CHAPTER 21

THE PSYCHOLOGIST'S PERSPECTIVE

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OVERVIEW:

Having worked in the sex offender evaluation and treatment field for 30 years in New Jersey, I can attest to the fact that times have changed. In 1976, when I first began working as a psychologist at the Adult Diagnostic and Treatment Center (ADTC), New Jersey's sex offender treatment center, the field was young. There were no standardized risk assessment scales and not even a generally accepted treatment protocol for sex offenders. Risk assessments were limited to an interview and some psychological testing (none of which had any established empirical relationship to recidivism), which yielded a result such as, "In my clinical opinion, this man is [low, moderate, high] risk." Beyond that conclusory statement, it was difficult if not impossible to articulate the reasons why an individual might present a certain level of risk. Treatment of sex offenders had no empirical foundation at the time, and each therapist used his or her own approach, with little regard to any professional literature, since little literature was available.

Over the ensuing decades, there has been a gradual accumulation of knowledge about sex offender evaluation and treatment. A number of structured, empirically supported risk assessment scales (two of which are New Jersey's own Registrant Risk Assessment Scale[1] (RRAS) and Juvenile Risk Assessment Scale[2] (JRAS)). There has also been considerable research over the years on what forms of treatment are effective with sex offenders.[3] Although clearly there is much to be learned, we now have a firmer foundation on which to work in this field. The field as a whole has become more professional, with a national organization, the Association for the Treatment of Sexual Abusers, devoted solely to the study of this population and a journal, *Sexual Abuse: A Journal of Research and Treatment*, focusing on theoretical and empirical works regarding sex offenders.

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[1] Witt, P. H., DelRusso, J., Oppenheim, J., & Ferguson, G. (1996). Sex offender risk assessment and the law. *Journal of Psychiatry and Law*, *24*, 343-377; Ferguson, G. E., Eidelson, R. J., & Witt, P. H. (1998). New Jersey's sex offender risk assessment scale: Preliminary validity data. *Journal of Psychiatry and Law, 26,* 327-351.

[2] Hiscox, S. P., Witt, P.H., & Haran, S.J. (2007). Juvenile Risk Assessment Scale (JRAS): A Predictive Validity Study. *Journal of Psychiatry and Law, 35*, 503-539

[3] Witt, P.H., Greenfield, D.P., & Hiscox, S.P. (2008). Cognitive/behavioral approaches to the treatment of adult sex offenders. *Journal of Psychiatry and Law, 36,* 245-269.

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In the present article, I will review the assessment and treatment approaches with sex offenders, so that legal professionals can be informed on these issues. When possible, I will apply that information to specific legal contexts in New Jersey.

Legal context for sex offender evaluations

The legal contexts for which a forensic psychological evaluation in sex offense cases can be summarized are detailed in Figure 1:

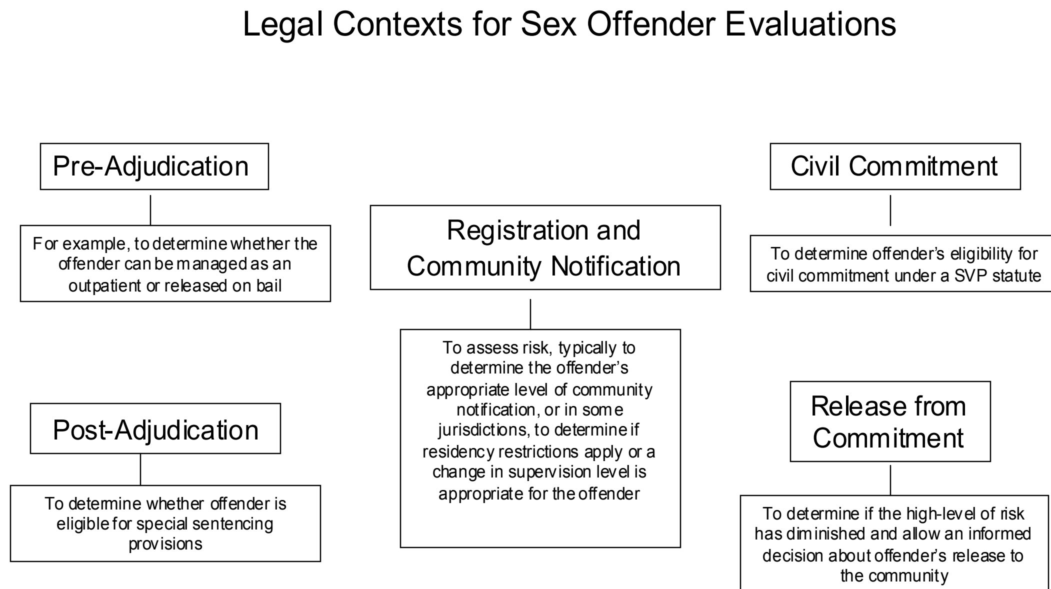

Figure 1

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Pre-Adjudication

The earliest context for sex offender evaluations, with both adult and juvenile defendants, is pre-adjudication. Many evaluation referrals regarding sex offenders come shortly after the individual has been arrested for a sex offense (or in the case of child pornography offenders, after a search warrant has been executed). Because pre-adjudication evaluations frequently occur (and should occur) very early, the individual may not even be indicted, and there may be no discovery available yet.

The lack of discovery materials presents difficulties for an evaluator. It is always helpful to be able to review investigation reports and the statements of witnesses, victims, and even the alleged perpetrator. Evaluators typically prefer to rely on multiple sources of information, not solely the interview account of the alleged perpetrator. Nonetheless, as long as the evaluator does not overstep his or her bounds, pre-adjudication evaluations, even without discovery materials, can be helpful.

First, defense attorney and prosecutor alike have an interest in a risk assessment. What risk the individual presents may well have a bearing on the eventual plea agreement. If a credible risk assessment—using accepted, empirically founded methods—indicates that the alleged perpetrator could be managed in the community, then this information might form one element of plea negotiations or, if the alleged offender is housed in the county jail, of suitability for bail. Of course, risk is not the only consideration. There are legal considerations, such as the seriousness of the offense and prior criminal history, and tactical considerations, such as the strength of the evidence, but these factors are beyond the purview of a forensic mental health evaluator. Moreover, the wishes of the victim or victim's family are increasingly considered, and of course, these wishes are beyond an evaluator's purview as well. In addition, for a sex offense not requiring a mandatory psychological evaluation at the ADTC under 2C:47-1, prosecutors frequently require the defendant to receive a psychological evaluation as part of a plea bargain.

Nowadays risk assessment almost always involves administration of structured, empirically based scales. Even though the evaluation is pre-adjudication, the defense attorney may want a forecast of what risk tier the defendant is likely to be found when and if he is assessed by the prosecutor's office in compliance with New Jersey's community notification law. I will address in detail how to perform such a community notification risk assessment in detail below, in the section on that legal context.

In addition, the evaluation frequently includes a treatment and management plan. This aspect of the evaluation addresses questions such as: Can

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the defendant be managed on bail (if he is incarcerated in the county jail)? What treatment plan would be appropriate for him? Are there any special management or supervision recommendations that would be helpful?

There is one question that cannot be addressed: Did the alleged perpetrator commit the offense (if he denies having done so)? Sometimes attorneys refer an alleged (but denying) perpetrator for an evaluation with the expectation that the evaluator can determine whether the alleged perpetrator matches the "profile" of a sex offender. No such profile exists. Sex offenders come in all personality styles. Although some classification systems exist for sex offenders, these classification systems are all predicated on the assumption that the individual in question has committed the alleged sex offense. These systems do not start from a premise that the offense has yet to be proven. In fact, the current practice standards for the Association for the Treatment of Sexual Abusers states (at 11): "Evaluators do not offer conclusions regarding whether or not an individual has or has not committed a specific act of sexual abuse."[4]

I recommend that defense attorneys obtain an evaluation of the client as soon as possible. Sometimes attorneys wait until the last minute, when finalizing plea negotiations with the prosecution. This is inadvisable. The earlier a defense attorney has his or her client evaluated, the sooner the attorney can obtain answers to important questions involved in plea negotiations: Is the client likely to be found repetitive and compulsive when and if evaluated at the ADTC? What risk does the client present? In which risk tier is the client likely to be classified? What treatment plan best suits the client? Moreover, the earlier that the client enters treatment, based on the treatment plan in the evaluation, the more credible will be any representation by the defense to the prosecution about the client's motivation and progress in treatment.

The psychologist should also clarify with the client the limitations of confidentiality. Under normal circumstances, what a client tells a psychologist is confidential (with the exception of risk to self or others or information that triggers New Jersey's child abuse reporting law). In a forensic evaluation of a sex offender, however, the very purpose is to provide information to a third party—typically a prosecutor or defense attorney. At the outset of the evaluation, the client should be informed of the limited confidentiality, and his consent obtained.

- What to expect from a pre-adjudication evaluation
    - Risk assessment
    - Treatment/management plan

[4] Association for the Treatment of Sexual Abusers (2005). Practice Standards and Guidelines. Beaverton, OR: Author.

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    - Any specific psycholegal referral questions addressed (e.g., likely risk tier, repetitive-compulsive)

- What not to expect from a pre-adjudication evaluation
    - Conclusion on whether the alleged perpetrator committed the offense, if he denies having done so
    - Whether the alleged perpetrator meets some (non-existent) sex offender profile
- **Recommendation 1: Have the alleged perpetrator evaluated as early as possible.** [Emphasis supplied by editor]
- **Recommendation 2: See recommendation 1. It's that important.** [Emphasis supplied by editor]

Repetitive-Compulsive Offenders

In New Jersey, after an individual is convicted by trial or pleads guilty to any of a number of enumerated sex offenses, he is evaluated at the ADTC pursuant to 2C:47-1 to determine whether he meets four criteria:

- Is he repetitive?
- Is he compulsive?
- Is he amenable to treatment?
- Is he willing to accept treatment?

Repetitive simply means that the illegal sexual behavior occurred more than once, even if with only one victim, although in some cases repetitive fantasies can be used as evidence of repetition. Compulsive means that the offender felt strong urges to perform the illegal sexual behavior, urges that he felt unable to control. Essentially, the compulsive aspect of the evaluation focuses on the presence of at least some volitional impairment—that is, did the offender know that his illegal sexual behavior was wrong, try to prevent himself from acting on those urges, but act on the urges anyway?[5]

If the individual meets all four tests—repetitive, compulsive, amenable, and willing—then he can be sentenced to the ADTC; otherwise, he is sentenced to the general prison system (*N.J.S.A.* 2C:47-1). The final determination on these four criteria is made by the court, even if the ADTC findings are not contested.

[5] See more extended discussion of this point in Witt, P. H. & Frank., M. (1988). Psychological Evaluations under the New Jersey Sex Offender Act. *New Jersey Trial Lawyer, 2(2)*, 37-43.

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There are pros and cons to each sentence. Regarding the advantages of being sentenced to the ADTC, elsewhere I have noted:

> The advantage of serving a sentence at the ADTC is that the offender has the opportunity to participate in a comprehensive sex offender treatment program, whereas little if any treatment is available in the general prison system. Moreover, because all individuals sentenced to the ADTC are sex offenders, an individual serving his sentence there does not need to fear harassment and abuse by other inmates, as he might as a sex offender serving a sentence in a general prison.[6]

Despite these advantages to serving a sentence at the ADTC, some lawyers encourage their clients to do everything possible not to be found repetitive and compulsive. The reason is that the offender is likely to serve more time if incarcerated at the ADTC than in the regular prison system. However, lawyers should be aware that this time differential is not what it once was. An offender's first parole eligibility hearing may well occur relatively soon in the general prison system if not found repetitive and compulsive. However, his eventual release date is likely to be well beyond his first parole eligibility hearing, given that the parole board in recent years appears to have grown cautious about releasing any sex offender from prison, even those not found repetitive and compulsive. Consequently, the length of time served in a regular prison sentence before parole has crept upwards over the years, approaching, if not quite reaching, the length of time served on an ADTC sentence.

If an offender is found repetitive and compulsive by the ADTC, he is allowed to challenge that finding, obtaining his own expert and calling for a *Horne* hearing.[7] Such challenges are rarely successful. The burden of proof, although on the State, is at a relatively low level—preponderance of the evidence. Moreover, the ADTC evaluators are quite experienced. These evaluations are all they do, day in and day out. So the odds of success in a *Horne* hearing are low. I recommend that attorneys obtain an opinion as early as pre-adjudication as to whether the client is likely to be found repetitive and compulsive and on what basis; this early opinion will help inform the attorney's plea negotiations and discussions with the client.

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[6] Witt, P. H. & Barone, N. (2004). Sex offender risk assessment: New Jersey's methods. *Federal Sentencing Reporter*, *16*, 171-176, at 171.

[7] *State v. Horne* 56 *NJ* 372 (1970).

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- What to expect in a repetitive-compulsive evaluation
    - Determination as to whether the offender meets specific statutory requirements for this finding
    - If for the defense, whether a challenge to an ADTC finding is credible (and therefore has a reasonable likelihood of success)
- What not to expect in a repetitive-compulsive evaluation
    - Formal risk assessment
    - An opinion on whether the client meets DSM-IV criteria for a diagnosis of obsessive-compulsive disorder; this diagnosis is irrelevant
    - An opinion that a challenge to an ADTC finding in a *Horne* hearing is likely to succeed (because such success is rare)
- **Recommendation:** As a defense attorney, get the client evaluated as early as possible regarding this issue, even pre-adjudication, so that consideration of this factor and the associated sentencing options can be addressed with the client.

SVP Civil Commitment Evaluations

After a sex offender has served his criminal sentence, but before he is released to the community, he is evaluated to determine whether he is civilly committable under New Jersey's sexually violent predator (SVP) statute, the NJSVPA (*N.J.S.A.* 30:4-27.24). Although it is possible that a sex offender could be civilly committed as an SVP from a different referral source, such as after the sex offender finishes a course of inpatient psychiatric hospitalization, such referrals are rare. The SVPA defines an SVP as:

> A person convicted, adjudicated delinquent or found not guilty by reason of insanity of a sexually violent offense, or who has been charged with a sexually violent offense but found incompetent to stand trial, and suffers from a mental abnormality or personality disorder that makes the person likely to engage in acts of sexual violence if not confined in a secure facility for control, care and treatment.[8]

[8] *N.J.S.A.* 30:3-27.26(b).

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The actual process of such SVP commitments in New Jersey is complex, beginning with an evaluation, including a formal risk assessment, conducted shortly before the inmate's scheduled release from the NJ Department of Corrections. If deemed a candidate for commitment, the inmate is referred to the Attorney General's office, which then has the option of filing the motion for commitment, supported by two clinical certificates, one of which must be by a psychiatrist. These materials are forwarded to a judge, who has the authority to determine if the inmate meets criteria for temporary commitment, pending a full commitment hearing. At the full commitment hearing before the judge, the offender can present his own expert to counter the State's position regarding commitment.[9]

- What to expect from an SVP evaluation
  - The evaluation should have a foundation in accepted risk assessment instruments and methods and be closely tied in to the professional literature regarding risk assessment
  - Clear relationship between the findings in the evaluation and New Jersey's statutory and case law criteria
- What not to expect from an SVP evaluation
  - Comments on the appropriateness of the SVP statute itself (since SVP laws sometimes cause polarized opinions among both laypersons and professionals); regardless of which way the expert leans in this regard, opinions about the law itself will lower the expert's credibility
  - An overly high level of certainty regarding the likelihood (or lack of likelihood) of future sex offending by the inmate; the most credible opinion is one that appropriately acknowledges the limitations of predictions of future offending

Community Notification Evaluation

Psychological evaluations also occur with convicted sex offenders in the community for assignment to low, moderate, or high risk categories in conformance with New Jersey's community notification law, commonly referred to as Megan's Law (*N.J.S.A.* 2C:7-6). The law requires all offenders convicted of specific enumerated sex offenses to register with the local police. The

[9] The reader interested in more information about SVP evaluations and procedures can see Witt, P.H. & Conroy, M.A. (2009). *Evaluation of sexually violent predators.* New York, NY: Oxford University Press.

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prosecutor's office in the county in which that offender lives then classifies the offender as low, moderate, or high risk, relying on one of New Jersey's sex offender risk assessment scales, the Registrant Risk Assessment Scale (RRAS)[10] for adults and the Juvenile Risk Assessment Scale (JRAS)[11] for juveniles. The higher an offender's assessed risk, the more broadly the community is notified. Moderate risk offenders have identifying information posted on the New Jersey State Police website; high risk offenders also have door-to-door notification in the areas where they live and work.

Psychological evaluations in contested community notification cases can be called by either the prosecution or the defense, although in practice, most are used by the defense, with the prosecution usually relying on cross examination of the defense's expert. Most psychologists administer additional risk assessment scales, beyond the RRAS or JRAS. When the RRAS was developed in 1995, no other standardized, empirically supported risk assessment scales had been developed, so New Jersey by necessity had to start from scratch and develop its own scale. Since then, a number of risk assessment scales have been developed, with excellent research support, and are in wide use throughout North America. Consequently, most forensic mental health experts will supplement the RRAS by administering one if not more than one additional risk assessment scale, such as the Static-99,[12] the MnSOST-R,[13] the Stable-2007,[14] and the Acute-2007[15]—ideally looking at both static, historical risk factors and dynamic, changeable risk factors, such as current and recent adjustment. Regarding the assessment of dynamic risk factors, I recommend the use of structured risk assessment scales, such as the Stable-2007 and Acute-2007, mentioned above. At times, one will see experts testify to broad dynamic risk factors, relying on little more than their

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[10] Ferguson, G. E., Eidelson, R. J., & Witt, P. H. (1998). New Jersey's sex offender risk assessment scale: Preliminary validity data. *Journal of Psychiatry and Law, 26,* 327-351; Witt, P. H., DelRusso, J., Oppenheim, J., & Ferguson, G. (1996). Sex offender risk assessment and the law. *Journal of Psychiatry and Law*, *24*, 343-377.

[11] Hiscox, S. P., Witt, P.H., & Haran, S.J. (2007). Juvenile Risk Assessment Scale (JRAS): A Predictive Validity Study. *Journal of Psychiatry and Law, 35*, 503-539.

[12] Hanson, R. K., & Thornton, D. (1999). *Static-99: Improving actuarial risk assessments for sex offenders*. (User Report 99-02). Ottawa, Ontario: Department of the Solicitor General of Canada

[13] Epperson, D. L., Hesselton, D., & Kaul, J. D. (1999). *Minnesota Sex Offender Screening Tool-Revised (MnSOST-R): Development, performance, and recommended risk level cut scores*. Minneapolis, MN: Minnesota Department of Corrections.

[14] *Hanson*, R. K., *Harris*, A. J. R., *Scott*, T. L., & *Helmus*, L. (*2007*). *Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project* (User Report *2007*-05). Ottawa, ON: *Public Safety Canada*.

[15] Id.

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unstructured clinical opinion, a method likely to, if anything, reduce the validity of their risk assessments.[16]

In many cases, there are disputes regarding the facts underlying the scoring of the RRAS. For example, there may be allegations regarding additional victims that were not charged. In my experience, prosecutors frequently score the disputed items with the most negative set of factual assumptions, and defense attorneys frequently score the disputed items with the most favorable set of assumptions. It is not the evaluator's job to determine the facts in the case; the judge is the finder-of-fact. The evaluator has two options regarding these factual disputes. The evaluator can score the RRAS making a given set of factual assumptions, acknowledging that these are only assumptions for the purpose of scoring the RRAS and that the score might vary if other factual assumptions are made. In the alternative, the evaluator can give a range of risk that the individual presents, depending upon what factual assumptions are made.

- What to expect in a community notification evaluation
    - Rescoring of the RRAS or JRAS to reach an independent conclusion regarding the individual's score, apart from the usually divergent scorings by the prosecution and defense
    - Administration of additional well-accepted risk assessment scales, ideally scales that assess both static, historical risk factors and dynamic, changeable risk factors (such as current and recent adjustment)
    - Assessment of dynamic risk using structured, empirically supported instruments, rather than unstructured clinical opinion
    - Acknowledgement by the expert that he or she is not the finder-of-fact and therefore is not the one to reach conclusions regarding disputed facts
- **Recommendations**
    - Have realistic expectations regarding the case. Also, for credibility's sake, understand that your expert should advocate only for his or her opinion, not for the registrant or the State.
    - Be cautious when relying on experts who use relatively unstructured clinical judgment to "adjust" findings on standardized scales. Current research indicates that such "adjustment" is likely

[16] Hanson, R. K. & Morton-Bourgon, K. E. (2009). The accuracy of recidivism risk assessments for sexual offenders: A meta-analysis of 118 prediction studies. *Psychological Assessment, 21,* 1-21.

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to actually lower the accuracy of risk assessments.[17] Moreover, the use of "clinical adjustment" to scale findings lends itself to incorrect double counting (for example, concluding that because of antisocial traits, the offender presents higher risk than the scale would indicate, when those antisocial characteristics are already taken into account by the scale itself).

- Be cautious when relying on experts who include in their formal risk assessment substantial therapeutic material, such as presence or absence of a relapse prevention plan; such factors, although valuable for treatment and management, are rarely part of the formal risk assessment instruments on which these evaluations should be based.

Treatment

Treatment of sex offenders in some ways has come full circle. In the early days, say the mid-70's, treatment was relatively unstructured and focused on broad personality issues. The next wave, perhaps the late 70's through the late 80's, was the high water mark of behavioral treatment—focusing on reconditioning exercises to alter deviant sexual interest patterns.[18] Since then, the focus has broadened again, although treatment typically is more structured than it had been in the past. Most current sex offender treatment is a broad-based cognitive-behavioral relapse prevention approach. This approach was first developed by Alan Marlatt with substance abusers[19] and later adapted and applied to sex offenders by William Pithers.[20] Relapse prevention is both a broad treatment framework (focusing on managing future high risk situations) and a set of structured exercises (identifying personal risk factors, doing written assignments to develop relapse prevention plans). The previously emphasized behavioral treatment components (such as social skills training or sexual reconditioning exercises) are still components of treatment, but are integrated into

[17] Hanson & Morton-Bourgon (2009), op cit.

[18] Marshall, W. L. & Lippens, K. (1977). The clinical value of boredom: a procedure for reducing inappropriate sexual interests. *Journal of Nervous and Mental Diseases, 165*, 283-287. Laws, D.R. & Marshall, W.L. (2003). A brief history of behavioral and cognitive-behavioral approaches to sexual offender treatment: Part 1. Early developments. *Sexual Abuse: A Journal of Research and Treatment, 15*, 75-92.

[19] Marlatt, G. A. & Gordon, J. R. (1985). *Relapse prevention*. New York, NY: Guilford Press.

[20] Pithers, W. D., Marques, J. K., Gibat, C. C., & Marlatt, G. A. (1983). Relapse prevention with sexual aggressives : A self-control model of treatment and maintenance of change. In J. G. Greer & I. R. Stuart (eds.) *The sexual aggressor: Current perspectives on treatment* (pp. 241-259). New York, NY: Van Nostrand Reinhold.

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a broader treatment plan. In its original formulation by Marlatt, relapse prevention was a program to maintain gains and prevent therapeutic backsliding; in its current application with sex offenders, it is both a treatment and maintenance program.[21] Moreover, there has been recent movement to include positive treatment goals, such as increasing capacity for emotional intimacy, spirituality, mastery experiences, and positive community involvement. This focus on positive treatment goals has been called the "good lives" model.[22] So although more empirically based and structured, sex offender treatment has moved back to including broad personal goals and stable personality features as appropriate targets for treatment. However, one must realize that one size does not fit all, and there are cases in which some elements are not included or are at least not emphasized.

Is sex offender treatment effective? There are many methodological difficulties that make a clear assessment of sex offender treatment problematic. Studies of treatment effectiveness vary in their definitions of success and failure. Treatment is conducted differently in different studies. It is frequently difficult if not impossible to engage in long-term follow up, especially for untreated sex offenders, who are studied as a comparison group.[23] Some authorities, in fact, have concluded that evidence of treatment efficacy does not exist for sex offenders.[24] However, over the past decade, evidence has been accumulating that sex offender treatment is effective. A variety of studies indicate lower levels of recidivism for treated as opposed to untreated sex offenders, especially for more current methods of treatment.[25]

When referring a sex offender client to a therapist, the defense attorney should consider the extent of the therapist's relevant experience. Does the therapist have sex offender treatment experience? Is the therapist a member of the Association for the Treatment of Sexual Abusers, which has experience and supervision requirements for membership? Does the therapist have relevant professional publications? None of these is a guarantee of competence, of course, but at least

[21] Laws, D. R. & Ward, T. (2006). When one size doesn't fit all: The reformulation of relapse prevention. In W. L. Marshall, Y. M. Fernandez, L. E. Marshall, & G. A. Serran (eds.) *Sexual offender treatment: Controversial issues*. Chichester, England.

[22] Ward, T. & Stewart, C.A. (2003). The treatment of sex offenders: risk management and good lives. *Professional Psychology: Research and Practice*, *34*, 353-360.

[23] The interested reader can see a more detailed discussion in Witt, P.H. & Zgoba, K.M. (2005). Psychological treatment of sex offenders: Current status. *Sex Offender Law Report*, *6*, pp. 3-34, 45-47; and Witt, P.H., Greenfield, D.P., & Hiscox, S.P. (2008). Cognitive-behavioral approaches to the treatment of adult sex offenders. *The Journal of Psychiatry and Law, 36*, 245-269.

[24] E.g., Furby, L., Weinrott, M.R., & Blackshaw, L. (1989). Sexual offender recidivism: A review. *Psychological Bulletin, 105*, 3-30.

[25] See review in Marshall, W.L. (2006). Appraising treatment outcome with sexual offenders. 255-274. In Marshall, et al., op cit.

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an indicator of bona fide interest and experience. However, even here, there is room for flexibility: some sex offenders do quite well in treatment with a general practitioner, so each case needs to be considered individually.

- **Recommendation:** Expect that some common elements be covered in sex offender treatment, such as relapse prevention and victim empathy, but be aware that offenders' treatment needs vary, and individual treatment plans for a given offender may emphasize or de-emphasize various aspects of treatment.

Conclusion

In this article I have attempted to introduce New Jersey lawyers, both prosecution and defense, to the basics of sex offender assessment and treatment. I have reviewed the contexts in which sex offenders receive psychological evaluations in New Jersey, indicating how the psycholegal referral issues are addressed in each context. Finally, I have briefly reviewed current treatment approaches. My hope (and expectation) is that a well informed attorney by understanding the issues involved in each legal context for sex offender psychological evaluations can make better use of psychological experts in these cases—clarifying referral questions and understanding how forensic psychologists approach these referral issues.

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