Sex Offenders: General Information and Treatment

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ABSTRACT

Sex offenders are often neglected by psychiatrists due to a deficiency in training and a lack of knowledge in the area of sexual offenders. Many sex offenders have a comorbid psychiatric illness, including paraphilic disorders. Research has established that sex offenders can be treated with evidence-based principles. Psychiatrists can serve a pivotal role in the evaluation and biological treatment of sex offenders. Together, psychiatrists can work toward primary prevention of sexual violence by learning the requisite skills to identify and treat risk factors of sexual abuse. **[*Psychiatr Ann*. 2018;48(2):120-128.]**

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The topic of sex offenders is not commonly covered in psychiatric texts or psychiatric training programs. Although sexual offending is not a symptom of mental illness, some people who commit sexual offenses have a mental illness. Comparatively, some people with mental illnesses engage in problematic sexual behavior.[1,2] Regardless of the etiology, the impact of a sexual assault can be devastating for victims, leaving them with profound and enduring psychiatric sequelae.[1,2] Sexual violence is a public health problem in the United States. Based on National Crime Victimization Survey (NCVS) data, an estimated 431,840 rape/sexual assault victimizations occurred in the US in 2015,[3] with a rate of 1.6 victimizations per 1,000 persons age 12 years and older.[3,4] The Centers for Disease Control and Prevention (CDC) reported that approximately 8% of girls and 0.7% of boys in the US experience rape or attempted rape before age 18 years, and 1.3% of boys are either made to penetrate someone or an attempt is made to force them to penetrate someone.[4] Among the general public and medical profession, it is a commonly accepted belief that the propensity to commit sexually abusive behaviors is chronic and enduring over the life-course with no known cure.[5] However researchers have found sexual-offending behaviors are generally temporal,[6] with average recidivism rates between 7% and 15% after 5 years.[7,8] Treatment reduces these outcomes further, as the most recent five meta-analyses of sex offense recidivism have found that treatment is effective, with a mean reduction of 22% across

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studies.[9] Educating mental health clinicians about the successful evidence-based treatment of sex offenders is one step toward the prevention of sexual violence. This article outlines the important aspects of working with sex offenders.

PARAPHILIC SEX OFFENDERS

Although paraphilic disorders are included in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*),[10] the question of what constitutes a pathologic sexual behavior remains. *DSM-5* attempted to answer this question by changing the nomenclature of paraphilias to paraphilic disorders. The change in nomenclature reflects the understanding that a paraphilia (which is an intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners) is a disorder if it is present for at least 6 months and causes distress, impairment, harm, or the risk of harm.[4] This significant change separates paraphilic interests from behaviors that are of clinical significance.

Not all sexual offenders have paraphilic disorders; however, sexual offenders who have deviant sexual interests have a higher risk of sexual recidivism than sexual offenders without deviant sexual interests.[11] The prevalence rates for paraphilas are difficult to determine due to the changes in *DSM* terminology as well as the heterogeneity in study samples. In non-offending populations, Ahlers et al.[12] found that 64% of men reported sexual interest in at least one paraphilic activity, with 44% reporting paraphilic behavior. The most commonly reported fantasies in this study were voyeurism (35%), fetishism (30%), sadism (22%), masochism (16%), and frotterurism (13%).[12] Langstrom and Seto[13] sampled men and women who were not sex offenders and found 3% were aroused by exhibitionism and 8% were aroused by voyeurism. Among sex offenders, Abel et al.[14] found that sexual offenders frequently had more than one paraphilia and that the presence of a single paraphilia was rare. A meta-analysis by Hanson and Morton-Bourgon[11] found that pedophilia significantly predicted sexual recidivism in multiple studies, but the presence of other paraphilias has been less predictive.

COMORBID PSYCHIATRIC DISORDERS

Sex offenders who are mentally ill may engage in problematic sexual behavior as a result of deviant sexual interests (paraphilias), personality traits, poor impulse control, or as a direct result of their major mental illness. Historically, research indicated that most sex offenders do not have a major mental illness.[15] Early studies of sex offenders with mental illness revealed a high incidence of family psychopathology, criminal behavior, and substance abuse, similar to offenders without mental illness.[16] However, the first studies to report on the prevalence of psychiatric diagnosis in sex offenders found high rates of mood disorders, substance abuse, and parpahilias.[17] Other authors found that sex offenders may have psychiatric disorders (including psychotic disorders) and personality disorders.[18,19] Kafka[20] conducted a meta-analysis of comorbid Axis I nonsexual psychopathology in sex offenders with paraphilias and found unipolar and bipolar mood disorders, social anxiety disorder, attention-deficit/hyperactivity disorder, and other neurodevelopmental conditions (eg, mental retardation, fetal alcohol spectrum disorder, Asperger's syndrome) comorbid with paraphilic sexual offending. Paraphilic sex offenders, namely child molesters, have higher rates of borderline, histrionic, depressive, and obsessive-compulsive personality disorders.[21] Schroeder et al.[22] examined personality disorders in sex offenders with and without violence in comparison to violent nonsexual offenders. This study found 32.8% of sex offenders met criteria for a personality disorder compared with 68.3% of sexually violent offenders and 49.5% of nonsexual violent offenders.[22] The most common diagnosis in all groups was antisocial personality disorder followed by borderline personality disorder.[22] Data from a nationally representative survey of more than 43,000 adults, the National Epidemiologic Survey on Alcohol and Related Conditions,[23] indicated strong associations between sexual assault and lifetime psychiatric disorders often associated with impaired impulse control such as antisocial personality disorder, conduct disorder, psychotic disorders, and cocaine use disorder.

The research examining the prevalence of psychotic disorders in sex offenders is mixed. Some studies found a low rate of psychotic illnesses in sex offenders.[24] In a study of pedophilic offenders by Raymond et al.,[25] only 1 of 45 (2%) participants had a diagnosis of schizophrenia or schizoaffective disorder. Dunseith et al.[17] found no evidence of a psychotic spectrum disorder in 113 men convicted of sexual offenses.

Other studies[16] have found psychotic illnesses, such as schizophrenia, associated with an increased risk of sexual reoffending. Langstrom et al.[26] found psychotic illness increased the risk for sexual recidivism in sex offenders with mental illness. Fazel et al.[18] found sex offenders were 4.8 times more likely to receive a diagnosis of schizophrenia and 3.4 times more likely to have bipolar affective disorder.

Despite these referenced studies, the true prevalence of psychiatric disorders in sex offenders is still not well known. Future directions aimed at better understanding the prevalence of mental illness in sex offenders, as well as the relationship between mental illness and sexual offending, will serve to guide risk assessment tools for sex offenders with psychiatric comorbidity.

EVALUATION AND RISK ASSESSMENT

A comprehensive assessment is an essential aspect of sex offender treatment and risk evaluation. Data should be gathered from several sources, including official police records, when possible. Consistent with the principles of risk, need, and responsivity,[27] the goal of a treatment assessment is to guide and direct treatment, including the identification of treatment intensity level and specific, individualized treatment needs. Part of the individualized treatment includes identifying and separating offenders based on their level of risk for reoffending. Specifically, treatment intensity should be determined primarily based on the level of risk posed by an offender. Research-based static and dynamic factors should be combined to identify risk, which should be considered in the context of recidivism data reflecting groups of reoffenders.[28]

The components of a psychosexual assessment are included in **Table 1**. The evaluator should work to identify the behaviors an offender may engage in to obtain his or her values, particularly the maladaptive ways in which an offender uses sexual offending behavior. The interview process allows the evaluator to acquire information about the offender's ability to attain his or her values in a healthy way. Additionally, the specific offense pathway may be identified and explored. Yates et al.[29] discuss four pathways to offending: (1) avoidant-passive, (2) avoidant-active, (3) approach-automatic, and (4) approach-explicit. To accurately assess offense pathways, the governing sexual offense and other previous offenses are examined. If the offender followed different pathways for multiple offenses, this may be addressed in the evaluation. The focus of the pathway analysis in the assessment is on the recent offending patterns and general progression of sexual offending. The evaluation may also detail the person's ability and capacity for emotional regulation and behavioral control.

The evaluation should incorporate an examination of the offender's general amenability as well as individual factors that may hinder or advance the person's treatment progress. Moreover, it may be clinically indicated to use the assessment process to ascertain potential flaws and strengths in the offender's abilities that may contribute significantly to the treatment process. Highlighting individualized deficits and strengths will enhance and guide the treatment while tailoring it to the individual person.

Risk assessment tools are also integrated into the evaluation of an offender. Risk factors are identified to have targeted treatment goals that are associated with offending.[24] The two strongest predictors of future sexual offending include deviant sexual interests and antisocial orientation.[7] Antisocial orientation refers to such factors as antisocial personality, psychopathy, and antisocial traits such as impulsivity and problems with general self-regulation, substance abuse, reckless behavior, and a history of rule violations. Evaluating risk includes assessing both static and dynamic factors (**Table 2**). The dynamic factors and criminogenic needs that are associated empirically with reoffending are ones that can be changed through intervention and, therefore, are of primary focus when formulating and detailing the individualized treatment recommendations.[30,31]

Offenders who are identified as having similar traits and characteristics as those who have previously reoffended are generally placed in a treatment of higher intensity, whereas offenders who have been identified as having factors that are consistent with others who had a lower likelihood of reoffending are generally offered a moderate or low level of intensity of treatment interventions.[32] Therefore, level of risk is assessed to help facilitate the assignment of each offender to the appropriate treatment intensity. In addition to the risk factors that may aid in designating the level of intensity for an offender, the evaluation process provides a structure to identify other factors that may contribute to the level of treatment intensity an offender needs, such as cognitive functioning and mental illness.

Based on the information gathered during the evaluation process, a clinical formulation and specific recommendations for treatment are generated. Specific treatment recommendations also include treatment-responsivity factors, such as learning style, cognitive ability, personality characteristics, and additional factors.[32,33]

OBJECTIVE TESTING

Penile plethysmography (PPG) and the Abel screen of sexual interest are objective tests used to determine a person's sexual interests. PPG uses a strain gauge to measure changes in penile circumference while the person is presented with different sexual stimuli (audio and visual). The Abel screen measures visual reaction time to images of clothed males and females of varying age as an indicator of sexual interest. Both tests may provide additional information when an offender is not forthcoming in reporting his sexual preferences.

PSYCHOLOGICAL TREATMENT

The treatment of sexual offenders should be routinely informed by new research and advances in sex offender assessment, treatment, and management. The field is thriving with ongoing research, so mental health providers should be continually modifying and updating treatment approaches as new developments in the field emerge. Currently, best practice for providing psychological treatment to people

who have sexually offended is using a cognitive-behavioral approach while applying the "risk need responsivity" model.[27] In addition, modified relapse prevention and strength-based approaches are supported by the research.

The establishment of a strong therapeutic alliance is integral to treatment success with offenders who have sexually offended. Wong et al.[34] found that a strong therapeutic alliance was associated with reduced recidivism rates, whereas Marshall et al.[35] found that therapist characteristics, such as empathy and warmth, predicted therapeutic gain.

Best practice for treatment of sex offender includes assessment-based treatment. Treatment needs and risk assessment are recommended to determine the amount of treatment needed, to identify individual treatment targets, and to identify factors that may facilitate and inhibit treatment progress. Sex offender treatment is most often delivered through a group format, including psychoeducational content and opportunities for processing. The frequency and duration of treatment should be consistent with the risk level and treatment needs identified in the initial assessment. Recent studies have found a complex relationship between denial and sexual recidivism.[36] Consistent with this recent field research and practice, sex offender treatment programs should include offenders in treatment who deny, minimize, or take only partial responsibility of their sexual offending, with the goal to engage and motivate the offender to begin to accept responsibility and to recognize the benefits of treatment. Treatment plans are developed collaboratively with the patient and are updated to reflect the treatment process and change in risk over time. Continuity of care and communication with others involved in the person's care is essential in effective risk management.

TABLE 1.

Components of a Psychosexual Assessment

Category	Information Gathered
Psychosocial history	Development, family, relationships, sexual history, criminal history, sexual offending history
Psychiatric history	Major mental illnesses, personality traits, paraphilic disorders
Substance use	Role of substance on sexual behavior
Medical history	Medical conditions that relate to sexuality and sexual functioning
Legal history	History of previous offenses including sexual offenses
Offender's account of version of sexual offense	Defendant's report given during evaluation
Official account of sexual offense	Police, victim, witness reports
Response to treatment	Treatment and outcome history
Static risk factors	Evidence-based factors related to reoffending **(see Table 2)**
Dynamic risk factors	Evidence-based factors related to reoffending **(see Table 2)**
Assessing offender's values	Personal values; motivations to behaviors; motivation or interest in reducing likelihood of reoffending; attitude toward offending; attitude toward treatment; perception and distorted thinking regarding aspects of offending; and current level of self-insight, the offending actions, and general patterns of behavior
Diagnostic opinion	Using *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, criterion
Treatment recommendations	Risk of sex offender recidivism, role of treatment on risk

Behavioral assessment and treatment can serve to supplement therapy and the overall management of sex offenders. Behavioral treatment assists participants in learning skills to intervene on sexual arousal with the goal of suppression and effective management of deviant sexual urges and behaviors or hypersexuality. Offenders benefit from becoming proficient in several different arousal-management techniques. Behavioral treatment services should be offered to those deemed medically and clinically appropriate, such as those distressed by sexual thoughts, those whose sexual thoughts and urges interfere with their ability to function, or those whose sexual behavior is dangerous.

BIOLOGIC TREATMENT

Selective Serotonin Reuptake Inhibitors

Although the research is limited, selective serotonin reuptake inhibitors (SSRIs) have demonstrated clinical efficacy in the treatment of sexual offenders. According to a meta-analysis by Thibaut et al.,[37] the rationale for the use of SSRIs in sex offenders is based on the literature showing that enhanced central serotonin activity reduced sexual

TABLE 2.

Examples of Static and Dynamic Factors to Evaluate Risk

Static risk factors
Age
Ever lived with lover for 2 years or more
Criminal history (history of sex offenses)
Prior sexual offenses
Prior nonsexual violence
Dynamic risk factors
Hostility toward women
General social rejection
Sexual preoccupation
Cooperation with supervision

Adapted from de Vries et al.[71] and Helmus et al.[72]

behavior in animal models, the clinical literature showing SSRIs are effective in obsessive-compulsive behaviors, the clinical literature showing SSRIs decrease impulsivity, the efficacy of SSRIs in comorbid psychiatric illnesses that are common in sex offenders, and the hypothesis that chronic administration of SSRIs increases the neuroplasticity of the brain through brain-derived neuroprotective factor. These authors concluded that using SSRI to treat patients with paraphilias (including sex offenders with paraphilias) was not favorable; however, the review did suggest that the lack of efficacy might be related to the heterogeneity of the samples as case reports did report favorable results.[37] Given the low side-effect profile of SSRIs, they are commonly used as first-line biologic treatment in sex offenders.

Surgical Castration

Surgical castration of sex offenders is a largely a historical treatment.[37] The treatment is rarely used today due to the availability of chemical agents, which achieve castration that is reversible and without the disfigurement incurred with surgery.

Testosterone-Lowering Medications

Sex offenders who do not respond to conventional psychotherapeutic modalities and SSRI treatment may be candidates for testosterone-lowering medications. Such medications in the US include medroxyprogesterone (an antiandrogen) and leuprolide (a gonadotropin-releasing hormone) agonist. The rationale for such treatments is based on the data that demonstrated decreased sex offender recidivism in surgically castrated men.[38] Both medroxyprogesterone and leuprolide have been shown to decrease sex offender recidivism.[37] However, both medications have serious side effects that require careful medical evaluation and monitoring.

SPECIALIZED POPULATIONS

Children and Adolescents

Researchers have estimated that people younger than age 18 years account for more than one-third of those who sexually harm other children and adolescents.[39] In the US, nearly one-half of all sexual crimes for which youth are prosecuted involve fondling or sexual touch; roughly one-third involve genital, anal, or oral penetration; and the remaining portion is made up of nonforcible sexual acts, such as genital exposure, public masturbation, or possession of child pornography.[39]

Early understanding of youth who sexually harm was based on research of adult male sexual offenders, as investigators determined that many of these men began their sexual offending behavior during adolescence.[40] Although contemporary beliefs about the nature of sexual offending stem from these early findings, support for the continuation hypothesis of sexual offending has not been substantiated by more recent findings. Firstly researchers using birth cohort data have found that more than 90% of adult sexual offenders commit their first offense after age 18 years.[41,42] Secondly, among youth who have committed sexual harm, sexual recidivism has been typically estimated at rates between 4% and 10% through age 30 years,[41,43] with one oft-cited meta-analysis finding a youth sexual recidivism rate of 7%.[44]

Although no single mental health factor is believed to be responsible for the commission of sexual harm by youth, elevated symptoms of depression and anxiety have been long been reported in etiological investigations of the population,[45-48] as well as sexual offense recidivism studies.[49-51]

A growing body of research has revealed that youth who sexually harm are a heterogeneous population across a variety of domains, including demographics, family backgrounds,[52] and mental health indicators.[46,53] It is unclear how this heterogeneity might affect treatment. For example, authors of a recent meta-analysis of sexual offender treatment found that treatment in general has been effective in reducing sexual recidivism among youth, reporting a mean reduction in recidivism of 25% across studies using a variety of comparison groups, including those with random assignment and quasi-experimental designs.[9] Although this finding is promising, there is no single, commonly practiced, sexual offender treatment for these youth. In other words, treatment of sex offenders can look different with regard to frequency, modality, and theoretical orientation. Given the wide variance in treatment across a great number of agencies and providers who serve this population, it remains unclear what might account for treatment efficacy and for whom treatment might be most effective.

Female Sex Offenders

Initially, data about sex offending were extrapolated to female offenders despite the absence of empirical evidence. Literature specific to female sex offenders started to emerge in the late 1980s, although research continues to be sparse.

There is limited research on the prevalence of paraphilic disorders and major mental illnesses in female offenders. Cortoni and Hanson[54] found a sexual recidivism rate of 1% with a 5-year follow-up period in a sample of 380 female sexual offenders. Sandler and Freeman[55] investigated women who were convicted of a "registerable" sexual offense in New York State (n = 1,466). They found the rate of sexual recidivism to be 1.8%, but 5.2% for a violent felony. In addition to gender-responsive treatment targets, traditional goals of sex offender treatment are applicable to female offenders.[56] Treatment for female sex offenders should be based on each person's treatment needs with a focus on establishing and maintaining healthy intimate relationships, increasing understanding of healthy sexual development and boundaries, developing a positive sense of self, improving assertiveness and self-sufficiency, processing traumatic experiences, and effectively regulating emotions.[57] As of this writing, there are no empirically validated, risk-assessment measures based on female sex offenders.[56]

Older Sex Offenders

As with general offending, sexual recidivism risk is lower among older people compared to younger people. For example, Levenson and Shields[58] found that people age 50 years and older who committed a sexual offense are 50% less likely to recidivate sexually compared with younger populations. Using data from eight samples (n = 3,425), Hanson[59] found that older adult sexual offenders scored lower than younger adults on the Static-99, the most widely used, empirically validated risk assessment tool in the US and Canada. Although these findings make it clear that older offenders present a lower risk of recidivism than younger offenders, the reasons for this warrant further investigation, as much remains to understood about the potential biological, neurological, and cognitive factors that might contribute to this decline in risk profile.

LEGAL ISSUES

Civil Commitment

Civil commitment laws in the US allow for convicted sex offenders to be civilly committed for treatment at the conclusion of their prison sentence.

Registration and community notification are public policies in the US designed to allow law enforcement to monitor and track sex offenders.

These laws are also known as sexually violent predator (SVP) or sexually dangerous person laws. These were initiated to ensure community safety related to sex offenders.[60] Twenty states and the District of Columbia currently have civil commitment laws.[61] Such laws were initiated in Washington State in 1990 through the Community Protection Act.[62] The United States Supreme Court upheld the constitutionality of SVP laws in *Kansas v Hendricks* (1997),[63] through which three criteria for the civil commitment of sex offenders were identified. The criteria include a history of criminal sexual behavior, a mental disorder, or personality disorder that predisposes the person to sexual violence, and the likelihood that the person will engage in sexual violence without treatment and custody. States have different legal procedures and definitions for civil commitment (eg, definition of mental abnormality, determination likelihood of reoffense). Once civilly committed, people are confined until the court finds them no longer sexually dangerous. States have different procedures for evaluation and treatment of civilly committed sex offenders, as well as differences in conditional and supervised release procedures. SVP laws are controversial due to low base rates for sexual reoffending, the use of actuarial (eg, applying group data to an individual) techniques, and generally low release rates for offenders who have been civilly committed.[64]

Registration and Community Notification

Registration and community notification are public policies in the US designed to allow law enforcement to monitor and track sex offenders and inform the community about the whereabouts of sex offenders. States are required to create and maintain a database with information related to convicted sex offenders' whereabouts and sexual offending histories (ie, a registration) and disseminate that information to the public when applicable (ie, community notification).[62] The state of Washington was the first to implement a statewide sex offender registry and community notification protocol through the Community Protection Act in 1990.[62] Sex offender registration became a federal requirement in 1994 through the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act,[65] and community notification was federally required through Megan's Law in 1996.[66] The Adam Walsh Child Protection and Safety Act (AWA)[67] of 2006 is the most recent federal legislation targeting registration and community notification. Title I of the AWA is the Sex Offender Registration and Notification Act (SORNA).[68] SORNA created a national sex offender registry, updated registration requirements, and a detailed a three-tier classification system related to risk of engaging in sexual reoffense. As of August 2017, 18

states were in full compliance with the SORNA requirements.[68]

Researchers within the field of sex offender evaluation and treatment consider registration and community notification policies to be controversial, largely due to the lack of empirical support.[62] These policies do not prevent or reduce sexual violence. In fact, these policies have unintended consequences that may increase an offender's risk and therefore compromise public safety. For instance, registration and community notification often result in social stigma, homelessness, and unemployment for sex offenders.[63] The Association for the Treatment of Sexual Abusers (ATSA) recommends that research should inform public policies related to sex offenders.[69]

ROLE OF PSYCHIATRISTS

Because paraphilic disorders are psychiatric disorders that are responsive to treatment, psychiatrists should be familiar with this patient population. In addition, because biological treatments have been shown to reduce sex offender recidivism, either through the treatment of comorbid mental illnesses or treatment of a paraphilia, psychiatrists are in a unique position to contribute to the prevention of sexual violence.

Whether or not psychiatrists choose to work with sexual offenders or patients with paraphilias, a general knowledge of this population is important. Given the prevalence of sexual offenders with a nonparaphilic mental illness and the research showing that people with paraphilias may be high consumers of psychiatric care, most general psychiatrists will encounter a paraphilic sex offender during their career.[70] The role of the psychiatrist working with such patients is to identify appropriate consultation to ensure the patient is treated with the most effective evidence-based treatment. Consultation may include a referral to a forensic psychiatrist if the patient is involved with the legal system. Forensic psychiatrists are consulted to address a variety of areas that relate to sexual offending, including aid in sentencing (eg, treatment, supervision needs), assessment of dangerousness, civil commitment, and sex offender registration.

CONCLUSION

Sexual violence is an international public health problem. Psychiatrists can serve a pivotal role in the prevention of sexual violence by the identification of people with high-risk behaviors, which include a history of sexual offending, and/or dangerous paraphilic disorders. Sex offender treatment works but it cannot be implemented if clinicians are not able to identify offenders or provide evidence-based treatment. The successful prevention of sexual violence requires concerted multidisciplinary efforts, including the skills of educated physicians.

REFERENCES

1. Chapman PD, Dube RS, Anda RF. Adverse childhood events as risk factors for negative mental health outcomes. *Psychiatr Ann*. 2007;37(5):539-64.
2. Randolph ME, Mosack KE. Factors mediating the effects of childhood sexual abuse on risky sexual behavior among college women. *J Psychol Human Sexuality*. 2006;18(1):23-41.
3. Truman LJ, Morgan ER. Criminal victimization, 2015. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/cv15.pdf. Accessed December 21, 2017.
4. Smith GS, Chen J, Basile CK, et al. The National Intimate Partner and Sexual Violence Survey (NISVS): 2010-1012 State Report. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf. Accessed December 21, 2017.
5. Colorado Sex Offender Management Board. Standards and guidelines for the evaluation, assessment, treatment, and supervision of juveniles who have committed sexual offenses. Updated November 2017. Colorado Department of Public Safety, Division of Criminal Justice. https://cdpsdocs.state.co.us/dvomb/SOMB/Standards/SAdult.pdf. Accessed December 21, 2017.
6. Lussier P, Davies G. A person-oriented perspective on sexual offenders, offending trajectories, and risk of recidivism: a new challenge for policymakers, risk assessors, and actuarial prediction? *Psychol Public Policy Law*. 2011;17:530-561.
7. Hanson KR, Morton-Bourgon EK. The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. *J Consult Clin Psychol*. 2005;73(6):1154-1163. doi:10.1037/0022-006X.73.6.1154.
8. Helmus L, Hanson KR, Thornton D, Babchisin MK, Harris JA. Absolute recidivism rates predicted by Static-99R and Static2002R sex offender risk assessment tools vary across samples: a meta-analysis. *Crim Justice Behav*. 2012;39(9):1148-1171. doi:10.1177/0093854812443648.
9. Kim B, Benekos JP, Merlo VA. Sex offender recidivism revisited: a review of recent meta-analysis on the effects of sex offender treatment. *Trauma Violence Abuse*. 2016;17(1):105-117. doi:10.1177/1524838014566719.
10. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, VA: American Psychiatric Publishing; 2013.
11. Hanson KR, Morton-Bourgon EK. The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. *J Consult Clin Psychol*. 2005;73:1154-1163. doi:10.1037/0022-006X.73.6.1154.
12. Ahlers CJ, Schaefer GA, Mundt IA, et al. How unusual are the contents of paraphilias? Paraphilia-associated sexual arousal patterns in a community-based sample of men. *J Sexual Med*. 2011;8:1362-1370. doi:10.1111/j.1743-6109.2009.01597.x.
13. Langstrom N, Seto MC. Exhibitionistic and voyeuristic behavior in a Swedish national population survey. *Arch Sexual Behav*. 2006;35(4):427-435. doi:10.1007/s10508-006-9042-6.
14. Abel GG, Becker JV, Cunningham-Rathner J, Mittleman M, Rouleau JL. Multiple paraphilic diagnoses among sex offenders. *Bull Am Acad Psychiatry Law*. 1988;12(2):153-168.
15. Dietz PE, Hazelwood RR, Warren J. The sexually sadistic criminal and his offenses. *Bull Am Acad Psychiatry Law*. 1990;18(2):163-178.
16. Chesterman P, Sahota K. Mentally ill sex offenders in a regional security unit. I: psychopathology and motivation. *J Forensic Psychiatry*. 1998;9:150-160.
17. Dunseith NW Jr, Nelson EB, Brusman-Lovins LA, et al. Psychiatric and legal features of 113 men convicted of sexual offenses. *J Clin Psychiatry*. 2004;65(3):293-300.
18. Fazel S, Sjostedt G, Langstrom N, et al. Severe mental illness and risk of sexual offending and men: a case-control study based on Swedish national registers. *J Clin Psychiatry*. 2007;68:588-596.
19. Fazel S, Hope T, O'Donnell I, Jacoby R. Psychiatric demographic and personality characteristics of elderly sex offenders. *Psychol Med*. 2002;32: 219-226.
20. Kafka M. Axis I psychiatric disorders, para-

philic sexual offending and implications for pharmacological treatment. *Isr J Psychiatry Relat Sci*. 2012;49(4):255-261.
21. Bogaerts S, Daalder A, Vanheule S, Desmet M, Leeuw F. Personality disorders in a sample of paraphilic and nonparaphilic child molesters. *Int J Offender Ther Comp Criminol*. 2008;52:21-30. doi:10.1177/0306624X07308261.
22. Schroeder M, Iffland JS, Hill A, Berner W, Briken P. Personality disorders in men with sexual and violent criminal offense histories. *J Pers Disord*. 2013;27(4):519-530. doi:10.1521/pedi_2012_26_050.
23. Hoertel N, Le Strat Y, Schuster JP, Limosin F. Gender differences in firesetting: results from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). *Psychiatry Res*. 2011;190(2):352-358. doi:10.1016/j.psychres.2011.05.045.
24. Bonta J, Andrews AD. Risk-need-responsivity model for offender assessment and treatment, 2007-06. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx. Accessed December 21, 2017.
25. Raymond NC, Coleman E, Ohlerkin F, Christenson GA, Miner M. Psychiatric comorbidity in pedophilic sex offenders. *Am J Psychiatry*. 1999;156(5):786-788.
26. Langstrom N, Sjostedt G, Grann M. Psychiatric disorders and recidivism and sexual offenders. *Sex Abuse*. 2004;16:139-150. doi:10.1177/107906320401600204.
27. Andrews DA, Bonta J, Wormith J. The risk-need-responsivity (RNR) model. *Crim Justice Behav*. 2011;38:735-755. doi:10.1177/0093854811406356.
28. Hanson RK, Harris AJ, Scott TL, Helmus L; Public Safety Canada. Assessing the risk of sexual offenders on community supervision: the Dynamic Supervision Project. https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/ssssng-rsk-sxl-ffndrs/index-en.aspx. Accessed January 23, 2018.
29. Yates MP, Prescott SD, Ward T. A*pplying the Good Lives and Self-Regulation Models to Sex Offender Treatment: A Practical Guide for Clinicians.* Brandon, VT: Safer Press; 2010.
30. Hanson RK. Stability and change: dynamic risk factors for sexual offenders. In Marshall WL, Fernandez YM, Marshall LE, Serran GA, eds. *Sexual Offender Treatment: Controversial Issues.* Chichester, England: Wiley; 2006:17-31.
31. Hanson RK, Harris AJR. Where should we intervene? Dynamic predictors of sex offender recidivism. *Crim Justice Behav*. 2000;27:6-35.
32. Andrews DA, Bonta J. *The Psychology of Criminal Conduct*. Cincinnati, OH: Anderson; 1994.
33. Hanson RK, Bourgon G, Helmus L, Hodgson S. The principles of effective correctional treatment also apply to sexual offenders: a meta-analysis. *Crim Justice Behav*. 2009;36:865-891.
34. Wong S, Witte T, Nicholaichuk PT. Working alliance: utility in forensic treatment program. Ottawa, Canada: Nation Health Services Conference; 2002.
35. Marshall LW, Serran AG, Moulden H, et al. Therapist features in sexual treatment: their reliable identification and influence on behaviour change. *Clin Psychol Psychother*. 2002;9(6):395-405.
36. Duncan BL, Miller SD, Wampold BE, Hubble MA. *The Heart and Soul of Change: Delivering What Works in Therapy*. Washington, DC: American Psychological Association Press; 2010.
37. Thibaut F, De La Barra F, Gordon H, Cosyns P, Bradford JM. The World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for the biological treatment of paraphilias. *World J Biol Psychiatry*. 2010;11(4):604-655. doi:10.3109/15622971003671628.
38. Stone E, Thurston G. Castration for sexual offenders. *Medico-Legal J*. 1959;27:136-139.
39. Finkelhor D, Ormrod R, Chaffin M. Juveniles who commit sex offenses against minors. US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, 2009. https://www.ncjrs.gov/pdffiles1/ojjdp/227763.pdf. Accessed December 28, 2017.
40. Abel GG, Osborn CA, Twigg DA. Sexual assault through the life span: adult offenders with juvenile histories. In: Marshall WL, Hudson SM, eds. *The Juvenile Sex Offender*. New York, NY: Guilford Press; 1993:104-117.
41. Lussier P, Blokland A. The adolescence-adulthood transition and Robins's continuity paradox: criminal career patterns of juvenile and adult sex offenders in a prospective longitudinal birth cohort study. *J Crim Justice*. 2014;42(2):153-163.
42. Zimring FE, Jennings WG, Piquero AR, Hays S. Investigating the continuity of sex offending: evidence from the second Philadelphia birth cohort. *Justice Quart*. 2009;26(1):58-76.
43. Lussier P, van Den Berg C, Bijleveld C, Hendriks J. A developmental taxonomy of juvenile sex offenders for theory, research, and prevention: the adolescent-limited and the high-rate slow desister. *Crim Justice Behav*. 2012;39(12):1559-1581.
44. Caldwell MF. Study characteristics and recidivism base rates in juvenile sex offender recidivism. *Int J Offender Ther Comp Criminol*. 2010;54(2):197-212. doi:10.1177/0306624X08330016.
45. Becker JV, Kaplan MS, Tenke CE, Tartaglini A. The incidence of depressive symptomatology in juvenile sex offenders with a history of abuse. *Child Abuse Neglect*. 1991;15(4):531-536.
46. Boonmann C, Nelson RJ, DiCataldo F, et al. Mental health problems in young male offenders with and without sex offences: a comparison based on the MAYSI-2. *Crim Behav Mental Health*. 2016;26(5):352-365. doi:10.1002/cbm.1961.
47. Hunter JA, Figueredo AJ, Becker JV, Malamuth, N. Non-sexual delinquency in juvenile sexual offenders: the mediating and moderating influences of emotional empathy. *J Fam Viol*. 2007;22(1):43-54. doi:10.1007/s10896-006-9056-9.
48. Jencks JW, Burton DL. The role of trait anxiety in reducing the relationship between childhood exposure to violence/victimization and subsequent violent behavior among male delinquent youth. *Int J Offender Ther Comp Crim*. 2013;57(8):985-995. doi:10.1177/0306624X12448856.
49. Worling JR, Bookalam D, Litteljohn A. Prospective validity of the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR). *Sex Abuse*. 2012; 24(3):203-223. doi:10.1177/1079063211407080.
50. Worling JR, Curwen T. Adolescent sexual offender recidivism: success of specialized treatment and implications for risk prediction. *Child Abuse Neglect*. 2000;24(7):965-982.
51. Worling JR, Langstrom N. Risk of sexual recidivism in adolescents who offend sexually: correlates and assessment. In: Barbaree HE, Marshall WL, eds. *The Juvenile Sex Offender*. 2nd ed. New York, NY: Guilford Press; 2006:219-247.
52. Christiansen AK, Vincent JP. Characterization and prediction of sexual and nonsexual recidivism among adjudicated juvenile sex offenders. *Behav Sci Law*. 2013;4(31):506-529. doi:10.1002/bsl.2070.
53. Harris AJ, Walfield SM, Shields RT, Letourneau EJ. Collateral consequences of juvenile sex offender registration and notification: results from a survey of treatment providers. *Sex Abuse*. 2016;28(8):770-790. doi:10.1177/1079063215574004.
54. Cortoni F, Hanson KR. A review of the recidivism rates of adult female offenders. May, 2005. http://www.csc-scc.gc.ca/research/092/r169_e.pdf. Accessed December 28, 2017.
55. Sandler JC, Freeman NJ. Female sex offender recidivism: a large- scale empirical analysis. *Sex Abuse*. 2009;21(4):455-473. doi:10.1177/1079063209347898.
56. Giguere R, Bumby K; Center for Sex Offender Management. Female sex offenders. http://www.csom.org/pubs/female_sex_offenders_brief.pdf. Accessed December 28, 2017.
57. Elliott AJ, Kayser DN, Greitemeyer T, et al. Red, rank, and romance in women viewing men. *J Exp Psychol*. 2010;139(3):399-417. doi:10.1037/a0019689.
58. Levenson JS, Shields RT; National Institute of Justice. Sex offender risk and recidivism in Florida. http://www.floridaatsa.com/Levenson&Shields_FloridaRiskRecidivism2012.pdf. Accessed December 28, 2017.
59. Hanson RK. Does Static-99 predict recidivism among older sexual offenders. *Sex Abuse*. 2006;18(4):343-355. doi:10.1177/107906320601800403.
60. Grudzinzkas AJ, Brodsky DJ, Zaitchik M, Fe-

doroff JP, DiCataldo F, Clayfeld JC. Sexual predator laws and their history. In Saleh FM, Grudzinskas AJ, Bradford JM, Brodsky DJ, Appelbaum J, eds. *Sex Offenders: Identification, Risk Assessment, Treatment and Legal Issues.* New York, NY: Oxford University Press; 2009:386-411.

61. Association for the Treatment of Sexual Abusers. Civil commitment of sexual offenders: introduction and overview. www.atsa.com/sites/default/files/%5BCivil%20Commitment%5D%20Overview.pdf. Accessed January 23, 2018.
62. Washington Community Protection Act of 1990, Wash §71.09.010-.902 (Supp. 1990-91).
63. *Kansas v Hendricks*, 521 US 346 (1997).
64. Association for the Treatment of Sexual Abusers. Controversial issues with sexually violent predator (SVP) laws: a guide for professionals. www.atsa.com/.../%5BCivil%20Commitment%5D%20Controversial%20Issues_0.pdf. Accessed January 23, 2018.
65. Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act, 42 USC §14071 (1994).
66. Megan's Law. Pub L No. 104-145 (1996).
67. The Adam Walsh Child Protection and Safety Act. Pub. L. No. 109-248 (2006).
68. Sex Offender Registration and Notification Act (SORNA). State and territory implementation progress check. https://www.smart.gov/pdfs/SORNA-progress-check.pdf. Accessed January 23, 2018.
69. The Association for the Treatment of Sexual Abusers. Informed policy. http://www.atsa.com/policy. Accessed January 23, 2018.
70. Marsh JP, Odlaug LB, Thomarios N, et al. Paraphilias in adult psychiatric inpatients. *Ann Clin Psychiatry*. 2010;22:129-134.
71. de Vries Robbé M, Mann RE, Maruna S, Thornton D. An exploration of protective factors supporting desistance from sexual offending. *Sex Abuse*. 2015;27(1):16-33. doi:10.1177/1079063214547582.
72. Helmus L, Thornton D, Hanson RK, Babchishin KM. Improving the predictive accuracy of Static-99 and Static-2002 with older sex offenders: revised age weights. *Sex Abuse*. 2012;24:64-101. doi:10.1177/1079063211409951.