

Myths About Violent Sexual Predators and All That Pesky Legislation

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Mental health has a new rallying cry: “Stop the sexual predator legislation.” It seems the organizations that purport to speak for patients or mental health professions are falling all over themselves to criticize the 1997 U.S. Supreme Court decision in *Kansas v. Hendricks*, and to predict doom and gloom in other states’ laws that are sure to follow in the next several years.

At the center of all this is a Kansas law that allows, with a number of “due process” safeguards, a form of involuntary commitment that focuses on violent sexual predators. Mental health professionals and public agencies are concerned about issues of government encroachment into professional issues, social policy encroachment into clinical policy, and substantial financial implications for public agencies. Many of the clinicians I meet from day to day misunderstand the Supreme Court’s action, and the Kansas law that was allowed to stand.

Myth #1: Sexual predator legislation is a treatment issue, so psychiatrists and other professionals should get indignant about this new commitment process.

The purpose of recent sexual predator legislation is not so much to treat the perpetrator as to stop him. The commitment process thus has a social, rather than a medical, source. Before we leap to the conclusion that this is a bad thing, however, we should recall that civil commitment is no longer a parent-like state effort to help the patient. The constitutional basis for commitment has long been the State’s police power, not its *parens patriae* responsibility.

Myth #2: Using a civil procedure to preventively detain someone is unconstitutional.

First, preventive detention is exactly what we do in other forms of civil commitment. Second, the U.S. Supreme Court in *Hendricks*—all the justices, not merely the majority that confirmed the Kansas law’s constitutionality—found nothing unacceptable about adding a new category of commitment provided it serves a legitimate state interest and preserves the civil rights (including those of due process) of the person committed.

Myth #3: Paraphilias are not traditional mental illnesses, therefore they can’t be reasons for commitment.

Many paraphilias are indeed manifested primarily by their antisocial or criminal behavior; it’s the second part

that makes the “myth.” Commitment is a state-by-state issue. As the U.S. Supreme Court ruled, there is no constitutional reason that a state may not create a new class of people eligible for commitment (just as many have with substance abusers), and the justices unanimously agreed that sexual predator commitment procedures need not require a “traditional” mental illness in order to be constitutional.

Myth #4: Commitment is for treatment, and we can’t treat these people.

Many clinicians believe that commitment requires treatment. In fact, the constitutional basis for commitment laws requires a generic *quid pro quo* of “something more” in return for detention, but not treatment *per se* (although a state may require it). What’s more, we can often treat paraphilias, pedophilia, and violent predation as well as we treat many severely and chronically mentally ill patients. Whether doctors and legislatures choose to allow, provide, or afford the methods we know may work is another matter.

Myth #5: “Sexual predator” can be defined so broadly that we’ll be on a slippery slope to social control and psychiatric abuses.

The current and proposed sexual predator statutes with which I am familiar contain so many modifiers and due process considerations that it is difficult to imagine the draconian scenarios that make my more liberal friends cringe. I admit that I’m glad the concept of “paraphilic rapism” fell on its figurative face and I’d hate to see “ordinary” and statutory rape by themselves become “sexual predator” issues; nevertheless, “slippery slope” makes a better sound bite than logical argument.

Social issues such as this are more often like a pendulum than a slippery slope. They oscillate. If things start to go too far in one direction, people protest, lawsuits get filed, and politicians get nervous. Exhibitionists, *frotteurs*, and adulterers seem unlikely to get caught up in sexual predator legislation. They just don’t scare us—or hurt us—enough.

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Finally, we already define those diagnoses most likely to be associated with violent sexual predation. The trick is to remember that behavior and functioning are the point, not diagnosis. This is true whether one is speaking of patients with schizophrenia, mania, brain injury, rare impulse control disorders, primitive character pathology, or idiopathic paraphilia.

Myth #6: The causes of sexual predation are so varied that we must not lump them into a single form of “sexual predator” commitment.

But that’s just what we do with other mental illness commitments. Psychiatrists and psychologists understand that involuntary hospitalization revolves, once some mental illness is established, around function, not diagnosis or prognosis. We generally agree that if the patient is a danger to self or others, or is at grave risk of marked deterioration, commitment is not only permissible but necessary, whatever the mental disorder. Some care during hospitalization is specific (e.g., treatment for the disorder), and some is generic (e.g., protection and support).

Myth #7: Treatment should start, and largely stay, in prison, while the person is serving his criminal sentence.

This one turns the idea of patients’ rights on its ear. Years of Federal caselaw establish that prisoners have an almost inalienable right to refuse treatment. Biological therapies for paraphilic behaviors, often the treatments most likely to work and be socially reliable, are a real problem in prison—even when a prisoner wants them—since anything that suggests coercion (such as the prospect of an earlier release) can easily void the consent. Things look bad from the other direction as well. With few exceptions, the due process safeguards required for sexual predator commitment and treatment are far more difficult for the state to overcome than those for criminal incarceration. Once convicted, the state need not provide any care or treatment for the behavior itself. The commitment process, on the other hand, is so strict that few of even the most severe offenders are detained (see below).

Myth #8: Our treatments aren’t reliable enough for such dangerous people.

It’s often not so much a matter of what works but of using it; and it’s not so much a matter of succeeding with everyone but of giving our best efforts and succeeding with some. Many offenders will be released eventually, often with community notices, close monitoring, and/or high-tech surveillance. Whatever treatment they receive will add to, not detract from, neighborhood safety.

The above having been said, medicine (particularly) and psychology do have a number of treatments that are reliable, when “used as directed,” for many patients with

predatory sexual behaviors (e.g., anti-androgenic medications, surgical castration, stereotactic neurosurgery, and treatments for primary disorders such as schizophrenia or bipolar illness). Note that I did *not* say that all are easily available or without controversy, but we do know about them, and given the seriousness of the conditions they are designed to address, their risk-benefit ratios are often quite good. If current social and political climates don’t allow these treatments, this is a practical issue (and an important one), not a scientific issue.

Myth #9: Non-biological treatments are just as good as biological ones; empathy training, sex education, restructuring of cognitive distortions, and other psychosocial tools can take the place of biological modalities.

Here’s where I may part company with some nonmedical colleagues (and a few psychiatrists). I believe that the basic treatment for primary paraphilia manifested as chronic, characterologic, violent, predatory behavior is *biological*. Many of the psychotherapeutic, operant, and cognitive approaches have merit, and I have treated many nonpredatory patients with them alone; however, they should be viewed as adjuncts to somatic therapies for changing the behaviors envisioned by most current sexual predator laws. One should not view the nonbiological treatments as reliable for dangerous people (see Myth #8).

Corollary 1. Every patient must have 6 or 8 hours each day of psychosocial groups, individual psychotherapy, sex education, self-esteem support, and the like. Some specialized nonbiological modalities (e.g., sequence-interruption strategies and other relapse-prevention training, or conditioning approaches similar to those developed by Abel and Becker) are very important to the outcome of the biological ones. Neither medication nor surgery should be provided in a vacuum, but it seems silly to require hours of nonspecific experiences for every patient every day, and even sillier to rely solely on even the most sophisticated behavioral or operant approach when the stakes are this high. If a program cannot, for whatever reason, use anti-androgenic medications (or their hormonal equivalent) or surgical approaches when indicated for patients who are a serious threat to society, then the community is justified in doubting its outcomes.

Corollary 2. Primary paraphiliacs undergo structural psychological change when they experience sex education, empathy training, “skills training,” and/or psychotherapy for cognitive distortions. NAMBLA* and other groups and individuals who talk about children “wanting it,” needing hands-on sex education, or being able to consent are not, in my opinion,

*North American Man-Boy Love Association. Honest

saying that because of some “cognitive distortion,” but because they want to keep doing what they do. I’m a great believer in the unconscious and in overdetermination of behavioral motivation, but *these people have an extremely refractory motivation for what is for them an extremely pleasurable behavior; any statement of empathy for the victim at the time of the sexual act is purely, consciously or unconsciously, self-serving.* Treatment must focus on observable, measurable control of either the impulse or the pleasure it provides; anything less is usually insufficient.

Myth #10: The issue of coercion prevents prisoners and those committed for sex offenses from giving legally adequate consent.

I’ve read *Brave New World* and *1984*, too, but one should remember that we are starting with the premise that the patient has clearly demonstrated—to some high level of proof—chronic, violent, sexually predatory behavior. In existing civil commitments (of psychotic or severely depressed patients, for example), we already predicate discharge on clinical and behavioral improvement, treatment compliance, and follow-up monitoring, and thus “coerce” treatment compliance to some extent. It seems reasonable to consider the same for this new class of committed patients.

Myth #11: Allowing sexual predator commitment further stigmatizes mental illness, and the public will confuse mental patients with paraphiliacs.

We shouldn’t fight stigma by saying that some patients are worthy and others aren’t. The key to credibility in the fight to decrease stigma is to be honest about disorders that occasionally produce abhorrent behavior and those few which are routinely associated with it. Like it or not, some people with schizophrenia are dangerous and many are very hard to live with. Some depressed patients kill their children, and some hypomanic patients have bizarre sexual appetites. We try to help, and once it’s feasible, we try to reconnect these patients with society.

Myth #12: Sex offenders represent a danger to vulnerable other patients.

I agree to some extent, but let’s not become hysterical. I often suggest highly specialized programs in a separate

and secure treatment environment, but the point is that these patients should be assessed and placed individually, just as one does (or should do) for other kinds of patients. Some states have programs in existing state hospitals where they have treated patients with paraphilias for years. They know that assaults occur with many kinds of patients, not especially paraphiles, and they cope with the danger (low or high) through recognizing individual impulses and control problems, adequate staffing and monitoring, appropriate treatment, and sometimes physical barriers.

The danger may be an emotional rather than physical one. Treatment programs should be sensitive to the needs of, for example, those women who are vulnerable to the *idea* of having an abusive or predatory male in the same milieu. This, of course, is not a concept limited to convicted sex offenders.

Many sexual predators—especially pedophiles—are model inpatients when the hospital environment is secure, monitored, and free of their victims-of-choice. Violent psychopaths or psychotic killers are a different story, and prudent hospitals shouldn’t house them on an ordinary hospital unit anyway, regardless of their sexual behavior.

Myth #13: The very long length of stay associated with treatment of sexual predators will clog facilities and deplete scarce public mental health dollars.

Length of stay, facility crowding, and clinical priorities are operational issues, not clinical or constitutional ones. Of course there are practical problems, but that doesn’t justify avoiding either patient or community need.

This Month’s Take-Home Lesson

Much of the current criticism of modern sexual predator commitment laws by psychiatrists and psychologists is unreasonable. To dismiss these legitimate community issues and clinical needs out of hand with a few incomplete (or just wrong) phrases about rights or treatment refractoriness doesn’t help the people who have these problems, their victims and potential victims, or the society in which we live and practice. Let’s work *with* those who are trying to do good.