child pornography sex offenders in his program.[71] In a group of 62 Internet sex offenders (possessors/distributors of child pornography and online solicitors travelling across state lines) who were known to have

committed contact sexual offenses against 55 total victims, he reported that these same offenders disclosed in treatment committing sexual crimes against an additional 1,379 victims.

Understanding and Assessing the Federal Sex Offender

Many federal sex offenders may differ from traditional state sex offenders and have a history of non-contact sex offenses such as Internet solicitation and pornography possession. These offenders are not represented well on actuarial risk assessment tools. Furthermore, the AWA allows for one-time offenders to be considered for civil commitment.

The expert witness evaluating AWA cases must not only be well-versed with the research and diagnostic issues related to child molesters and rapists but the witness must also be aware of risk assessment issues related to federal sex offenders, some of whom have histories of primarily non-contact sex offenses.

When considering the assessment of federal sex offenders, several questions arise. What are the risks of reoffending for pornography and solicitation offenders? Does pornography possession lead to future contact and non-contact sex offenses?

Online Solicitation — Police Posing as Juveniles

Many federal sex crimes are non-contact and "hands-off" in nature. They often include solicitation and pornography possession cases. These offenders are still vulnerable to AWA commitment proceedings. The attorney and expert must be aware of the prevalence and risk factors of solicitation-type cases, and in particular, "to catch a predator" type cases in which police pose as juveniles on the Internet.

Each year, one in five youth encounters online solicitations that are sexual in nature via chat rooms or instant messaging routes. The National Juvenile Online Victimization Survey has studied law enforcement investigations of Internet sex crimes against minors. They have found that 25 percent of all arrests for Internet sex crimes against minors were due to "proactive" investigations where police pose online as minors or pretend to be mothers teaching their children about sex.[72] These investigations allow law enforcement to catch suspects before they have an opportunity to offend. Undercover investigations can be referred to as "reactive" or "take over" when police learn of a solicitation and then pose as the original minor and target the suspect.

In the year 2000, one-fourth (644) of the Internet sex crimes against juveniles (about 2500 total arrests) were based on proactive investigation. Other arrests were for crimes committed by the offenders who met the juveniles online (20 percent), other sex crimes committed against juveniles by family members or acquaintances against juvenile victims (19 percent), and the possession, distribution, or trading of pornography on the Internet (36 percent of arrests).[73]

Since proactive and many reactive solicitation cases include non-contact sex offenses, the sexual dangerousness and characteristics of these offenders are questioned. Offenders who attempt to target online (law enforcement) victims have a tendency to be lower risk than those who targeted actual juvenile victims.[74] Those who target actual juvenile victims are likely to have more prior arrests for non-sexual offenses and for sexual offenses against minors, have a lower income, and are less likely to be employed full time at the time of the offense. Both groups have similarly high rates of child pornography possession and drug and alcohol use patterns.[75]

Pornography and Sex Offending

Many federal sex offenders have only child pornography possession and/or distribution-type cases in their sex offending history. Others will have contact offenses in addition to their pornography-type cases, and still others may have multiple types of non-contact sexually related offenses. There is scant research on the criminal histories and later offending of child pornography offenders. Research data reveal that child pornography offenders with prior criminal records are significantly more likely to offend in various ways (general, violent, sexual).[76] Those child pornography offenders who have committed a prior or concurrent contact sex offense are the most likely to offend again, either generally or sexually, more so than sole pornography possessors. As expected, a history of contact sex offenses is predictive of future hands-on sex offenses.

Child molesters and rapists often have similar rates of exposure to pornography in the home or during their developmental years. However, child molesters are more likely than rapists to utilize pornography in adulthood and use materials prior to and during their offenses.[77] The child molesters who have been sexually assaulted during childhood (and their perpetrator used pornographic materials) are more likely to have followed similar behavior patterns during their sex offenses as a perpetrator. Child molesters are more likely than rapists to utilize pornography to relieve the impulse to commit a sex offense.[78]

There is little scientific evidence to support a causal association between pornography use and sexually violent behavior.[79] The expert witness examining these cases must be able to assess the role of pornography as a catalyst for sex offending behaviors through mediating risk factors such as antisocial personality, use of alcohol and intoxicated states, sexually deviant interests and disorders, social isolation, intimacy deficits, and masturbatory practices.

Recommendations for The AWA Attorney

The Adam Walsh Act's civil commitment scheme correctly follows the U.S. Supreme Court's holding in *Crane*,

which establishes a volitional requirement in that a sex offender must have a serious difficulty refraining from future sex crimes. There is no scientific basis for distinguishing whether an act is a function of freewill or an irresistible impulse.[80] Rather, one's serious difficulty refraining from sexually violent conduct is a moral question ultimately to be decided by the trier of fact with aid from the expert witness.

The AWA attorney must emphasize that *Crane* requires distinguishing the typical recidivist (implying civil commitment detainees should have more than one sex offense conviction) from the sex offender who cannot control his behavior and resist his impulses. Interested parties should never solely equate psychiatric diagnoses or scores from actuarial instruments with volitional impairments. Nor should they confuse the term "likely" with "inability to refrain/control."

Attorneys must utilize experts who are well-versed in sexual violence risk assessment issues, especially in the following areas:

- ❖ Diagnoses related to legal "mental abnormality" requirements including paraphilias (sexual deviance disorders) and personality disorders, especially antisocial personality disorder and psychopathy (severe criminal personality);
- ❖ Assessment of relevant levels of mental disorder to distinguish and define volition impairments;
- ❖ Strengths and weaknesses of actuarial risk assessment instruments;
- ❖ Research relevant to static and dynamic risk factors and scholarly works that critique the adjustment/modification of actuarials;
- ❖ Risk factors related to child pornography, solicitation, and online solicitation sex offenders;
- ❖ Similarities and differences between contact and non-contact sex offenders; and
- ❖ Literature relevant to the impact of aging process and recidivism.

The criminal defense attorneys who find themselves representing individuals in AWA cases must realize that they are in an advantageous position to some degree. Proving whether a person has a *serious difficulty refraining* from sexually violent conduct or child molestation if released should be a very difficult issue to prove since most criminals and sexual offenders exercise significant control over their behaviors.

The U.S. Supreme Court in *Crane* essentially differentiated a typical sex offender from one who should be civilly committed by incorporating an abstract "freewill" doctrine. It is easy for an expert witness to simply say an offender lacks control over his behaviors. And yet, experts need to utilize an assessment process that attempts to dissect this offender's offending patterns to satisfactorily answer the legal question. The challenge is for the expert to attempt to accurately differentiate the typical recidivist who chooses to commit the crimes and is willfully dangerous or unwilling to restrain himself from the recidivist who cannot control his behaviors.

Notes

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