SECOND EDITION

FORENSIC NURSING SCIENCE

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Ref - Aggrawal A. (2011) Sexual Deviant Behavior and Crimes. In: Lynch, VA, Duval, JB (Eds.) Forensic Nursing Science, 2nd ed, ch 41,Pp. 512-20. Elsevier Mosby, Missouri.

CHAPTER 41 Sexual Deviant Behavior and Crimes

Anil Aggrawal

Forensic nurses, especially those working in the psychiatric field, will continue to work with sexual offenders and deviants. This chapter highlights some salient features of sexual offenders and how forensic nurses can best cooperate with medical and legal personnel for the psychiatric assessment and evaluation, treatment, and legal commitments relating to these offenders.

Who Is a Sexual Offender?

Contrary to popular belief, sexual offenses and deviant behaviors are not a product of modern civilization. Both sexual offenses and deviant behaviors have been mentioned in ancient books such as the Holy Bible (Aggrawal, 2009b). **Sexual offender** is a term that is still in search of a universally acceptable definition. Plainly put, a sex offender is one who offends sexually. However, sexual behaviors within a group or community are greatly influenced by prevailing sociocultural norms. A behavior that may offend one person, group, or culture may not offend another, because it may be the norm in that culture. For instance, in some cultures, shaking hands with a female might be regarded as grossly inappropriate behavior, if not a downright sexual offense. In other cultures, shaking hands–even social kissing–may be considered quite appropriate. A sexually explicit behavior is also not necessarily a product of advanced civilization. In some primitive tribes of Africa, going topless for females is a norm, whereas if a woman walked topless on the streets of New Delhi or New York, she would almost certainly be arrested as a sexual offender (Aggrawal, 2009a). In addition, norms within a particular community may change over time.

One would imagine that sexual acts that are construed almost universally as loathsome or harmful behaviors may be agreed on as sexual offenses by all societies, but even this is not true. The case of rape–forcible sexual intercourse against the will of the other party–illustrates this point. Among the *Hmong* tribe of Laos, where marriage by bride capture is a continuing cultural practice, rape under certain circumstances is perfectly legal. This practice continues even among Hmong communities that have migrated to the United States and has even given them the so-called "cultural defense" against allegations of rape.

Marriage by bride capture is a practice whereby a man abducts a woman he likes and holds her captive for three days. During this time, he repeatedly rapes her. After the third day, the girl is freed and given a choice to either reject or marry him. In practice, however, the girl always ends up marrying her abductor, either willingly or under her parents' pressure. Rape, at least under these circumstances, thus is a perfectly legal activity among the Hmongs. In one highly publicized case (1985), Kong Moua, a male member of the Hmong community in America, kidnapped Seng Xiong, a female member of his own community, and had repeated sexual intercourse with her. Moua genuinely believed he was following Hmong customary marriage practices. After she was set free, Xiong not only rejected the marriage-by-capture tradition but filed kidnapping and rape charges against Moua. Moua sought "cultural defense." Allowing the defense, the judge asked Moua to plead guilty to one misdemeanor count of false imprisonment and sentenced him to just 120 days in jail and a mere $1000 fine (Aggrawal, 2007).

Sex crime, sexual offense, and *sexual offender* are terms that have no universal meanings. In broad and general terms, however, a sex crime is a sexually explicit behavior that is illegal in a given jurisdiction. It has been determined to be a criminal act because it exploits, caters to, makes possible, or is dependent on explicit sexual behavior (MacNamara & Sagarin, 1977). A useful definition of sex offenders was offered in 1965 by the Kinsey group: "A sex offender is a person who has been legally convicted as a result of an overt act, committed by him for his own immediate sexual gratification, which is contrary to the prevailing sexual mores of the society in which he lives and/or is legally punishable" (Gebhard, Pomeroy, & Christenson 1967). Definitions provided by most workers are similar or simple modifications of this one. Some authors include specific crimes, such as pedophilia or incest, within this general definition, signifying, perhaps, a personal weight given by them to a specific sex crime. Glass (2004), for instance, includes pedophilia in the previous definition, and in her modified definition states that a sex offender is "someone who has committed or attempted to commit any type of illegal or nonconsensual sexual act and/or any sexual behavior involving children under the legal age of consent, based upon the laws governing the location where the sexual behavior occurred (p. 222)."

Another term that appears frequently in discussions of sexual offenses is sexual violence. **Sexual violence**, according to the World Health Organization (WHO), refers to "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion (i.e., psychological intimidation, physical force, or threats of harm), by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (NSVRC, 2004, p. 4).

Sexual offenses have been committed in virtually every condition and setting. More recently, sexual offenses in a military environment, the so-called *military sexual trauma* (MST), has been making headlines both in the lay press and in academic publications (David, Simpson, et al., 2006; Himmelfarb, Yaeger, et al., 2006; Kelly, Vogt, et al., 2008; Kimerling, Gima, et al., 2007;

Kimerling, Street, et al., 2008; O'Brien, Gaher, et al., 2008; Regan, Wilhoite, et al., 2007; Valente & Wight, 2007; Suris & Lind, 2008; Yaeger, Himmelfarb, et al., 2006)

What Is Deviant Behavior?

Sexually deviant behaviors are more commonly known among medical parlance as *paraphilias*. Just as there can be no universal definition of a sexual offender, there cannot be a universally accepted definition of *sexually deviant behavior*. The case of homosexuality perhaps demonstrates this best. Homosexuality, even between two consenting adults, is considered a sexually deviant behavior in many societies. But in several other societies, it is legally acceptable. Even within the same communities, the behavior has been viewed differently at different times. In Ancient Greece, homosexual behavior was not considered abnormal and was even considered to be more elevated and spiritual than heterosexual relationships. As time passed, however, it gradually began to be considered a sexual perversion and even a criminal behavior. Until 1968, homosexuality was listed as a sexual deviation in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1968). However, during the next decade, it began to be considered normal sexual behavior and finally in 1980, it was removed from DSM-III (Lamberg, 1998). It is, however, not considered an exalted form of sexual relationship yet.

Other sexual behaviors, such as fellatio, cunnilingus, anal sex, prostitution, and some categories of visual and literary erotica and pornography, which were once considered sexually deviant behaviors, have been decriminalized in many societies and are tolerated relatively better than in other societies. Sexually deviant behavior, or paraphilia, may thus be conceived more as a social rather than a medical concept. There is, however, a core of extremely deviant behavior (say lust murder) that has always been, and perhaps always will be, considered abnormal.

From a biomedical point of view, paraphilias have been defined explicitly in the *Diagnostic and Statistical Manual*, fourth edition, revised (*DSM-IV-TR*) (American Psychiatric Association, 2000). It specifically mentions 15 paraphilias by name. Of these, eight have been allotted specific diagnostic codes (Table 41-1).

Seven other paraphilias—telephone scatologia (obscene phone calls), necrophilia (sexual attraction to corpses), partialism (exclusive focus on part of body), zoophilia (sexual attraction to animals), coprophilia (erotic attraction to feces), klismaphilia (erotic attraction to enemas), and urophilia (erotic attraction to urine)—are grouped in the category "Paraphilia not otherwise specified." It is specifically stated that these are examples, but this category is not limited to these.

Table 41-1 DSM-IV-TR Codes for Paraphilias

302.2	Pedophilia
302.3	Transvestic fetishism
302.4	Exhibitionism
302.81	Fetishism
302.82	Voyeurism
302.83	Sexual masochism
302.84	Sexual sadism
302.89	Frotteurism
302.9	Paraphilia not otherwise specified

Etiology of Sexually Deviant Behavior

Several theories have been advanced regarding the etiology of sexually deviant behavior. Some of the most common ones are discussed next.

PSYCHODYNAMIC THEORY

According to the psychodynamic theory of the mind, human psyche is composed of three primary elements: the id, which is guided by the pleasure principle; the superego, the rational component of human psyche, which controls the id to a great extent; and the ego. Sexual deviancy occurs when the id is overactive. This theory appears to have a strong clinical foundation as well, especially as successful treatments have been based on this theory (Lohse & Hauch, 1983).

BIOLOGICAL THEORY

According to this theory, sexually deviant behavior can be explained by abnormal sex hormone levels (Saleh & Berlin, 2003), testosterone levels (Studer, Aylwin, et al., 2005), and even chromosomal makeup (Wiedeking, Lake, et al., 1977). This theory also has a sound clinical basis, especially as antiandrogens (e.g., leuprolide acetate) seem to have a corrective effect on sexually deviant behavior (Bancroft, Tennent, et al., 1974; Berlin, 1988; Briken, Berner, et al., 2000; Buvat, Lemaire, et al., 1996; Cooper, 1986; Cooper, Ismail, et al., 1972; Gagne, 1981; Kravitz, Haywood, et al., 1995, 1996; Krueger & Kaplan, 2001; Rosler & Witztum, 1998; Rousseau, Couture, et al., 1990; Thibaut, Cordier, et al., 1993, 1996; Thibaut, Kuhn, et al., 1998).

FEMINIST THEORY

Feminists tend to explain sexually deviant behavior, especially rape, from a cultural, historical, and even political context. Rape is explained as men's tendency to oppress women. According to this theory, psychodynamic and biological factors do not play a part in sexual offending. Sexual offending results merely from men's desire to suppress women (Drieschner & Lange, 1999).

ATTACHMENT THEORY

According to this theory, all humans love to establish strong emotional bonds with others. An individual who has experienced some loss or emotional distress may act out abnormally because of loneliness and isolation.

BEHAVIORAL THEORY

Initially developed by Pavlov, behavioral theory tends to explain all behaviors in terms of rewards or punishments. A behavior that is rewarded tends to become a habit, whereas a behavior that is punished becomes extinct. Sexually deviant behavior is rewarded by the sexual pleasure that the culprit enjoys. If the behavior is not punished (say, if the culprit is not apprehended), it is not extinguished. Thus, a sexual deviant who remains free will tend to repeat the sexual behavior. Behavioral theory, on its own, is unable to completely explain such complex behavior as sexual deviancy.

COGNITIVE-BEHAVIORAL THEORY

This theory takes into account cognitive factors too. If the offender does not have feelings of guilt or shame or rationalizes them through excuses and justifications, the sexually offending behavior is enforced.

PSYCHOSOCIAL THEORY

Psychosocial theory, initially propounded by Erikson, conceived child development occurring as a series of fixed, predetermined stages. This model extends Freud's psychoanalytical theory by

focusing on the child's emotional development. According to this theory, deviant sexual behavior may be viewed as a response to external social factors.

INTEGRATED THEORY

This theory tends to integrate all previous theories. It takes into account elements such as motivations to offend, rationalization of behavior, diminishing of internal barriers, and various external social factors.

Cycle of Sexual Offending

The term *cycle* is used in two senses in the literature on sexual exploitation. The first sense refers to the theory of *generational cycle*, whereby some people who are sexually abused as children go on to become abusers themselves. This theory has been challenged because, whereas clinical evidence supports the view that some abusers were abused themselves as children, it cannot account for the gender imbalance in female victims and male perpetrators. There are far more female victims than female perpetrators of sexual crimes, and if all or even most of the female victims were to become sexual offenders, the gender imbalance would not be as much. The second sense of the term *cycle* refers to a *behavioral cycle*, sometimes also known as *Wolf's cycle of offending* (Wolf, 1984). This cycle refers to a self-reinforcing sequence of sex offender behavior (Fig. 41-1).

Wolf's model was initially applied to pedophile offending and later was developed for work with adolescents. Sexual offenders are often people whose self-esteem is low and who expect rejection from others. Often they have poor social skills. Some may have experienced some kind of emotional trauma in their lives, such as a divorce, a bereavement, or a redundancy, which may leave them feeling bad about themselves. As a result, these people can withdraw from others, thus becoming emotionally isolated.

Not all people from this group become sexual offenders. Those who are likely to offend sexually tend to compensate for their isolation, low esteem, and personal unhappiness by developing relationships with children, which may lead to sexual offending.

KEY POINT Before sexual culprits can offend, they must overcome their inhibitions and convince themselves that their deviant acts will do no harm.

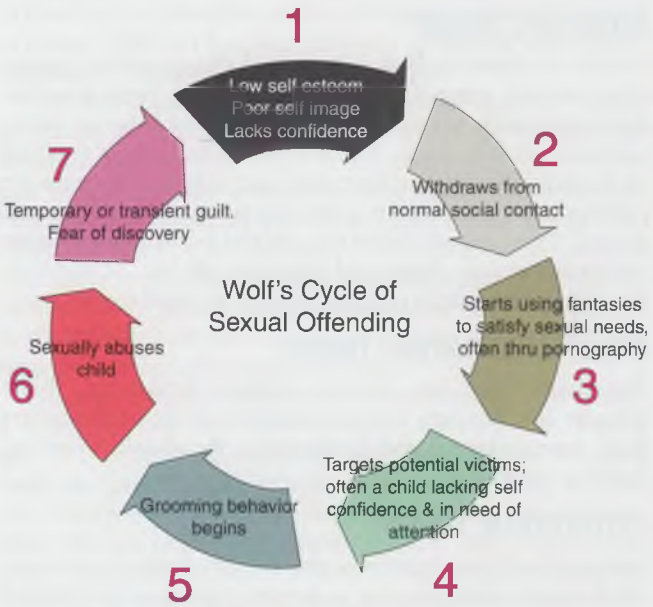

Fig. 41-1 Wolf's cycle of sexual offending.

For sexual offending to take place, the potential culprits have to first overcome their "internal inhibitions." They have to convince themselves that what they want to do is not wrong. They must quiet their conscience and persuade themselves that no harm will be done if they engage in the sexually offending behavior. This occurs through a process called *cognitive distortion*.

The next stage consists of identifying a target child. Often, the child will be vulnerable in some way. For instance, the child may have a low self-esteem and may be looking for attention. Initial fantasies about the child may be reinforced by using pornography, perhaps using the Internet. Internet chat rooms may also be used to find a child.

Now the stage comes to overcome the *external inhibitions*. These include the child's parents, the society, and the child's own resistance. To break the child's resistance, the perpetrator engages in the *grooming process*, a way of gaining the child's trust (Table 41-2). The perpetrator may lure the child with chocolates, toys, or by simply paying attention to him or her to make the child feel special (Lang & Frenzel, 1988). The child thrives on this attention and becomes attracted to the perpetrator.

The perpetrator may now tell the child that sexual activity is a way for them to show their love for each other. If the child is aroused, the perpetrator may say that the child must want the activity to continue and may suggest that the child will enjoy the sexual relationship.

Following the abuse, the child often feels confused, guilty, ashamed, betrayed, lost, and afraid. The perpetrator may quiet the child with bribery or threats. Any initial guilt a perpetrator experiences will lead to further lowering of self-esteem and the cycle starts all over again.

An understanding of this cycle is vital for law enforcement authorities and for personnel engaged in treating sexual offenders. The cycle has to be broken by increasing the self-esteem of perpetrators. Law enforcement authorities may look with suspicion at any person who is a loner and whose house is full of chocolates, candies, and toys.

Female Sexual Offenders

The term *female sexual offender* may sound like an oxymoron to many, especially as females, usually considered the weaker sex, are seen as victims rather than as perpetrators of sexual abuse.

Table 41-2 Some Examples of "Grooming" Behavior

Be nice to the child.
Take the child for rides on motorcycle or snowmobile.
Give the child money.
Get into playful horseplay and wrestling around.
Take off their clothes during horseplay.
Play Nintendo together.
Sleep in the same room and climb on top of the child's body and act as if asleep.
Play house.
Buy toys and candy.
Sleep with the child.
Give the child piggyback rides or invite lap-sitting.
Appear to be hugging, but thinking sexual thoughts.
Pretend to be interested in toys of the child.
Be kind and then become more than a friend.
Spend free time with the child and discover their special interests.
Exhibit porn magazines to the child.

However, recent crime reports and academic papers are fairly consistent in showing that the number of females who commit sexual offenses is not trivial (Oliver, 2007). According to a 1999 Bureau of Justice Statistics report, between 1993 and 1997, 2.2% of offenders arrested for forcible rape each year were female. This amounts to roughly 10,000 female sexual offenders being arrested each year in the United States alone (Greenfeld, Snell, et al., 1999).

Among the female sex offenders, mothers are also involved. By interviewing them in depth, Denov (2004) derived data from a small sample of 14 adult victims (7 men, 7 women) of child sexual abuse by females. Most respondents reported severe sexual abuse by their mothers. It might also intuitively appear that female-perpetrated sexual abuse may be relatively harmless as compared to sexual abuse by men. However, in Denov's study, a vast majority of victims reported that the experience of female-perpetrated sexual abuse was harmful and damaging. Both male and female victims reported long-term difficulties with substance abuse, self-injury, suicide, depression, rage, strained relationships with women, self-concept and identity issues, and a discomfort with sex.

BEST PRACTICE When assessing children who have been victims of sexual abuse, forensic nurses should consider the mother as a suspect or potential offender.

More recently, Peter has compared male- and female-perpetrated sexual abuse in terms of victim and abuser characteristics, type of abuse, family structure, and worker information, and has shown a prevalence rate of 10.7% for female-perpetrated sexual abuse (Peter, 2008). According to this study, girls were more likely to be victimized for both male- and female-perpetrated sexual violence. Also females tended to abuse younger children. The majority of children came from families with lower socioeconomic status although one in five victims of female-perpetrated sexual abuse came from middle-class homes. Also, when females abused, referrals to child welfare agencies were more likely to be made by nonprofessionals.

Assessment of Sexual Offenders

The assessment of risk for *criminal recidivism* (reoffending) among sex offenders is a task of great concern to the judicial system, the correctional services, and society at large. Data from the United States Bureau of Justice Statistics (Langan, Schmitt, et al., 2003) show that 5% of about 10,000 sex offenders who were released from prison in 1994 were rearrested for a sex crime within three years. More recently, a review of 61 studies (n = 23,393) demonstrated that the sexual offense recidivism rate was 13.4% (Hanson & Bussiere, 1998). There were, however, subgroups of offenders who recidivated at higher rates. Sexual recidivism rates of up to 42% have been reported (Hagan, Anderson, et al., 2008).

The assessments of sexual offenders aid in making several crucial decisions about these individuals. These include sentencing, prison classification, parole, and whether these individuals should be restrained (in some kind of treatment facilities) after their sentences are over (conditional release).

The enactment of "sexual predator" laws with regard to the long-term incapacitation of high-risk sex offenders after serving their criminal sentences have further increased the need for such assessments. Furthermore, limited monetary and professional resources have created a need for assessment tools that are simple in nature and sound with regard to their accuracy in identifying offenders with risk of reoffending.

There is now a legal necessity of such assessments too. Case law and legislation, on a number of occasions (*Tarasoff v. Regents of the University of California, 1976; Macintosh v. Milano, 1979*), have charged mental health professionals with the responsibility of identifying potentially violent patients and protecting the public from them. Several jurisdictions have codified such clinician responsibility (Weinberger, Sreenivasan, et al., 1998).

KEY POINT Sexual offender assessments are essential for judicial decisions about correctional care and for determining the risks for recidivism.

RISK FACTORS

Several key variables—the *risk factors*—are known to increase the likelihood of committing an offense. These variables are subdivided into *static* and *dynamic* factors. Static factors are historical and unchangeable, whereas dynamic factors are current and changeable. Static factors include age at first offense, history of prior convictions, gender, type of victim, and motivation for committing past crimes. Dynamic factors include present economic situation, marital status, attitudes supportive of crime, faulty cognitions, sexually deviant preference, family condition, leisure activities, criminal friends, substance abuse, and employment status. Most assessment tools seek to uncover and quantify these risk factors.

TOOLS FOR ASSESSMENT

BEST PRACTICE The forensic clinical team should employ actuarial methods, rather than unstructured clinical decision making, to predict the future behaviors of sexual offenders.

Predicting how an individual will behave in the future is a difficult—if not impossible—task. Yet clinicians entrusted with the assessment of sexual offenders must make this prediction fairly accurately. It is now known that sexual offense recidivism can be predicted to a certain extent by measures of sexual deviancy (e.g., deviant sexual preferences, prior sexual offenses) and, to a lesser extent, by general criminological factors (e.g., age, total prior offenses).

A variety of tools for the assessment of sex offender recidivism risk have been devised. The three main tools are (1) unstructured clinical decision making, (2) actuarial decision making, and (3) structured professional judgment (SPJ) approach (Hall, 2008). The three tools have been likened to the three legs of a stool, the top of which represents public safety from sexual offenders (Fig. 41-2).

UNSTRUCTURED CLINICAL DECISION-MAKING

Clinical decision making, the traditional approach, relies on clinical examination of the sex offender and is heavily dependent on the competence and acuity of the assessor. Because of this drawback, this approach is inherently unreliable. It may, however, be more suited to "on-the-fly" assessments, where speed and cost are more of an issue than accuracy and reliability. Noted authorities have described such approaches as informal, 'in the head,' impressionistic, or subjective conclusions reached somehow by a human clinical judge (Douglas and Ogloff, 2003; Grove and Meehl, 1996). Some have referred to it as "little more than the best intuitive guess on the part of the clinician" (Monahan, 1996, p. 107).

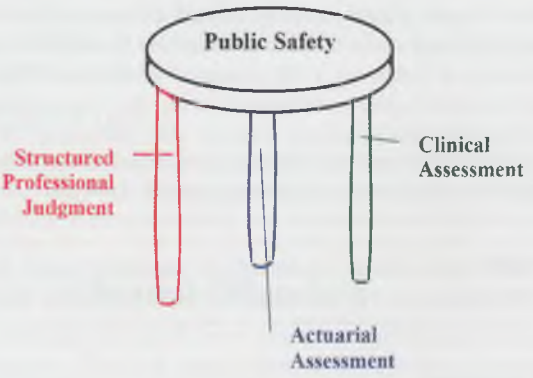

Fig. 41-2 The three assessment tools–clinical assessment, actuarial assessment, and structured professional judgment–may best be visualized as three legs of a stool on which public safety from sex offenders rests.

Actuarial Methods

Actuarial methods are more rigorous. They rely on *known* statistical correlations between certain "risk factors" and occurrence of future sexual violence. For instance, a person who has committed a greater number of sex offenses previously is likely to reoffend more often. Similarly, a person who is a drug and alcohol addict is more likely to display sexual violence than a person who is not. A number of such risk factors are taken and weighted according to their known correlations with the existence of future sexual violence. A final score is then calculated, which predicts the rate of future sexual violence.

This approach can perhaps best be understood by an analogy. When setting premium costs, a medical insurance company needs to have some indication as to which groups of individuals are likely to be at an increased risk of having a heart attack in the future (so they can charge more premium from them). Known risk factors of heart attack are obesity, cigarette smoking, hypertension, and high levels of cholesterol. Statistical correlations exist between these risk factors and the occurrence of heart attack. Insurance companies can use these data to set up premium amounts for individuals.

Based on this approach, different individuals and groups have devised different actuarial instruments or tests. Those used most commonly for risk assessment among sex offenders are (1) the *Violence Risk Appraisal Guide* (VRAG) (Harris, Rice, & Quinsey, 1993), (2) *Sex Offender Risk Appraisal Guide* (SORAG) (Ducro & Pham, 2006), (3) *Rapid Risk Assessment for Sexual Offense Recidivism* (RRASOR) (Hanson, 1997; Sjostedt & Langstrom 2001), (4) *Static-99* (Ducro & Pham, 2006; Nunes, Firestone, et al., 2002; Sjostedt & Langstrom, 2001), (5) *Minnesota Sex Offender Screening Tool* (Revised) or MnSOST-R (Epperson, et al., 1998), and (6) *Colorado Sex Offender Risk Scale* (English, Retzlaff, et al., 2002).

Each of these tests takes into account a fixed number of risk factors, "loads" them according to the known risk of reoffending associated with them, and arrives at a score. For instance, RRASOR rates an individual based on either the presence or absence of four identifiable risk factors: (1) the number of sex offenses for which the individual has previously been either charged or convicted, (2) the individual's current age, (3) the gender of the individual's former victims, and (4) the nature of the individual's relationship to them (intra- or extrafamilial). Predictions are made according to a scoring guide. Individuals scoring 1 on RRASOR have a 2.4% and 6.5% risk of recidivism at 5 and 10 years, respectively; those with a score of 3 have a 21.8% and a 36.9% risk of recidivism at 5 and 10 years, respectively; and that those with a score of 5 have a 49.8% and 73.1% risk of recidivism at 5 and 10 years, respectively. Similarly, The Minnesota Sex Offender Screening Tool–Revised (the MnSOST-R) is a 16-item actuarial tool. Scoring is as below (Table 41-3). Based on this scoring method, an MnSOST-R score of 8 or higher is considered suggestive of a high risk of recidivism.

Structured Professional Judgment

Actuarial tools offer little scope for any subjective interpretation. Thus, while unstructured clinical decision making is overly subjective, actuarial tools are strictly objective. Structured professional judgment (SPJ) tools are third-generation tools, which judiciously mix elements from both of the previous tools and may be the best approach to predict recidivism. Major SPJ tools in use today are the Sex Offender Need Assessment Rating (SONAR) (Hanson & Harris, 2001), Psychopathy Checklist Revised (PCL-R) (Bolt, Hare, et al., 2007; Pereira, Huband, et al., 2008; Urbaniok, Noll, et al., 2007), Historical, Clinical, Risk Management-20 (HCR-20) (Dietiker, Dittmann, et al., 2007; Gray, Taylor, et al., 2008), Level of Service Inventory-Revised (LSI-R) (Dahle, 2006; Manchak, Skeem, et al., 2008), and Structured Assessment for Violence Risk among Youth (SAVRY) (Lodewijks, Doreleijers, et al., 2008). Each takes into account a fixed number of items that are scored. The clinician's judgment is also factored in.

The forensic psychiatric nurse (FPN) has a great role to play in the assessment of sexual offenders. A forensic psychiatric evaluation of risk performed by an FPN can influence conviction, sentencing, and course of treatment, thereby preventing violence or recidivism (Patterson & Campbell, 2009).

Management and Supervision of Sex Offenders in the Community

Treatment and management of sex offenders has been a contentious issue. Opinions have varied from treating sex offenders like any other psychiatric patient to giving them antiandrogens and even castrating them.

One of the central goals in the treatment of sex offenders is the reduction of recidivism. Studies have shown that offenders who fail to complete treatment are at higher risk for reoffending than those who complete treatment (Hanson & Bussiere, 1998).

During sex offender treatment programs (SOTPs), the therapists aim at certain objectives. Among these are (1) patient honesty with therapists, group members, family, and other important people; (2) patient compliance with treatment procedures; and (3) patient compliance with supervision conditions (Kokish, 2003). There has been an increasing belief that with the use of the polygraph (lie detector) during such treatment programs, the ability of the therapists to attain these objectives is significantly enhanced (Kokish, Levenson, et al., 2005). American clinicians have even argued that polygraph testing in the treatment of sex offenders is akin to urine analysis in the treatment of drug addiction (Meijer, Verschuere, et al., 2008). This is now widely known as Post Conviction Sex Offender (polygraph) Testing (PCSOT).

PROBATION AND PAROLE

Sex offenders are a unique population to manage. Most convicted sex offenders at some point in time would be under the supervision of either a probation officer or a parole officer, with approximately 60% of sex offenders receiving probation sentences (Terry, 2006).

Table 41-3 Scoring Method for MnSOST-R

S. NO	RISK FACTOR	SCORING
1.	Number of sex/sex-related convictions (including current conviction)	Score 0 for one previous conviction and +2 for two or more previous convictions
2.	Length of sex offending history	If history is less than one year, score −1; if 1–6 years, score +3 and if >6 years, score 0
3.	Was the offender under any form of supervision when they committed any sex offense for which they were eventually charged or convicted?	No (0); yes (+2)
4.	Was any sex offense (charged or convicted) committed in a public place?	No (0); yes (+2)
5.	Was force or the threat of force ever used to achieve compliance in any sex offense (charged or convicted)?	No force in any offense (−3); force present in at least one offense (0)
6.	Has any sex offense (charged or convicted) involved multiple acts on a single victim within any single contact event?	No (−1); probable but not fully documented (0); yes (+1)
7.	Number of different age groups victimized across all sex/sex-related offenses (charged or convicted): Age group of victims: (check all that apply) __ Age 6 or younger __ Age 7 to 12 years __ Age 13 to 15 and the offender is more than 5 years older than the victim __ Age 16 or older	No age groups or only one age group checked (0); two or more age groups checked (+3)
8.	Offended against a 13- to 15-year-old victim and the offender was more than 5 years older than the victim at the time of the offense (charged or convicted)	No (0); yes (+2)
9.	Was the victim of any sex/sex-related offense (charged or convicted) a stranger?	No victims were strangers (−1); at least one victim was a stranger (+3); neither of the above can be confirmed, because of missing data (0)
10.	Is there evidence of adolescent antisocial behavior in the file?	No indication (−1); some relatively isolated antisocial acts (0); persistent, repetitive pattern (+2)
11.	Pattern of substantial drug or alcohol abuse during the most recent 12 months in the community (generally, this will be the 12 months before the arrest for the instant sex offense, but in some cases offenders will have been in the community for 12 or more months before being returned on a revocation or a new nonsex conviction)	No (−1); yes (+1)
12.	Employment history during the most recent 12 months in the community (generally, this will be the 12 months before the arrest for the instant sex offense, but in some cases offenders will have been in the community for 12 or more months before being returned on a revocation or a new non-sex conviction)	Stable employment for one year or longer prior to arrest (−2); homemaker, retired, full-time student, or disabled/unable to work (−2); part-time, seasonal, unstable employment (0); unemployed or significant history of unemployment (+1); file contains no information about employment history (0)
13.	Discipline history while incarcerated (does not include discipline for failure to follow directives to complete treatment successfully)	No major discipline reports or infractions (0); one or more major discipline reports (+1)
14.	Chemical dependency treatment while incarcerated	Treatment recommended and successfully completed or in program at time of release (−2); no treatment recommended/not enough time/no opportunity (0); treatment recommended but offender refused, quit, or did not pursue (+1); treatment recommended but terminated (+4)
15.	Sex offender treatment while incarcerated	Treatment recommended and successfully completed or in program at time of release (−1); no treatment recommended/not enough time/no opportunity (0); treatment recommended but offender refused, quit, or did not pursue (0); treatment recommended but terminated (+3)
16.	Age at release from institution	Age 30 or younger (+1); age 31 or older (−1)

Civil Commitment of Sexual Offenders

Unlike other criminal offenders, sex offenders who have done time do not always regain their liberty. Many jurisdictions around the world, including many U.S. states, now use the legal term **sexually violent predator** or *SVP*, which refers to any person who has been convicted of or charged with a crime of sexual violence and who suffers from a mental abnormality or personality disorder that makes the person likely to engage in predatory acts of sexual violence again, if not confined in a secure facility. These jurisdictions have laws that treat SVPs strictly, allowing them to be held in state-run, in-custody mental institutions *after* their sentence is complete if they are considered to be a risk to the public (civil commitment).

The first sexually violent predator law in the U.S. was the Community Protection Act of 1990, passed in the state of Washington. As of now, 16 other states have passed similar laws. These programs have been fiercely debated at many forums, not only because they are considered a severe drain on public exchequer but also because they are thought to be inhumane. However, the justification of these programs has often been cited as recidivism, which among sex offenders poses a serious problem

(as noted earlier). Civil commitment laws have been challenged time and again, but the U.S. Supreme Court, in *Kansas v. Hendricks 521 U.S. 346* (1997), has upheld their constitutionality (Box 41-1) (Grudzinskas & Henry, 1997).

Registration and Community Notification Laws Regarding Sexual Offenders

Sex offender registration is a system in place in a number of jurisdictions designed to allow governmental authorities to keep track of the residence and activities of sex offenders, including those who have completed their criminal sentences. In some jurisdictions–especially in the United States–information in the registry is made available to the general public via a website or other means (community notification). In many jurisdictions, registered sex offenders are subject to additional restrictions, including housing. Those on parole or probation may be subject to restrictions that do not apply to other parolees or probationers. Sometimes these include restrictions on being in the presence of minors, living in proximity to a school or daycare center, or owning toys or other items of interest to minors.

Box 41-1 *Kansas v. Hendricks*—Upholding the Constitutionality of Civil Commitment of Sexual Offenders

Under the Kansas *Sexually Violent Predator Act*, any person who, because of "mental abnormality" or "personality disorder," is likely to engage in "predatory acts of sexual violence" can be indefinitely confined. Leroy Hendricks and Tim Quinn had an extensive history of sexually molesting children. When they were due to be released from prison, Kansas filed a petition under the act in state court to involuntarily commit Hendricks and Quinn. Hendricks and Quinn challenged the constitutionality of the act on several grounds: (1) it was a case of *double jeopardy* (i.e., they were being tried twice for the same crime; double jeopardy is prohibited by the Fifth Amendment); (2) *ex post facto application* of a law (i.e., they were being punished for a law that was enacted *after* the crime was committed; (3) they were being detained *without due process of law*, something that is ensured by the Fourteenth Amendment; and, finally, (4) it was a *cruel and unusual punishment* unconstitutional under the Eighth Amendment.

A trial by jury was requested, which the court granted. Hendricks and Quinn testified during the trial that they agreed with the diagnosis by the state psychiatrist that Hendricks and Quinn suffer from pedophilia and admitted that they continued to experience uncontrollable sexual desires for children when they are under extreme stress. The jury decided that they qualified as *sexually violent predators*. Because pedophilia is defined as a mental abnormality under the act, the court ordered that Hendricks be civilly committed. Hendricks appealed the validity of his commitment in the State Supreme Court. The court ruled in favor of Hendricks, declaring that the act was invalid. Finally the case reached the U.S. Supreme Court.

The Supreme Court ruled against Hendricks in a 5-4 decision. It agreed with the act's procedures and the definition of a "mental abnormality" as a "congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses to the degree that such person is a menace to the health and safety of others." It agreed with Kansas that the act limits persons eligible for confinement to persons who are not able to control their dangerousness. Further, the court decided the act does not violate the Constitution's *double jeopardy* prohibition nor the ban on *ex post facto law* because the act does not establish criminal proceedings and therefore *involuntary confinement under it is not punishment*. Because the act is civil, Hendricks's confinement under the act is not a second prosecution nor is it double jeopardy. In other words, *the confinement is civil rather than criminal* (please note the phrase "civil commitment of sexual offenders").

Hendricks's other contentions were also dismissed on similar grounds.

Summary

With the rise of the incidence of sexually deviant behavior, forensic nurse practitioners are going to witness an increasing number of such cases in the course of their practice. By understanding the sexual offending behavior in all its aforementioned dimensions, the forensic nurse can meaningfully help and assist in the management of sexual offenders.

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