

There lies before us, if we choose, continual progress in happiness, knowledge, and wisdom. Shall we, instead, choose death, because we cannot forget our quarrels? We appeal as human beings to human beings: Remember your humanity, and forget the rest." – Bertrand Russell, The Bertrand-Einstein Manifesto

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- ✓ Barbaric Conditions in NJ SOCC
- ✓ Different Backgrounds: Different Perceptions of SO Policies
- ✓ SOCC: A Tale of 3 States
- & Many more to come!

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**Just When You Thought Things Could Not Get Any More Surreal...**

**Legionnaires Disease???**

by Cyrus Gladden

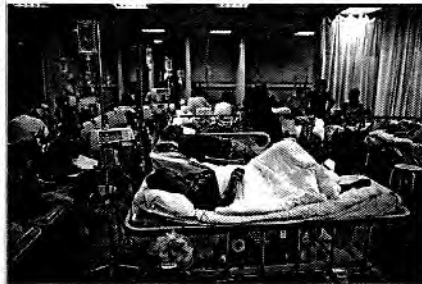
For at least the last ten years, some confinees at the High Security MSOP-Moose Lake (ML) facility have had symptoms of either an undiagnosed allergy or a low-grade upper respiratory infection. During this period, complaints to health services were either ignored or simply shrugged off as something the complaining individual would have to endure until, it was conjectured, such symptoms would fade away on their own. However, in most cases, such symptoms did not fade away but turned out to be chronic. Still, Health Services personnel in the MSOP-Moose Lake facility did essentially nothing to diagnose the condition, increasingly terming it an allergy of unknown cause. Over-the-counter symptom relief medications intended to quell symptoms of allergies or colds seemed to have little or no effect on this condition.

The Covid-19 pandemic occurred in the heart of this period. The first wave of Covid-19 virus infection was severe. As everywhere else, many were stricken fairly suddenly and impacted severely. MSOP-ML Health Services staff acted quickly, imposing room quarantines on those exhibiting Covid symptoms. Within days, the number of those impacted badly grew rapidly. Simultaneously, testing for the Covid-19 virus became available, with results available as quickly as 24 hours post sample swabbing. The results confirmed that a fairly large number of MSOP-ML confinees were infected with the Covid-19 virus. Most with positive test results either had already developed suspicious symptoms or developed them within a day or two post-test. By this time, some of those first stricken were bedridden by their symptoms. The ferocity of that virus caused the prognosis for some of those individuals to be in grave doubt.

Given the transmissibility of that virus, a decision was made to open two living units in MSOP-ML not then in use and to designate them as medical quarantine units for the infected. Mostly, those confined in these quarantine units were merely monitored to see whether individuals suffering from that infection would eventually recover to a point considered no longer capable of passing on the infection, or whether their condition would worsen markedly. Those deemed no longer an infective threat to others were returned to their regular living units; those in substantially worse condition were temporarily transferred to hospitals as space became available. Three individuals died as a direct result of that Covid-19 first wave. Fortunately, even over the ensuing additional Covid-19 waves, involving at least three additional Covid-19 virus variants, no further victims of the infection died.

During all of this follow-on period, stretching right up to the present, the presumptive method of handling the possibility of a further Covid-19 outbreak remained the immediate quarantining

or anyone who presented with symptoms thought to comprise a reason to suspect a Covid-19 infection. As it happened, however, particularly in light of the less-lethal Covid-19 variants, the difference between such Covid-19 symptoms and symptoms of various variants of common cold virus infections became more attenuated and uncertain. Erring on the side of caution, however, an individual typically would remain in quarantine until a swab-base test returned a finding of no Covid-19 viral involvement. As a result, a term of quarantine would typically last anywhere between two to ten days for individuals who had not actually had Covid-19.



In the meantime, application of a standing MSOP-ML procedure resulted in all of the individual's possessions being packed up by staff and transferred to storage. In that status, such possessions would usually be searched through and any items found that did not fully comport with even the smallest of rules of the facility or, in the aggregate, merely transgressed MSOP-ML's small limit on individuals' belongings, were impounded. Some of these were confiscated (expropriated), and the rest were simply forced to be sent out of the facility without possibility of return. Even though MSOP proclaims that it is a treatment system, this set of protocols is effectively identical with prison procedures and picky standards.

As a result, word spread throughout the facility that the penalty for telling Health Service personnel that one had symptoms of a cold or flu would very likely be as much as ten days of confinement in a quarantine unit run very much like a prison segregation unit and exposure to loss of property that, albeit nonstandard or slightly over-limit, served a useful purpose in a handy way with no harmful aspect. A great disincentive to reporting such symptoms to Health Services developed, creating a false impression that living unit, many bouts occurred daily of coughing, sneezing, sore throats, low fevers and even flu-like vomiting and/or diarrhea. These bouts continue to the present moment, and in the last three months have stricken far more individuals than at any time since the first Covid-19 wave. Yet even though quite a few individuals have been tested for Covid-19, very few among them have had a positive test result.

Something else, something undiagnosed, is impacting too many individuals to be ignored. This has been happening just as much to those who have conscientiously accepted vaccinations against RSV, influenza (in its currently common variants), pneumonia (bacterial, viral, and fungal), as well as against the latest variants of Covid-19 itself. Hence, any of these cannot be considered likely culprits for these persistent and varying symptoms. Indeed, other oddball symptoms for which no diagnoses have been reached, such as extreme joint and muscle pains, weird misbehavior of nerves resembling pains, tingling, and numbness in varying body locations, and certain allergy symptoms, including, in at least one individual, an irritating skin rash without apparent cause and which does not appear responsive to any treatment tried to date.

Again, as soon as Covid-19 is ruled an unlikely cause, Health Services personnel seem to lose interest in further attempts at diagnosis or treatment. Instead, as ever, they simply counsel the individual to wait and see if the problem goes away. When it does not, and the individual complains about it again, they tell him that the passage of time meanwhile makes them believe that it is a new problem, which they again tell him to wait to see if it simply goes away. Those who have taken their unaddressed health complaints to a higher authority, such as the hotline for complaints of inadequate health care in state-run facilities, promptly find themselves given the quarantine-and-property-removal treatment, in what, intentionally or otherwise, serves as an effective retaliation for having the temerity to gain a second opinion on the condition complained about.

Lacking any cogent explanation for what is happening to them, those suffering any of these varying symptoms in MSOP-ML have mentally reached widely for some credible explanation of their own. Some have considered some unusual allergen. The weather changes caused by local manifestations of global warming make this at least somewhat plausible. Others believe that some fungus may be the source. In support of this, they point to a surprising number of different types of location in the facility where fungus that appears to be black mold has taken up residence, such as commonly likely places as showers, and even such unexpected places as cranies in the kitchen. Still others fault the air handling system, filters and other parts of which are since the construction of the buildings over a quarter century ago – is considered a possible haven for some pathogen.

As it happens, at just this moment of wide speculation, MSOP's administrative parent agency, Direct Care and Treatment (DCT), has just issued (September 3, 2024) new rules, by DCT Policy Number: 310-1045, for all DCT facilities, including those of MSOP, for "practices to minimize, or

eliminate, if possible, the risk of Legionella growth and exposure to clients," among others. This new policy replaces one that was instituted just last year. That previous policy was not available to this writer at press time for this *tLP* edition. Hence, specific changes cannot be determined at this time.

"Legionella" is "the name of the genus of bacteria that was subsequently identified as the causative pathogen associated with the 1976 outbreak of disease at the American Legion convention in Philadelphia. Legionella are common aquatic bacteria found in natural and building water systems and in some soils," according to this new Policy. This fails to mention that the 1976 outbreak was responsible to a micro-epidemic among attendees at that convention, killing at least 29 and rendering at least 153 more gravely ill. A least under certain conditions, including those of inadequate sanitation response to the possible presence of this bacterium, it can be a surreptitiously waiting killer of humans, especially those constrained to remain in buildings where it lurks, just waiting for conditions to ripen into an explosion of Legionella spores like that which spewed out of the air handling system in the convention hall in that 1976 outbreak over the heads of those unsuspecting attendees. All it took was just the unchecked gathering of some water condensate in that air handling system. That created an ideal environment for "amplification" of the bacteria, as the bacteria themselves, living, dying, and becoming nutriment for succeeding generations of more of the same bacteria, quickly turn into a thin, gelatinous substance known as "biofilm." Even just the "restart of [a] cooling tower each year" can prompt such explosive bacterial growth and make the resulting peril of "Legionnaire's Disease" exponentially more likely than otherwise. "Legionnaire's Disease" is defined by the Policy as "a serious type of pneumonia caused by Legionella" bacteria. The new policy identifies a staggering array of "...components and building systems within DCT that have the potential to grow Legionella:

- (a) hot and cold water storage tanks;
- (b) water heaters;
- (c) water softeners;
- (d) pipes (insulation and sizing)/valves/fittings;
- (e) water filters;
- (f) decorative fountains or water features;
- (g) showerheads, electronic/sensor faucets, faucet flow restrictors (1 gallon/minute or less) and hoses;
- (h) non-steam misters/atomizers/humidifiers;
- (i) saunas or hot tubs;
- (j) eyewash stations and showers;
- (k) ice machines and water bottle filler devices;
- (l) deadlegs/dead ends and stagnant areas;
- (m) cooling towers; and/or
- (n) medical devices (Continuous Positive Airway Pressure (CPAP) machines, nebulizers, oxygen humidifiers, etc.)."

Except for items (f) and (i), MSOP-ML has instances of each of these. Interestingly, by focusing on equipment involved in water

handling, the policy does not mention air handling units. In the 1976 fatal outbreak mentioned above, air handling equipment was the specific location of the water that condensed and stagnated, providing an ideal place for the deadly biofilm to grow.

The policy cites a number of risk factors for legionella infection. Among these are the following, which either are now affecting or at some point may affect some MSOP-ML confinees:

- (1) recent surgery, intubation, mechanical ventilation;
- (2) chronic lung disease, such as emphysema or Chronic Obstructive Pulmonary Disease (COPD);
- (3) aspiration history or presence of nasogastric tubes;
- (4) use of respiratory therapy equipment;
- (5) systemic malignancy;
- (6) immunosuppressive diseases, treatments and medications;
- (7) underlying illness, such as diabetes, renal failure or hepatic failure;
- (8) smoker (by history);
- (9) history of heavy drinking;
- (10) being male; [or]
- (11) being over 50 years old.

This is not to say that individuals without such risk factors cannot catch Legionnaires' Disease; in fact, they can. It only means that those with the foregoing risk factors or others should engage in self-monitoring to determine whether they have any symptoms (typically respiratory) that are possible signs of such an infection. Fortunately, as the policy notes, there is now a urine antigen test available to detect legionella bacteria in the human body. Best practice guidelines set forth by the CDC indicate the symptoms/circumstances under which that test is called for. So MSOP-ML Health Services personnel can and should provide that test where those guidelines call for it.

Described facility personnel are required under the policy to "collaborate to complete an annual risk assessment" for the facility identifying areas and devices having "potential risk to promote the growth or spread of Legionella." The report they generate is then reviewed by the Safety and Infection Prevention and Control Committees. The facility (in this case, MSOP-ML) also keeps a copy of this report, designated the "Legionella Building Risk Assessment (310-1045a) form on-site for three years.

Under the policy, each local facility, including ours, is tasked with a wide array of ongoing control measures, notably including:

- (1) conducting annual inspection, cleaning, and flushing of water heaters (or contract maintenance) to ensure thermostats are functional and to remove sediment, scaling, biofilm;
- (2) changing and dating water filters according to manufacturer's guidelines on all water filtration systems;
- (3) flushing areas or devices (i.e. eyewash or drenching showers) at least monthly where water may stagnate due to limited usage;
- (4) maintaining the cleanliness of (or contracted maintenance for) furnace humidifiers;

(5) following manufacturer's guidelines for the internal and external cleaning, sanitizing of removable parts (spouts, grate) and changing of filters in ice machines as well as water bottle fillers, and documenting completion of tasks onsite; and cleaning automatic dispensing ice machines in accordance with the checklist of the Ice Machine Cleaning Log;

(6) using a biocide or periodic flushing of the facility water system with a return temperature of 140°F (60°C) due to regulation and scalding risk of vulnerable populations as an alternative for maintaining water temperatures outside of the range of amplification (77°F to 122°F); and

(7) (specifically referring to MSOP-ML): monitoring cooling towers or evaporative condensers when in operation according to current industry standards and documenting all heterotrophic colony counts and high-risk event interventions.

In addition, items requiring "daily monitoring and maintenance by housekeeping or designated staff" include:

"(1) minimizing scale and corrosion on faucets, drinking fountains, shower heads, etc. by using disinfectants as needed with pH ranges of 6.5-8.5 to decrease the risk of biofilm;

(2) minimizing the use of aerosol-generating devices such as water diffusers, faucet aerators, and humidifiers;

(3) following manufacturer's guidelines for spa/whirlpool bath cleaning; and

(4) ensuring all hoses (housekeeping sinks, shower hoses, etc.) are stored in a drainage position to prevent stagnation of water."

It is clear from the foregoing that Direct Care and Treatment takes prevention of a Legionnaires' Disease outbreak very seriously. In addition to DCT and Health System Chief Executive Office Marshall Smith, the policy has been reviewed and approved by Dr. KyleeAnn Stevens, M.D., Executive Medical Director of DCT.

At press time, it is not yet known what steps Health Service in MSOP-ML is or will be taking to identify, treat, and prevent any infections of Legionnaires' Disease.

There is no reason to specifically believe that what is currently at large throughout MSOP-ML as a respiratory infection is or includes Legionnaire Disease. That infection is usually quite severe; were it already infecting individuals here, it very likely would already have hospitalized at least some. Nonetheless, that disease, if contracted by someone already adversely impacted by other respiratory illnesses or circumstances (see list above), it could literally mean the difference between life and death, especially if not immediately identified and treated aggressively. Under present circumstances especially, therefore, vigilance by everyone is the only sound course.

Each confinee in the MSOP-ML facility should do his part to pay attention to conditions that may provide a growing environment for Legionella bacteria and to report such conditions to the facility Director, Terry Kneisel. Follow-up monitoring to ensure that steps have been taken is included in this. It is, after all, our health that is most

endangered by any such neglected conditions.

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## SOCCPN Shows What Side It's On

by Cyrus Gladden

This newsletter has spoken about the Sex Offender Civil Commitment Programs Network (SOCCPN) before (see *tLP* #4:4, pp. 3-5: "Profiteers & Haters Unite in Takeover of SOCCPN in Propaganda Effort to Justify Our Permanent Confinement"). By that time, SOCC had been in existence for over 20 years. For many of those years, it claimed to see its mission as advocating for efficient treatment toward release from such confinement after a reasonably short time. In past years, its annual conferences showed this motivation and candidly reported the failings, as well as the successes of treatment efforts in such commitment facilities.

That earlier article focused on the change in focus by SOCCPN upon being co-opted by something of a takeover by one of the largest private contracting forms in the field of operation of sex offender civil commitment (SOCC) systems or facilities, Wellpath Recovery Solutions. In that takeover, Rebecca Jackson, Ph.D., then and currently Director of SVP Programs for Wellpath, became the President of SOCCPN. Had SOCCPN continued in its original focus, that takeover would have amounted to a kind of conflict of interest.

Because such contractors are paid by the number of those confined, they profit more by ensuring that their confinees are never released. Their policies and actions have been widely criticized as viciously capitalizing on perpetuating what was once envisioned as only a short-term commitment into natural-life incarceration for profits. Hence the conflict.

However, now, since the takeover, the "Mission" of SOCCPN only states that it seeks to "provide a forum to discuss and share information related to the effective management, assessment and treatment of individuals held under civil commitment laws addressing sexual violence and/or sexual dangerousness." It omits any mention whatsoever of release of committed sex offenders. Conflict resolved.

Where such contractors have won such contracts, they have immediately fired all state employees and brought in minimum-wage security personnel and only a "skeleton crew" of low-paid treatment staff, almost all of whom have been vastly under-qualified and inexperienced in the field of sex-offender treatment.

Now, SOCCPN's 25th Annual Membership Meeting agenda shows what side it's on. That meeting will be held in mid-October in San Antonio, TX. As reported in that article from four years ago, Wellpath's largest competitor in corporate-contracted operation of sex offender commitment systems, Liberty Healthcare Corporation -- this time by Ken Carabello, its Senior Vice

president -- will again conduct a session in this year's conference, titled "Political and Legal Updates." It should come as no surprise that this session focuses on case law development about the commitment process, "political themes influencing treatment and operations" in commitment systems and ways to create effective responses to legal and political challenges in order to maintain program integrity in SVP facilities across the nation." In short, this session illustrates that the new, replacement focus of SOCCPN is now in putting heads together to preserve the status quo, not to change it.

It is eye-catching that this and indeed all but two of the six presentations in this year's SOCCPN annual meeting, are closed to all but SOCCPN members. The two that are not limited to membership-only attendance, respectively: (1) concern GPS use for those released from confinement (presented by MSOP administrators Scott Halvorson and Kelly Esser); and (2) simply report annual statistics from reporting SOCC programs, which will in any event be made available to the public. Membership is available only to approved "professionals working on, or affiliated with civil commitment or treatment programs designed to prevent sexual offending -- implicitly, through confinement of former sex offenders.

Increasing the secrecy of their discussions, SOCCPN bans media from attending the annual meeting at all and prohibits all photography and "recordings of any kind." Two of the members-only presentations will be given by MSOP administrators: "What Shapes Our Perspective," by Lauren Herbert and Cassandra Lind, and "Developing Professional Resilience when Working with Individuals who Sexually Offend," by Skye Brister Korby and Kathryn Lockie.

In sum, SOCCPN has now demonstrated that it is firmly in the control of those who seek to perpetuate SOCC just exactly as it now is, rather than to consider even reform of, much less an end to SOCC.

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## B4QR Function Explained

Russell Dick, "Preface by Russell Dick, B4U-Act Chairperson and Co-Founder," *B4U-Act Quarterly Review*, Vol. 3, No. 1 (Winter 2023), p. 3

**Text Excerpt:** "...The B4QR journals demonstrate the contributions of researchers to expand our collective knowledge and understanding of persons who feel affection and attraction to minors. Our reviewers' critical assessments of the research help to highlight some of the shortcomings within the research, as well as potential avenues for additional research. B4U-ACT appreciates all the researchers who are risking exploring the previously unresearched aspects of the lived experience of persons who are minor-attracted. We urge our readers to support this research and speak out for academic freedom."

Allen Bishop, "Introduction by Allen Bishop, Editor-in-Chief," *B4U-Act Quarterly Review*, Vol. 3, No. 1 (Winter 2023), p. 4

**Text Excerpt:** "...The many virtues of the publications reviewed in this journal issue, and especially the concern given by the authors to the dignity of minor-attracted people (MAP), is a testament to the great progress made by this field of research in the past few years. Our team is excited to witness the coming-of-age of this research paradigm that treats MAP well-being and destigmatization as central foci. It is no hyperbole to speak of the current era as the Golden Age of MAP research!"

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## Review: Seto's Orientation Conclusion Confirmed

**B4QR Review:** Mundy, C., "10Years Later: Revisiting Seto's (2012) Conceptualization of Orientation to Sexual Maturity among Pedohebeophilic Persons", (*The Canadian Journal of Human Sexuality*: <https://doi.org/10.3138/cjhs.2022-0006>, *B4U-Act Quarterly Review*, Vol. 3, No. 1, 17-22 (Winter 2023).

**Review Excerpts:** [p. 17:] "This study by Crystal Mundy uses data from the author's 2020 dissertation on the resiliency of child-attracted persons to test the validity of Michael Seto's thesis, according to which sexual attraction to minors can be construed as an age-based sexual orientation.<sup>7</sup> According to Seto, an attraction can be considered a sexual orientation if it displays three key features: early age of onset, feelings of romance and love, and stability across time.

...Citing Finkelhor (1986), Mundy demonstrates how sexual attraction to minors has historically been perceived as a 'deviant sexual interest, one that develops out of traumatic childhood experiences and/or poor parenting practices,' leading to therapeutic methods rooted in 'removal and/or reduction of the attractions'.

Instead, Mundy cites studies showing that attraction to minors should be approached through acceptance and strengths-base practices that inculcate resilience and self-efficacy<sup>8</sup>, as attempts to reduce or eliminate attraction to minors have not proven effective or beneficial to minor-attracted people<sup>9</sup>. Citing Cantor and McPhail, (2016), the author writes 'if sexual attraction to children is unchangeable, then treatment needs to focus on behavioral change and how to enhance well-being'...

[pp. 17-18:] To test the applicability of Seto's three essential criteria of sexual orientation to the case of minor-attracted persons, Mundy conducted both quantitative and qualitative analyses. The author approached the B4U-ACT and Virtuous Pedophiles forums to recruit 116 minor-attracted persons who had never engaged in sexual contact with minors. The group consisted of 97 males, 10 females, and 9 others. Ages ranged from 18 to over 65,

but two-thirds were 35 and under. Nearly 90% were white, almost two-thirds were single, and almost two-thirds were non-religious. Among the 116 individuals who completed the survey, 23 agreed to also participate in an interview-based study. The interview questions covered a variety of topics, such as sexual identity, discovery of attraction, involvement with children, social support, and stigma.

[p. 18:] For the quantitative analysis, Mundy used a modified version of the Kinsey Scale (normally used for gender-based orientation) to measure the participants' age-based orientation. The response options ranged from 1 (exclusively attracted to adults) to 5 (exclusively attracted to minors). Mundy used a similar 5-point scale to measure gender-based orientation. She also used a revised version of the 59-question 'Sexual Life and Sexual Behavior Questionnaire (SLSB) to determine various aspects of the participants' sexual lives, such as frequency of sexual behaviors, sexual and gender identity, age of onset of sexual arousal, and degree of sexual attraction to minors.

### Male/Female

Exclusive Males = 17  
Mostly Makes = 13  
Both Males and Females = 24  
Mostly Females = 19  
Exclusively Females = 37

### Adult/Minor (Kinsey-R)

Exclusively Adults = 1  
Mostly Adults = 2  
Both Adults and Minors = 36  
Mostly Minors = 45  
Exclusively Minors = 27

### Sexual Maturity (SLSB-R)

Tanner Stage 1 = 63  
Tanner Stage 2 = 34  
Tanner Stage 3 = 14  
Tanner Stage 4 = 3  
Tanner Stage 5 = 1

The revised SLSB included 'a visual-based question that assessed participants' preferred Tanner Stage' (p. 447). Tanner stages measure the degree of physical development of individuals. They are often used to categorize individuals by age of attraction. A Stage-1 Tanner-stage applies to pre-pubescent children, and thus reflects a pedophilic attraction. Stages 2 (early pubescent) and 3 (late pubescent) reflect a hebephilic attraction. Stage 4 applies to adolescents and reflects an ephebeophilic attraction, while Stage 5 is the final stage of sexual maturity and corresponds to teleiophilia. Given the paucity of participants attracted to Tanner Stages 4 and 5, Mundy did not include them in her analysis.

These measurements resulted in the classification of the 116 participants along three spectrums of attraction: male/female, adult/minor, and degree of sexual maturity. The breakdown was as follows:

[pp. 18-19:] The results of the quantitative analysis supported all three of Seto's markers of sexual orientation. Concerning the

'romantic attraction' criterion, 64.1% of participants said that they had been 'in love with a child' in their life, and almost all (98.8%) identified that they 'loved children.' Concerning the 'early onset' criterion, the vast majority of participants reported discovering their attraction during childhood or around puberty.<sup>10</sup> Finally, the 'stability across time' criterion was assessed using the age-of-onset and information about age. Mundy noted that 'no participants experienced a cessation of their attractions across time, clearly meeting the requirement of sustained attraction.' (p. 453)

[p.19:] The qualitative analysis yielded similar results. With the data collected from her 23 interviews, Mundy conducted a thematic analysis<sup>11</sup> which identified three key themes: 'Sexual Development During Adolescence and Puberty,' 'Differing Attraction Components,' and 'Exclusivity of Attraction.' On the first theme, all but one participant said they identified and recognized their attraction before the age of 18, most often during early adolescence and puberty. Many recognized two stages in the process: an initial, typically vague recognition, followed later by a recognition that the attraction was 'not growing with them.'

On the second theme, different components of attraction were identified by the interviewees, which consisted not only of physical components -- e.g., small frame, larger eyes, and lack of body hair -- but also more general components about the nature of children, 'including their innocence and ability to engage in the world completely and be spontaneous' (p. 451). Four first-person testimonies are provided as concrete examples. Mundy distinguishes between 'emotional attraction' (engaging in youthful activities and working with children) and 'romantic attraction' (being in love with or wanting a personal relationship with a child). She frequently cites Martijn et al. (20290), which found that nearly three-quarters of their sample reported 'falling in love with a child during their lifetime.' The findings of Martijn et al. (2020), she concludes, 'in conjunction with the present study, clearly indicate that there is more to the attraction than simply sexual attraction' (p. 453).

Finally, on the third theme concerning exclusivity, while several participants identified an attraction to adults, it was rarely the primary attraction. For those who expressed an exclusive attraction to children, 'this was directly related to their ability to have meaningful relationships with adults.' (p. 452)....

[p. 20:] In discussing future directions, Mundy states that 'stigma among providers toward those seeking help remains a concern' and that efforts must be made to 'decrease stigma toward pedophilia in the general population' (p. 454). In order for pedohebeophilic persons 'to receive compassionate, evidence-supported treatment,' she concludes, both providers and the larger public must recognize that 'orientation to sexual maturity [i.e., body morphology] very closely mirrors the devel-

(Continued on page 4)

omplemental trajectory of gender sexual orientation' (ibid.)

...The notion of an 'emotional congruence with children,' or as Hermann et al. (2015) calls, 'an exaggerated emotional and cognitive affiliation with children,'<sup>12</sup> seems to delegitimize the emotional and/or romantic attraction that MAPs' [minor-attracted persons] 'confer with children' as being surprising (or 'exaggerated') in the fact that MAPs typically experience a strong emotional connection to minors.

Neither should it be surprising to hear a minor-attracted person describe their attraction to typically youthful traits (e.g., mindfulness, spontaneity, etc.) than it is to hear a female-attracted person describe their attraction to stereotypically feminine traits (e.g., elegance, tenderness, etc.) An emotional connection to (stereo)typical traits of the objects of one's attraction in nearly all cases is an accepted feature of a sexual orientation, further strengthening the conceptual link between gender-based sexual orientation and age-based sexual orientation. This criticism may be an overreach, however, as throughout the article Mundy seems to affirm that MAPs' emotional/romantic attraction to minors is an innate aspect of their sexual orientation as opposed to some 'cognitive affiliation.' ..."

Notes:

7 Seto 2012, 2017.

8 DeBord et al., 2017.

since the data is divided by both 'target of attraction' and 'body morphology', but discovery in childhood or around puberty is almost above 80%.

11 As outlined in the influential Braun and Clarke (2006).

12 Emphasis added.

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### MN's 1939 Psychopathic Personality Law:

## When the Lessons of History Are Ignored, Everyone Loses.

Molly Ladd-Taylor, "Ravished by Some Moron": The Eugenic Origins of the Minnesota Psychopathic Personality Act of 1939", 31(2) *Jour. Of Policy History* 192 (Cambridge Univ. 2019)

Text excerpts:

p. 204: "The St. Paul Council of Parents and Teachers, which struck its own committee on sex offenders after an apparent wave of molestations in its city, called for legislation that tightened parole and treated sex criminals as 'psychopathic cases.' The committee claimed that 'much of the trouble' was caused by repeat offenders who were charged with disorderly conduct, given for all suspected sex offenders.... St. Paul psychiatrist Gordon Kammann, ...agreed that intelligent psychopathic personalities 'whose transgressions against society take the form of sex perversion' constituted the largest group of recidivists. ...Privately, committee chair George Vold assured Governor Stassen that a psychopathic personality commitment law would facilitate the detention of some of the 'known sex perverts who are now a continual menace on the streets.'<sup>44</sup>

p. 205: ...[T]he committee reasoned, public safety should be given the benefit of the doubt in questionable cases. In the 1930s as today, political pressures and the principle of 'better safe than sorry' justified the detention of potential criminals and a strengthening of state power.<sup>45</sup>

The committee made just two recommendations for new legislation. The first was a sweeping extension of the state's power to control potentially dangerous offenders without having to wait for them to commit a crime.

p. 206: Minnesota's psychopathic personality law was put to the test within a week of its passage. A St. Paul police officer petitioned the Probate Court of Ramsey County to commit Charles Edwin Pearson, a fifty-three-year-old married sheet-metal shop owner accused of taking 'indecent liberties' with two thirteen- to fifteen-year-old girls. Pearson also faced a criminal charge for the same offense. He challenged the constitutionality of the new law, and his case



The Nazis practiced eugenics. For some there was no place.

went all the way to the U.S. Supreme Court, which upheld the Minnesota law in 1940.<sup>51</sup> pp. 206-07: Pearson's legal challenge pivoted on the concept of psychopathic personality. According to his lawyer, Otis H. Godfrey, the concept of psychopathic personality was too uncertain and indefinite to constitute valid legislation. After all, he declared, impulsiveness is a common trait, many people lack customary standards of good judgment, and 'we are all prone to fail to appreciate the consequences of our acts.' Yet under the new law, 'a perfectly sane man could be committed for life to an pathetic personality was not a defense to a criminal charge proved that the civil commitment law was a 'quasi-criminal statute' that went beyond the jurisdiction of the probate court.<sup>52</sup>

p. 207: The state's response, presented by Attorney General J.A.A. Burnquist, contended that the statute met a 'long felt need.'

'All too often and of recent years with growing frequency the public has been continually shocked at the vicious sex offenses that have been committed upon women and children. It is none too safe for grown women to be upon the streets after dark even in thickly settled portions of our large cities. Small children disappear and are subsequently found murdered after their bodies have been ravished by some moron. Parents live in constant fear that their child may be the next victim who may be enticed from their very doorstep or on their way to school.' Burnquist's reference to being ravished by a moron, the term for a 'high-grade' feeble-minded person, was not a diagnostic slip-up, but an intentional evocation of eugenics. He was reminding the court that although 'society has long accepted the idea of permanent segregation for insane or feeble-minded sex criminals,' prior to the enactment of psychopathic personality law, Minnesota lacked the legal means to detain potential sex offenders who had a normal or even superior IQ....

Burnquist's appeal to fear was persuasive. ...[T]he Minnesota Supreme Court rejected

Pearson's claim that the term *psychopathic* was too vague to constitute valid legislation. 'It is true that the term "psychopathic" is not part of the working vocabulary of most people,' Chief Justice Henry Gallagher wrote, 'yet the reasonably well informed recognize it as having reference to mental disorders' that rendered the afflicted person 'hopelessly immoral'....

p. 208: The U.S. Supreme Court upheld that decision in 1940. In *Minnesota ex rel. Pearson v. Probate Court*, the Court ruled that states had the right to control persons who constituted a 'dangerous element in the statute to what came to be known as the Pearson standard of an 'utter lack of power to control.' Although it conceded the potential for abuse, the court dismissed Pearson's due-process objections as premature, since no abuses had (yet) occurred.<sup>55</sup>

The Minnesota law and the rulings affirming it were controversial from the beginning. Lawyer James E. Hughes worried about the potentially 'harmful consequences' of such a far-reaching statute. He warned that the discretionary power given to probate judges and county attorneys, who were elected as members of a political party and not required to have any legal training, meant the law could easily be used against political opponents or homosexuals whose conduct was only considered irresponsible 'with respect to sexual matters and thereby dangerous to other persons' under existing moral codes. 'Some of the "victims" of dangerous sexual conduct or sexual assault may not be victims in the true sense of the word,' Hughes observed,.... Hughes wrote, 'We are treading on dangerous ground when, by considering a certain proceeding as an inquiry into behavior instead of the trial of a criminal charge, we dispense with the constitutional safeguards of our liberty.'<sup>56</sup> The fact that a court order was required for discharge, but releasing an 'undesirable' person into the community could be politically risky for an elected judge, meant that a psychopathic person-

(Continued on page 5)

ty designation could lead to commitment – and institutionalization – for life.

pp. 208-09: Critics also decried the law's arbitrary application and administrative (as opposed to therapeutic) function. A 1959 commission reviewing the legislation note wryly that there were 87 interpretations of this law in Minnesota, one for each county in the state.<sup>54</sup>

p. 210: "...Between 1939 and 1969, at least 474 men were civilly committed as psychopathic personalities and placed in a mental institution.<sup>50</sup>

By the 1970s, changing sexual mores and a new appreciation for criminal defendants' and mental patients' rights led many experts to conclude that sexual psychopath laws were 'social experiments that have failed and that lack redeeming social value.' As the Group for the Advancement of Psychiatry (GAP) pointed out in an influential 1977 report, sexual psychopathy is not a psychiatric diagnosis. Although the sex psychopath statutes of the 1930s were infused with psychiatric jargon, they were actually 'a manifestation of a political-legislative approach to a community problem.' For the most part, psychopath laws empowered administrators, rather than clinicians, to make critical decisions about treatment and the disposition of individual patients. The GAP Report acknowledged that there were real dangers from which the public had to be protected, but stressed that predictions of sexual dangerousness were unreliable, and civil commitment laws deprived alleged psychopaths of their legal rights. When 'community pressure to "do something"' results in questionable legislation, the report concluded, 'the integrity of everyone is compromised.'<sup>51</sup>

pp. 211-12: Historians have been harshly critical of mid-twentieth-century sex psychopath and eugenics laws, but as Philip Jenkins wrote nearly twenty years ago, they have 'scarcely responded' to similar measures in effect today.<sup>56</sup> Even scholars writing about recent sex panics and mass incarceration focus primarily on the mistreatment of racialized and LGBTQ youth and adults who commit nonviolent 'offenses' and are unquestionably wronged by the punitive turn. This narrow approach is unfortunate, for while violent sex offenders like Linehan may be the 'worst of the worst,' as Linehan's lawyer Eric Janus wrote in 2006, the preventive detention of 'sexually dangerous persons' today reveals troubling parallels with America's eugenics past. Sex predators now, like defective delinquents and psychopathic personalities in the last century, are seen as menacing, monstrous, and inherently abnormal. Experts still claim to be able to predict dangerousness and prevent crimes by assessing an individual's mental status. Civil commitment is still used to bypass the –constitutional protections of the criminal-justice system and impose indefinite incarceration in the basis of "who a person is" and "what "risk" he poses," instead of what he has done.<sup>57</sup> ...We should not shy away from discussing these human rights abuses just because many of the people affected by them are less than savory."

#### Notes:

- 44 George B. Vold to Harold Stassen, 23 March 1939, *Vold Papers*.
- 45 "Report of the Governor's Committee on the Care of Insane Criminals and Sex Crimes," typescript, 1939, *Vold Papers*.
- 51 "Court Upholds New Sex Laws," *Minneapolis Tribune*, 1 July 1939; *State of Minnesota ex rel. Pearson v. Probate Court of Ramsey County*, 309 U.S. 270 (1940).
- 52 *Relator's Brief, State of Minnesota ex rel. Charles Edwin Pearson vs. Probate Court of Ramsey County*, 1939, Minnesota Supreme Court Case # 32163, MHS.
- 55 *State of Minnesota ex rel. Pearson v. Probate Court of Ramsey County* (1940).
- 56 James E. Hughes, "The Minnesota 'Sexual Irresponsibles' Law," *Mental Hygiene* 25 (1941): 81, 83. Newspapers described the law as "the subject of a great deal of controversy." See "Psychopathic Personality Law Upheld," *Minneapolis Star*, 30 June 1939.
- 60 *Report of the Minnesota Legislative Commission on Sex Psychopath Laws*, 4; William Hausman, "Report on Sex Offenders: A Sociological, Psychiatric, and Psychological Study," 1 November 1972, A3, MHS. See also Frank T. Lindman and David M. McIntyre, eds., *Mentally Disabled and the Law: The Report on the Rights of the Mentally Ill* (Chicago, 1961), chap. 10.
- 61 Group for the Advancement of Psychiatry, "Psychiatry and Sex Psychopath Legislation: The 30s to the 80s," vol. 9, no. 98 (1977, 840, 853, 858, 940-41).
- 66 Philip Jenkins, *Moral Panic: Changing Concepts of the Child Molester in Modern America* (New Haven, 1998), 6.
- 67 Eric S. Janus, *Failure to Protect: America's Sexual Predator Laws and the Rise of the Preventive State* (Ithaca, 2006), 33.

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## PCL-R Psychopaths Are Not Recidivistic or Untreatable, & Do Not Lack Conscience, Empathy, or Moral Compass. So What's the Point?

Rasmus Rosenberg Larsen, Jarkko Jalava & Stephanie Griffiths, "Are Psychopathy Checklist (PCL) Psychopaths Dangerous, Untreatable, and without Conscience?", 26 (3) *Psychol. Pub. Pol'y & L.* 297 (Aug. 2020)

**Abstract Excerpt:** "...We found no evidence of PCL psychopathy being predictive of treatment and rehabilitation outcomes. We found no evidence of PCL psychopathy being predictive of a lack of conscience. These findings disprove widespread beliefs about PCL psychopathy among forensic practitioners and questions the current and future role of the PCL scales in forensic

settings.

#### Text Excerpts: [p. 299:] "Review 1: PCL Scales and Criminal Behavior

**Results** ...[T]wo large-scale comparative studies (Singh, Grann, & Fazel, 2011; Yang, Wong, & Coid, 2010) found the PCL-R to have either the lowest or among the lowest predictive validity for violent recidivism among common risk assessment tools.<sup>3</sup> Further, PCL-R Factor 1 was the only measure whose effect size was statistically indistinguishable from zero (Yang et al., 2010).

#### [p. 300, 302:] Review 2: PCL Scales and Treatment

...Specific findings suggest that PCL-R psychopaths demonstrate similar therapeutic progress to nonpsychopaths (Sewall & Olver, 2019), respond in a predictably positive way to therapeutic allegiance (Polaschek & Ross, 2010), and show reduced sexual and violent recidivism risk as well as serious reoffending after completing a treatment program (in a high-risk PCL-R sample; Wong, Gordon, Gu, Lewis, & Olver, 2012).

#### Review 3: PCL Psychopathy and Conscience

...The idea that psychopaths lack conscience is central to the PCL scales, as reflected in the scale items (e.g., lack of empathy and lack of remorse) and discussed in the three PCL manuals (Forth et al., 2003; Hare, 2003; Hare et al. 1995). ... An American survey of the legal use of the PCL-R (DeMatteo et al., 2014) found, predictably, that the scale was primarily used as a prosecutorial tool.

#### [p. 303:] Results

**Conscience** None of the eligible records evaluated PCL psychopathy and conscience. The absence of research on conscience in PCL psychopaths is presumably because there are no standard or operational definitions or methodologically reliable measures of conscience (e.g., Dahlqvist et al., 2007; Giubilini, 2016).

**Remorse** None of the eligible records evaluated PCL psychopathy and remorse.

#### [p. 304:] Empathy

Marsden et al. (2019) reported that there was no evidence of empathy deficits in psychopaths. ...Habel et al. (2002) measured the ability in PCL-R psychopaths (n = 17) to identify facial mood expressions (an ability associated with empathy). ... Surprisingly, they found a counter-intuitive positive correlation in performance with PCL-R Factor 1 scores (which includes the item callous/lack of empathy).<sup>5</sup>

**Moral judgment** ...Some studies found a positive correlation between PCL scores and moral judgment, others a negative correlation, and others found no statistically significant correlation....

Commenting on the overall results from their original analyses, Marshall et al. (2018) concluded that it was 'not clear' as to 'whether these findings provide evidence that psychopathic individuals lack normal moral understanding' (p. 47), and stressed that there is 'evidence against the view that psychopathic individuals possess a pronounced and overarching moral deficit.' (p. 47). Borg and Sinnott-Armstrong (2013)

reviewed the same research and concluded, 'if psychopaths have any deficits or abnormalities in the moral judgments, their deficits seem subtle.' (p. 124).

[p. 305:] In light of more recent findings showing that group differences in these judgments vanish after controlling for self-presentation effects, Borg and Sinnott-Armstrong (2013) emphasized that PCL psychopaths 'have the ability to distinguish moral from conventional transgressions, even if their ability is not obvious in all situations' (Borg and Sinnott-Armstrong 2013, p. 117; see also, Aharoni, Sinnott-Armstrong & Kiehl, 2012, 2014).<sup>7</sup>

In sum, we found no consistent, well-replicated evidence of observable deficits in conscience, remorse, empathy or moral judgments. Contrary to common beliefs, reviewers highlight that there is concrete evidence that PCL psychopaths are normally disposed in terms of conscience (hereunder remorse and empathy) and moral judgments.

#### Conclusion

#### PCL Psychopathy and Criminal Behavior

The most empirically substantiated claim was that the PCL scales can predict criminal behavior. However, these effects were not particularly robust, ranging from weak to moderate. The predictive validity was also not attributed to the Factor 1 personality traits, but to Factor 2 behavioral items (e.g., Gendreau, Goggin, & Smith, 2002; Leistico et al., 2008; Walters, 2003b; Yang et al. 2010). In fact, one large-scale study found that Factor 1 items decreased overall predictive validity (Yang et al. 2010). This is an important detail since it undermines the original and unique motivation for using the PCL scales in risk assessment (e.g., Hare, 1996). Because the Factor 2 behavioral items are mostly common risk variables included in other tools (e.g., Kroner, Mills, & Reddon, 2005; Skeem & Cooke, 2010), this should provoke a debate about whether the PCL scales are worth (scarce) resources as the PCL scales are more costly and resource-demanding than other assessments (Serin et al. 2016; Polaschek, Patrick, & Lillienfeld, 2011). The PCL scales were not superior to other risk assessment tools (e.g., Yang et al. 2010); in fact, one large-scale study found the PCL-R performed consistently worse than other measures (e.g., Singh et al., 2011). These findings suggest that the justifications for the widespread use of the PCL-R in criminal justice systems should be reevaluated (e.g., Singh et al. 2014), especially when it is used to assess specific, context-dependent risk (e.g., DeMatteo, et al., 2020).

#### PCL Psychopathy and Treatment

We found that widespread beliefs about PCL psychopaths and treatment were not empirically justified. PCL scales do not predict poor response to commonly known treatment/rehabilitation strategies; nor do treatments lead to iatrogenic effects. On the contrary, there was replicated evidence of positive treatment outcomes across treatment targets and methods; and early

(Continued on page 6)

concerns about iatrogenic effects were widely dismissed by reviewers.

### **PCL Psychopathy and Conscience**

[pp. 305-06:] We found very little evidence to suggest that the PCL scales can predict a lack of conscience. Surprisingly, we were unable to find a single empirical study on two of the most widespread beliefs about PCL psychopaths, namely, that they lack conscience (e.g., Hare, 1993) and they feel no remorse (e.g., Helfgott, 2019). We were also unable to find evidence that PCL psychopaths lack empathy, though there was some tentative evidence suggesting subtle differences in empathic responses compared with controls. Overall, we found a general absence of high-quality studies designed to convincingly answer the question about empathy in PCL psychopaths. Finally, evidence from moral judgment research was substantial, demonstrating that PCL psychopaths were equally capable compared with controls. This included comparatively normal responses in moral reasoning and moral foundation tests (e.g., Marshall et al., 2018), as well as answers in moral/conventional test paradigms (e.g., Borg & Sinnott-Armstrong, 2013). We found no empirical support for common perceptions of clinicians and laypeople that psychopaths are remorseless, unempathetic, and/or otherwise morally incapable.

### **[p. 306:] The Future Role of PCL Psychopathy.**

Our systematic review fundamentally questions whether the PCL scales provide forensically relevant information. In terms of the three reviewed issues, it is not clear what practitioners uniquely gain from using the PCL scales in risk assessment; it is not clear how a PCL assessment can uniquely inform treatment and rehabilitation strategies; and it is not clear what a PCL assessment uniquely conveys about conscience, empathy, remorse and moral judgment. However, it is not just that the forensic information and utility of the PCL scales is unclear. There is evidence that a PCL assessment can have harmful consequences, such as (1) increasing the risk of discriminatory practices in rehabilitation settings (e.g., Edens et al., 2018; Polaschek & Skeem, 2018); (2) creating stigma among jurors in court proceedings (e.g., Berryessa & Wohlstetter, 2019; Cox, 2015; Cox, Clark, Edens, Smith, & Magyar, 2013; DeMatteo et al., 2020; Edens et al., 2013; Edens & Cox, 2012; Kelley et al., 2019), and (3) increasing the rate of juvenile transfers to adult courts (e.g., DeMatteo et al., 2016; Forth et al., 2016; Olver, Stockdale, & Wormith, 2009). What remains to be answered is in what ways, if any, forensic practitioners are justified in utilizing the PCL scales. A convincing answer to this question must not only rest on strong empirical evidence, but, as highlighted by DeMatteo and colleagues (2020), the evidence must also be weighed in relation to the various potential harms that may follow from a PCL assessment."

### **Notes:**

3. These included the following: the Hare Psychopathy Checklist-Revised (PCL-R), the Violence Risk Appraisal Guide (VRAG), the Violence Risk Assessment Scheme

(HCR-20), the Violence Risk Scale (VRS), the Level of Service Inventory-Revised (LSI-R), the Psychopathy Check List: Screening Version (PCL-SV), the Lifestyle Criminality Screening Form (LCSF), the General Statistical Information on Recidivism (GSIR), the Offender Group Reconviction Scale (OGRS), Risk Matrix, 2000-Violence (RM2000V), the Sexual Violence Risk-20 (SVR-20), the Sex Offender Risk Appraisal Guide (SORAG), the Spousal Assault Risk Assessment (SARA), the Structured Assessment of Violence Risk in Youth (SAVRY), and Static-9.

6. The two other studies discussed in Marsden et al. (2019) measured aversive emotional conditioning in PCL-SV (Rothmund et al., 2012) and attentional biases in PCL-R psychopaths (Domes et al., 2013), which is not necessarily seen as a type of empathy research (e.g., Batson, 2009).

7. Borg and Sinnott-Armstrong (2013) also discussed evidence from brain scan studies, but this research did not report on problems with conscience, remorse, empathy and/or moral judgment. Instead, these studies explored differences in brain functioning and processes.

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## Would Paraphilics Prefer to Interact with a Sex Robot?

Review: Marečková, A., Androvičová, R., Bartová, K., Krejčová, I. & Klapišlová, K., "Men with Paraphilic Interests and Their Desire to Interact with a Sex Robot," *Journal of Future Robot Life* (2021) <https://doi.org/10.3233/FRL-210010>, reviewed at 2(1) *B4U-Act Quarterly Review* 35-37 (Winter 2022)

### Review excerpts:

"This article by Marečková et al. aims to explore the desire for Sex Robot Experience (SRE) among two target samples of men with 'paraphilic interests' ('PI groups'), namely, men with sexual interest in minors, in one case, and men with sexual interest in non-consent/violence', in the other case. A control group representative of the national Czech population of men was also included.

The authors found greater desire for SRE in the target groups rather than in the control group, with men with a PI in minors being more open to the idea of SRE. This is overall a quite interesting piece in a field that is both nascent and significantly under-researched, presumably not only because it is new, but also because it is perceived as highly controversial.

This study, which examines whether individuals with paraphilic interests want to interact with a sex robot, is important in the broader context of research that concerns whether sex robots can be of use in efforts to 'prevent actual sexual crimes' or in the 'clinical management of paraphilias' (p. 2).

The authors recruited a representative control sample of 806 Czech men online, through a sociodemographic agency. For their target groups, they recruited 48 men with PI in minors and 57 men with PI in non-consent/violence, again online. Inclusion criteria for the PI groups were determined by questions based 'on a five-point Likert scale, with responses ranging from 'definitely not' to 'definitely yes'.

The questions to determine whether men qualified for inclusion in the group with PI in minors were whether the men found sexually arousing 'intimate contact with a minor without physical signs of adolescence (up to 12 years of age)' or 'intimate contact with pubescent girls/boys (minors with signs of adolescence aged 12-15 of age' (p. 4).

Inclusion in the group with PI in non-consent/violence was decided based on questions about whether respondents found any of the following arousing: 'complete immobilization of a stranger (female or male), potentially using violence, and preventing them from resisting you', 'stalking and seizing a stranger'; 'sodomasochistic activities involving physical or mental subordination or humiliation'; and 'sodomasochistic activities that involve beating or other forms of torture' (p. 4).

Respondents had to reply 'yes' or 'definitely yes' to these questions in order to be included in the PI groups. All participants (i.e., control sample and target sample) agreed with the statement 'I desire sexual experience with a sex robot/doll' (p. 3) and had to indicate their agreement using a 4-category scale, ranging from 'strongly disagree' to 'strongly agree'.

The results showed that desire for SRE was expressed by 18% of participants in the control group, 37.5% of participants in the group with PI in minors, and 26% of participants with PI in non-consent/violence. The authors mention that, although differences did not reach a level of 'practical significance' across all groups, the results still showed that the group with PI in minors expressed a relatively greater desire for SRE.

This study is important in that it looks into whether men who are attracted to minors would want to interact sexually with a sex robot. As recognized by the authors, this willingness and self-motivation is 'a prerequisite for the currently extensively developing discussions about the use of sex robots in clinical management of paraphilic disorders' (p. 8).

However, it is important to differentiate between a desire to interact with a sex robot in general, for whatever reason, and a desire to use sex robots specifically in the context of 'therapy' or 'clinical management' of a 'paraphilic disorder'. The researchers acknowledge that this is a limitation of their study, and this is an area for future research to explore.

To assume that persons attracted to minors would – or –should – only desire to have an experience with sex robots in the context of 'managing' their 'paraphilic interests' is problematic and fails to take into consideration the depth, complexities, and (positive) impact that such an experimentation might have on someone's sexuality, outside the scopes of 'clinical management' and 'prevention'.

...Another critical point to raise is the fact that only men were recruited for the purposes of this study. The authors justify this by mentioning that they 'focus solely on men because paraphilic interests seem far more prevalent amongst men than women' (p. 3), but this ignores growing research evidencing the existence of female MAPs ...and offers no discussion on why this tendency persists....

[T]his is a significant study that adds another step in the exploration of the important topic of sex robots and whether they can be viewed as 'a legal surrogate of [the] desired partner' (p. 3) for persons who are attracted to minors.

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## The Conceptual Flaw of the PPG: It Can't Predict Sex Crimes.

by Cyrus Gladden  
The penile plethysmograph (PPG) has

been around for about a century at this point. Its first use as a tool to detect physical sexual response to specific types of stimuli in the laboratory was apparent in the throes of mass public homophobia deeming homosexual orientation to be a mental illness.

That view, of course, was later invalidated by psychological researchers, and homosexuality has been drummed out of the American Psychiatric Association's Diagnostic and Statistical Manual of Disorders (DSM) since its second edition in the 1960s.

However, for discussion purposes, even assuming that there had been any validity to that view and the related contention that homosexual relations were predatory and caused either homosexuality or some grave traumatized reaction on the part of someone introduced to homosexual conduct by another person 'experienced' in homosexuality, there was never any scientific study of whether having a sexual orientation inevitably led to homosexual conduct with an intimacy partner.

In the 1950s and certainly in earlier years, due to such widespread social taboo, many who felt a homosexual orientation maintained an asexual lifestyle or, if bisexual, confined themselves to heterosexual behavior. Therefore, a PPG test result that indicated some level of penile erectile response to homosexual imagery or other forms of homosexual stimuli never did indicate that the tested individual would ever engage in homosexual conduct.

In time, use of the PPG test on those believed to have a homosexual orientation disappeared along with repeal of the laws that previously had criminalized such conduct and that had declared such orientation (then deemed a form of "sexual deviancy" or "perversion") to be a basis for civil commitment.

With the beginning of the extant era of widespread concern about and social fear and revulsion against sexual conduct by adults with children, the notion became popularized that there was an identifiable subgroup of "pedophiles" in society who were at least partly sexually attracted and in some cases, exclusively oriented to sexual conduct with children. The operative assumption was that someone who could be identified as being a pedophile would inevitably, eventually sexually offend (or reoffend) against one or more children. Enter the resurrected PPG testing device to assist in such identification.

To understand whether the PPG has any utility toward pointing out individuals as purportedly likely to engage in sex crimes against children in the future, we must closely examine PPG procedure and the nature of the conclusions drawn from PPG test results.

First, the question of physical response is addressed by whether the tested individual (the "testee") experiences an erection in response to stimuli about children. Often such stimuli consist of photographs or video snippets shown digitally to the testee in succession. Such children are often depict-

ed either entirely naked or scantily clad or in poses that might be considered to be sexually provocative to one with such a sexual fantasy. Sexual terms about sexual actions with the depicted child that the speaker asserts to be exciting. These stimuli are alternated with analogous stimuli of images of adults. 'Intermediate' images of older children including teenagers and very young adults are also included in the full stimuli set.

The test result is judged by whether or not the testee experiences what is defined by the test protocol as an erection. Lack of PPG standardization shows here in that some PPG protocols define an erection as being as little as a 10 percent increase in penile girth, while others require an increase in girth to be as much as 40% over flaccidity to be declared to be an erection.

But even more troubling is that the decision about the existence of an erection is simply a yes or a no, rather than only a slight girth increase toward erection, as opposed to the maximum level of erection possible for the individual testee.

This is significant because an immediate, strong increase to maximum erection state typically would indicate a strong emotional reaction of sexual response. However, a significantly slower increase in girth (even if eventually to such maximum level) or more profoundly, only a 'slight' increase in girth, could very well indicate only a radically lesser state of responsive sexual excitement than being experienced by the testee.

Alternatively or in combination, an initial girth increase to some level (but perhaps never achieving maximum erection state), followed immediately by a girth decrease back to completely flaccid state, or at least partly toward that state, could very well indicate instead that any such slow or partial increase in girth was prompted by some aspect of the test or the particular stimulus that did not center on the intended sexual focus on the depicted child as such, or might (far more likely) indicate a consciously or unconsciously repressed reaction of sexual excitement, or even simply a far lower sexual excitement level altogether in response to the intended nature of the stimulus at the moment.

It is a profound flaw of PPG testing that the yes/no determination simply of the existence of an erection is not capable of distinguishing between these differing types of responses. Any girth increase to the minimum level defined as an erection is simply treated the same for significance purposes as if it were the maximum erectile state physically achievable by that testee, and as if that fully erectile state had been achieved in a same, minimal amount of time, and every time in response to each stimulus.

This 'level-up' method of scoring the test result casts every testee that produces any response set suggesting a sexual attraction to children as being at a maximum level of sexual excitability to thoughts of sexual actions with children. In fact, it is part of the  
(Continued on page 8)

operative assumption built into this testing protocol that any physical response to any such pedophilic stimuli inherently implies that the testee is strongly hyper-charged with sexual urges toward acting out sexual abuse of children and hence, very unlikely to be able in the moment of any real-world encounter with a child to restrain/contain himself from sexually abusing that child and/or other children at that time and place.

However, the very reaction described above of a lesser response, in all likelihood, actually reflects a greatly inhibited physical sexual response to such stimuli. Anyone capable of restraining an erectile response would certainly seem unlikely to have any difficulty with self-control in the moment in any such encounter with a child. More than that, such a test result would appear to reflect a pedophile of far less libido in that orientation than average, and/or a pedophile least likely to sexually abuse any child in any scenario at all, including one of gradual grooming and seduction.

Therefore, the lack of any measure in the PPG test to account for such inhibition or lesser level of sexual excitability toward children that barely exceeds the low threshold of an erectile response, and then perhaps only fleetingly, prevents the yes/no scoring of the PPG from having any real meaningfulness toward predicting future sexual offending.

Secondly, each stimulus image or video snippet is presented for a very short period, usually less than a minute and sometimes as short as only several seconds. (Because there is no standardization of PPG procedure, there is great variation from one PPG exam to the next.) There is also considerable variation in the overall duration of the test. Some tests have concluded within a single hour, while others have continued for a total as long as five to six hours. Typically, the length of the PPG test is at the discretion of the test administrator. In many cases, the PPG test is arranged at the behest of either a court or a treatment program that finds it difficult to believe that the testee is not hyper-charged with pedosexual libido or is not lacking in control of pedosexual lust. Particularly in such instances, the PPG examiner is very likely to extend the test when initial responses are lacking in erections or have only tepid, partial or fleeting erections. In such cases of test extension, the PPG test takes on a role effectively the equivalent of a browbeating police interrogation. At the end of such an extended test, the greatest responsive levels of erection achieved (usually toward the end of the test) will be proclaimed to reflect the 'true' test result, and earlier lack of erections or merely tepid or fleeting partial erections will be disregarded as mere momentary anomalies. This ignores that their real meaning was as indication of substantial self-control or lesser deviant libido that only collapsed after extended repetition of stimuli intended to batter down such resistance – and then report a result pretending that no such resistance existed.

But the fact of such lower libido or such self-control in resistance to any such pedosexual excitement even under such

prompting stimuli has far more meaning as a test result than merely that an erection was achieved at some point during the test. After all, in most cases, people being subjected to the PPG test have already been accused, and most often already convicted of a sexual crime against a child reflecting a probable pedophilic motivation of the defendant/treatment client. So the PPG test otherwise only confirms a highly probable fact precedent. However, the question of probability of future reoccurrence of such sexual abuse by the testee is most greatly impacted by his level of pedosexual libido and his ability to control his sexual excitement in the moment.

Thus, the inability of the PPG test to derive these two states of fact so seriously limits its ability to tell factfinders anything of use that, apart from all questions of accuracy of the limited result it reports, calls into question whether there is any earnest utility to the PPG test at all.

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## Fed Bill Refers Some Sex Offenders for Fed Charges & Takes Away Medicare & Medicaid Eligibility from Them.

Source: *Congress.gov*, Library of Congress, "H.R. 6382 – Stop Sexually Violent Predators Act," (8/12/24) by Cyrus Gladden

The website [www.congress.gov/bill/118th-congress-house-bill/6382/text](http://www.congress.gov/bill/118th-congress-house-bill/6382/text), published by the Library of Congress, reports that a bill proposed by long-time House member Darrell Issa proposes federal actions against sex offenders convicted under state laws. The first of these would require that state authorities submit to the federal Attorney General a list of individuals "convicted of a sexually dangerous offense in the previous fiscal year" and that the Attorney General review individuals on that list for possible "prosecution for a Federal offense." This bill has been referred to the House Subcommittee on Health and is under the jurisdiction of three House committees: Judiciary, Energy and Commerce, and Ways and Means.

In addition to the federal consideration of possible federal charges, the bill includes an unprecedented proposal to take away Medicare and Medicaid coverage from those the bill calls "specified individuals," defined as those convicted of "sexually violent offenses" and found to be a "sexually dangerous person." The latter label, among others, is used to commit people with such offenses.

Specifically, the bill bars eligibility for Parts A and B of Medicare coverage. Part A is called hospital insurance, since it covers much of the costs of hospitalization. Part B is called supplementary medical insurance, since its benefits pay for some of the costs incurred outside of the context of hospital stays. The bill does not directly

mention Parts C and D of Medicare coverage. Part D is expanded coverage that is directly paid by Medicare of one opting for that coverage and who pays Medicare an extra premium for it. Part C is privately contracted insurance that covers certain gaps and limited coverage percentages and co-pays that under Medicare the government does not cover. However, since both Parts C and D are based on the existence of coverage under Part A and B, it would appear that because this bill would bar Parts A and B, Parts C and D would not be accessible either. In short, there would be no Medicare coverage at all for such individuals.

As to Medicaid, the bill states that federal payment to states will not be made for medical assistance furnished to a "specified individual." This puts the burden on the states not to pay any such assistance benefits, on pain of not getting federal reimbursement for those paid benefits.

There is absolutely no relationship of any kind, either causative or simply correlative, between getting the benefits of Medicare and/or Medicaid and perpetrating sex offenses, whether on a first-time basis or as recidivism. Therefore, this portion of the bill appears to be unconstitutional as a denial of due process and of equal protection. The preamble of the bill states that its aim is "To increase protections against sexually dangerous persons, and for other purposes. Certainly "protections cannot be increased without such a causative relationship." Imposing such bars to benefits without such a relationship is what makes this provision unconstitutional.

The bill does make one exception, however: the Medicare and Medicaid bars do not apply to one who is confined involuntarily in a "hospital" (here meaning a sex-offender post-commitment confinement facility) receiving "involuntary treatment" there. Had the bill not made this exception, the cost of confinement under such sex offender commitments borne by the state having such a commitment system would jump geometrically in short order. In fact, firms contracting to take over and operate such facilities or whole systems of such commitment confinement would rapidly get eaten by the expenses required of them to fulfill their obligations under their contracts. The word "involuntary" is not defined here. At least in Minnesota, treatment in sex offender commitment is effectively voluntary. Whether denial of benefits to those refusing treatment (such as ineligibility for the greater number of work-for-pay hours per week for which treatment participants are eligible) could be deemed "involuntary" and therefore such 'refuseniks' would remain eligible for Medicare and Medicaid under the bill remains unclear. Just as unclear is whether, since treatment is voluntary in Minnesota, even opting for treatment in Minnesota's sex offender commitment facilities would qualify under the bill's "exception"? The lack of clarity on this point that determines who will get stuck paying the extremely burdensome bill for medical care of their (disproportionately aging) inmates would seem to make it a poor season for private

contractors in health care to seek more contracts as to sex offender commitment facilities. Better to wait.

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## Sex Offender Residence and Employment Restrictions

Joseph L. Lester, "Off to Elba: The Legitimacy of Sex Offender Residence and Employment Restrictions," *bepress Legal Series*, Year 2006, Paper 1818, *The Berkeley Electronic Press*, <http://law.bepress.com/expresso/eps/1818>.

Text excerpt:

pp. 14-15: "The real impetus of these bills is not on protecting children, but punishing former sex offenders once again.<sup>90</sup> In response to criticism of the residence restrictions in Kentucky, Kenton County Sheriff Chuck Korzenborn stated, "I don't care how inconvenient we make it for these guys.... Don't commit the crime and you won't have to do the time."<sup>91</sup> These zoning laws are so onerous to comply with that it is just a matter of time before innocent people are locked up. Take the situation in the New Jersey townships of Jackson and Lakewood, where four months after adopting sex offender residency ordinances they still had not produced maps showing the "pedophile-free zones."<sup>92</sup> "There will be a map generated, not so someone can say, 'Oh, that's not where I can live,'" said a Jackson police captain. "It's not a question of them knowing, but so we can know. If we want to charge them with the ordinance, we need the map."<sup>93</sup>

If the real purpose was protection, then states that have adopted these programs would offer proof that this community purging actually does protect the community and its children. In fact, the states that have actually given thoughtful consideration to this proposal before voting on it have found that there is no correlation between residency and employment locale and recidivism. Colorado and Minnesota both did extensive research on the issue and found that if anything, this forced exile only exacerbates the problem it purports to solve.<sup>94</sup>

This forced migration of a select group of former criminals is unprecedented. There were forced migrations of Indian Tribes in the 1830s<sup>95</sup> and of Japanese-Americans in the 1940s.<sup>96</sup> There have been times when suspect groups of people, such as foreign agents, Communists, and aliens were subject to monitoring and regulation.<sup>97</sup> It is unique [that none of these groups] were contagious.<sup>98</sup> It is outrageous for any court to mischaracterize laws that require citizens living in a law-abiding manner to quit their jobs and uproot their families, taking them out of their chosen communities and forcing them into underdeveloped areas by not calling it what it is – banishment.

### V. Penalties For Being In the Zone

Violations of the residence or employment restrictions are much more than just a slap

(Continued on page 9)

on the wrist. For most states the first violation is a felony.<sup>99</sup> In Alabama and Georgia, it is a severe felony with up to 30 years for one violation.<sup>100</sup> In many cases a violation of this prohibition is punished with greater severity than the crime that made the person a sexual offender to begin with.

Interestingly, for the most part there is no *mens rea* required to violate these restrictions. A sexual offender may be strictly liable for complying with these prohibitions.<sup>101</sup> The basic problem with this is the fact that the prohibited areas are growing daycare facility pop up near the sex offender. In such a case, the sex offender would have little recourse and no knowledge of such an event.

What is really going on is that these regulations are a way to punish sex offenders twice for one criminal act. Feeling unsatisfied and impotent, states and local communities set legal traps for the convicted sex offenders to fall into so that they can incarcerate them again. It is just a matter of time before a sex offender who tries to remain in a community will violate these specially crafted restrictions."

**Notes:**

90 Joyce Blay, "Police Waiting for Maps to Enforce Residency Law," *TRI-TOWN NEWS*, Sept. 22, 2005.

91 William Croyle, "Sex Offenders Put on Notice," *CINCINNATI ENQUIRER*, August 14, 2006.

92 *Id.*

93 *Id.* (emphasis added).

94 See *Colorado Dep't of Public Safety, Report on Safety Issues Raised by Living Arrangements For and Locations of Sex Offenders in the Community*, (prepared for the Colorado State Judiciary Committees, Senate and House of Representatives) 2004, (finding no correlation between where sex offenders lived in comparison to where other criminals lived therefore, a residence restriction would not be a productive method to control recidivism) available at [http://dcj.state.co.us/odvsom/Sex\\_Offender/SO\\_Pdfs/FullSLAFinal01.pdf](http://dcj.state.co.us/odvsom/Sex_Offender/SO_Pdfs/FullSLAFinal01.pdf), *Minnesota Dep't of Corrections, Level Three Sex Offenders Residential Placement Issues*, (Report to the Legislature) 2003 (finding that the residence restrictions would force the state to provide housing for those displaced by such an act and that the cost of creating new housing would be too high along with a belief that residential restrictions would not enhance community safety) available at [http://www.corr.state.mn.us/publications/legislativereports/pdf/2004/Lvl%203%20SEX%20OFFENDERS%20report%202003%20\(revised%202-04\).pdf](http://www.corr.state.mn.us/publications/legislativereports/pdf/2004/Lvl%203%20SEX%20OFFENDERS%20report%202003%20(revised%202-04).pdf).

95 Pursuant to the Indian Removal Act see <http://ngeorgia.com/history/nghisttt.html>.

96 Act of March 21, 1942, 56 Stat.173, 18 USCA 97a. See also *Korematsu v. United States*, 323 U.S. 214 (1944).

97 Michele L. Earl-Hubbard, "The Child Sex Offender Registration Laws: The Punishment, Liberty Deprivation, and Unintended Results Associated with the Scarlet Letter Laws of the 1990s," 90 *NW. U. L. REV.* 788, 815 fn.183. (1996).

98 In an effort to curb prostitution, Richmond, Virginia, city officials want to make parts of the city off limits to particular individuals unless they lived, worked or worshipped in the area. *Jim Nolan, Zones Would Bar Prostitutes, RICHMOND TIMES-DISPATCH* Sept.11, 2006.

99 Alabama, Arkansas, Georgia, Illinois, Indiana, Missouri, and Tennessee. See *infra* table 2.

100 See *infra* table 2.

101 Offenders are strictly liable in Iowa, Kentucky, Louisiana, Michigan, Missouri, Ohio, and South Dakota.

## Factors Shaping Attitudes About SOs That Impact Their Care and Treatment

Laura Challinor & Simon Duff, "Factors influencing attitudes toward sex offenders & impact of attitudes on SO care & treatment – a lit review 1985-2015," 41 *Aggression and Violent Behavior* 98-107 (July-Aug. 2018)

**Abstract:**

**"Background**

Research has investigated the attitudes of a range of professional and paraprofessional staff who are exposed to men who have sexually offended. The evidence emerging from this work suggests that many factors appear to have an effect on the attitudes that staff develop, including the number of years in their job, gender, or parental status.

**Method**

An electronic search of seven bibliographic databases was conducted to identify primary research studies in addition to scanning reference lists of existing studies and contacting experts in the field. The search generated 13,987 hits. After scanning the titles and abstracts, 51 papers were subject to the exclusion criteria. A total of 13 studies met the inclusion criteria and were included in the final synthesis process.

**Results**

A number of factors appear to be important when exploring the relationship between attitudes and the care and treatment provided to men who sexually offend. These include factors within the domains of cognitive, affective and behavioral attitudes.

**Conclusions**

The papers highlighted a range of factors that influence attitudes. These factors appear to influence the flavor of attitudes and the nature of attitudes is seen to be an influencing factor in terms of the quality of relationships between men who commit sexual offenses and professional staff. However, the definition of attitudes needs to be more carefully applied to empirical research. Results collected from the studies provide suggestions regarding the clinical implications."

**Text Excerpts:**

**"Introduction**

...Successful reintegration of men who sexually offend (MSO) into the community is a significant predictor in reducing recidivism rates (Laws & Ward, 2011)....

Protective factors are important in facilitating change and supporting the desistance process (Ward & Laws, 2010). A stable environment, pro-social support, intimate relationships, employment, aging, cognitive transformation, spirituality and military service have all been identified as factors Hanson & Morton-Bourgon, 2005; Hepburn & Griffin, 2004; Laws & Ward, 2012; Willis & Grace, 2009). Despite this knowledge, treatment programs have historically been deficit focused (e.g., Marlatt, 1982), which may increase feeling of worthlessness and low self-esteem due to focusing on an offender's negative characteristics rather than their potential strengths. Both factors are linked to increased risk of recidivism (Thornton, Beech, & Marshall, 2004). Therefore the more recent implementation of strength-based theoretical programs such as those utilizing the Good Lives Model (GLM; Ward & Stewart, 2003), addresses attitudes and reflects the need for a positive alliance. The GLM's (Ward & Stewart, 2003) basic premise is that offenders, like all humans, value a number of things in life that are defined as 'primary goods', including healthy living, hobbies, intimacy, spirituality and knowledge. Although there are extensive evidence-based directives for sex offender treatment (Laws & Ward, 2011), there is also evidence to suggest that treatment may only be successful if the man perceives the therapist to have positive characteristics that one believes to support their rehabilitation (Marshall, 2005). These include non-judgmental attitudes and warm, approachable characteristics (Marshall, 2005). This would seem to suggest that it is important for staff to adopt positive attitudes that are supportive of treatment and rehabilitation, which may subsequently have the potential for positive change and desistance.

The GLM (Ward & Stewart, 2003) can be used to direct treatment towards equipping offenders with the skills and knowledge to attain the primary goods highlighted as being necessary for desistance. This is an alternative to placing an emphasis on risk factors and avoidance of high-risk situations as in the Relapse Prevention Model (Laws, 1989)....

Staff who work with MSO require an understanding of the desistance process, which is considered a complex process of change (Bushway, Thornberry, & Krohn, 2003), to ensure they are equipped with the knowledge and skills to support this process adequately. The Integrated Theory of Desistance from Sexual Offending (ITDSO; Gobbels, Ward, & Willis, 2012) was designed as a complementary model to further understand the psychological processes within desistance. The ITDSO explains the desistance process in four phases: decisive momentum; rehabilitation; re-entry; and

normalcy. Particular emphasis on the role of staff is placed within phase two: rehabilitation. The rehabilitation phase places importance on thorough assessment and formulation of the offender's difficulties, goal setting and intervention. By working with the offenders to identify important primary goals, staff begin to develop an understanding of the needs of the offender beyond their label, which are influenced by media representations. Increased understanding allows for more effective support to facilitate change. On balance, it seems there is develop greater insight and understanding into the relationship between staff attitudes and the care and treatment provided to MSO."

**Selected References:**

*Bushway, Thornberry, & Krohn* (2003). Desistance as a developmental process: A comparison of static and dynamic approaches. *Journal of Quantitative Criminology* (2003).

*S. Gobbels, Ward, & Willis* (2012). An integrative theory of desistance from sex offending. *Aggression and Violent Behavior* (2012).

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## Will MN Cure Its SRB/CAP Case Backlog?

To: Those interested

From: Michael Benson

Date: June 24, 2022

Re: SRB/CAP backlog on cases

Hey, Gentlemen:

I talked to my attorney, Michael Biglow, because he had a meeting along with a number of other attorneys with Chief Judge Jay Quam from the Judicial Appeal Panel (now known as the "Commitment Appeal Panel," or "CAP." The meeting was brainstorming on how to best clear up the backlog of cases that are pending at the CAP. The main answer was to eliminate the "Special Review Board" ("SRB"), get more resources with which to process cases, and triple the number of CAP judges. The attorneys at the meeting were Michael Biglow, Doug McGuire, Dan Kufus, Jennifer Thon, Jill Avery, Cheri Templeman, Mark Gray, and Dan Wexler.

Judge Quam had already met with the examiners and informed them that delays and continuances was no longer an option. He told them if the report is needed in 30 days they should have the report done in three weeks.

Judge Quam had previously met with the DHS officials and Attorney General's representatives for ideas, but they were not forthcoming with information. Nonetheless, he stated he will meet with them again and give them his ideas that he expects to get results from.

Everyone was in agreement that the delays are Procedural Due Process violations.

(Continued on page 10)

Hence, Mr. Biglow expects that this issue will be seriously being addressed -- and soon. He stated that resources is the problem (but not ours) and that the removal of the SRB would have to be done by the Legislature.

That's it. Let your mind muddle on this for a moment.

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## Efficient Operation of CPS to Effect Prompt Release to Provisional Discharge Is Indispensable to Constitutionality of MSOP Program.

"Request of Legal and Treatment Experts for Leave to File Brief Amicus Curiae, in *McDeid and Garry v. Johnston et al.*, Appeal A21-0042 & A21-0043 (filed Sept. 14, 2021, granted Oct. 27, 2021; case pending in MN Supr. Ct.)

### Document Text Excerpt:

p. 5: "This Court has long recognized the centrality of treatment to the legitimacy of civil commitment. Its reasoning in *Linehan III* places the provision of treatment centrally: 'So long as civil commitment is programmed to provide treatment and periodic review, due process is provided.' 557 N.W.2d 171, 181 (Minn. 1996).... The Court detailed the treatment plan developed for MSOP, emphasizing that 'treatment and rehabilitation are essential to [MSOP's] mission.' *Id.*, at 188. The program, the Court reported, was to be 'a four-phase treatment program. ... [E]ach of the four phases will last approximately 8 months for model patients....' *Ibid.*" [emphases added]

[Editor's note: Beyond the importance of review toward release and of successful rehabilitation as important MSOP essentials, it is crucial to note that no MSOP treatment participants have ever attained phase progression within 8 months, whether singly as to any given phase or as an average over all phases. Note also that what once was "Phase IV" is now CPS. See attached excerpts from Addendum to Plaintiffs' appellate brief for stats on how many MSOP confinees languish in CPS.]

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## The Power of Belief

### Simply Believing in the Possibility of Desistance May Greatly Increase a Releasee's Ability to Achieve Desistance.

Kevin O'Sullivan et al., "Measuring Offenders' Belief in the Possibility of Desistance," 62 *Int'l Jour. Of Offender Therapy & Com-*

*parative Criminology* 1317-1330 (Issue 5, April 2018), <https://journals.sagepub.com/doi/abs/10.1177/0306624X16678940>

### Text excerpts:

#### Introduction

"...Research into recurrent crime has followed two main approaches and it is worth examining their differences and similarities: the 'risk-reduction/risk management' approach and the 'desistance' approach. The former has largely been developed by psychologists and the latter has mostly been the province of criminologists.

#### The Risk-Based Reducing Re-Offending Approach

"...The risk-reduction model is a deficit-based approach where risks are identified and interventions designed to lessen those risks. The issue as conceived by this approach is: 'Here is a person who is likely to offend -- how do we stop [him]?' The intervention is on a medical treatment model: we provide a certain dosage of treatment and observe what happens. To measure the effectiveness of the treatment, we observe how long it takes until the offender reoffends, and if this happens we may administer another 'dose' of treatment. This has been, and continues to be, an important and useful contribution to public safety, but it externalizes the problem and focuses on what needs to be 'done to' the offender by the correctional system or the clinician. It considers the offender 'as part of an aggregate risk-averse management strategy' (Liebling, Helley, & Crewe, 2011, p. 368).

[Thus, the RNR approach is basically pessimistic, implicitly conveying that such external measures 'done to' a former offender may well fail at creating replicable rehabilitation.]

#### The Desistance from Crime Approach

"...Desistance research is about what it means to stop [committing crimes] and not begin again rather than what it means to stop. ...The focus of desistance research is not on what the correctional system does to the offender, but rather on what happens in the offender's life that leads to both stopping the commission of crime and to 'staying stopped.' Farrall & Maruna (2004) have used the terms primary and secondary desistance to describe this process. Primary desistance is any instance of stopping and secondary desistance is the effort that the former [offender] makes, once having stopped committing crime, to make a good life for him or herself. More recently, McNeill (2014) has used the term 'tertiary desistance' to describe a more enduring, settled, state that emerges from a sense of belonging to the community.

Until the late 1990s, the explanations for desistance were loosely in two camps: the ontogenic view and the sociogenic view. The ontogenic view (see for example Hirschi & Gottfredson, 1983; Gottfredson & Hirschi, 1990) is that whatever happens is a function of the individual's own internal maturation: as people get older they simply stop committing crime and this happens regardless of any extraneous factors. The sociogenic view (see for example Laub & Sampson, 1993) considers the life events,

the milestones, and the turning points in a person's life that make a difference.

[However, statistics consistently show that at some point by middle age if not before, maturing/aging yields an end to crime -- strictly ontogenically, if nothing sociogenic causes such permanent desistance first.]

#### Desistance and Reoffending: The Two Literatures

So is the literature on desistance just the inverse of the reoffending literature? In other words, are the risk factors that contribute to crime by their presence, the same ones that contribute to desistance by their absence? The answer is: sometimes, and this is well described in a recent review by de Vries, Robbe, Maruna, Mann & Thornton (2015). Where they do not overlap, there may be two reasons. Firstly, the risk factors are derived by looking at circumstances and characteristics of people who have reoffended, not people who did not. The risk-based reoffending literature has not and does not systematically examine the characteristics and circumstances of the large number of people who succeed in desisting for good. This is not surprising because from a public risk point of view these people are of no concern, by definition, and so attract little attention from risk-oriented psychologists interested in crime.

Secondly, as discussed above, the reoffending literature sits largely within a medical treatment paradigm of deficit and intervention, and researchers measure this survival in arbitrarily agreed periods of 'one year survival,' 'two year survival,' etc. What may get lost in this model is the exploration of any variables that may not necessarily be implicated in reoffending, but may be important in not reoffending. This is the area of interest to desistance. The question that is posed by desistance researchers is not: 'Here's a person who is likely to offend -- how do we stop him?', but rather: 'Here's a person who is no longer offending, how did he do that?' or 'What will it take for this person who is offending to no longer do that?' The difference in focus is about the locus of change: In reoffending, the locus of change is the effort of the criminal justice system, in desistance, the locus of change is that of the individual and/or society.

In the same way that offenders struggle with self-belief and the possibility of change, so too does the general public, and the present study borrows a phrase used by Maruna & King in a 2009 study that examined public punitive attitudes or 'penal populism' (Bottoms 1995; Garland 2002). Using data from the Cambridge Recidivism Study, Maruna and King used attribution theory to test what they called the 'belief in redeemability,' the sense that it really is possible for ex-offenders to reconstruct their lives....

'Redeemability' is not a widely used term in the literature, being present in few papers other than the work of Maruna & King (2004, 2009). If it is to be useful, it is important to explore its components. Historically, writers have used such positive terms as hope, optimism, belief in self and narrative continuity, and such negative terms as shame, stigma, regret, and disdain to refer to the set of beliefs that offenders have

about themselves and their prospects for a 'straight' life. (O'Sullivan, Kemp, & Bright, 2015).

### Discussion

"...[Discussing a part of the experiments in their study.] In the card sort task the participants in the panel were able to identify categories underlying the construct of belief in redeemability and among these there were three that accounted for 70% of the categories. Other categories referred to issues such as choosing crime over desistance, the desirability of pro-social conduct and uncertainty and were difficult to amalgamate into smaller categories. Following this we identified three subscales with Cronbach's Alphas that indicated acceptable internal consistency. The first theme concerned a sense of belonging to the larger community and having a rightful place in it. We called this *Belonging*. The second was about the degree to which the statement evinced a sense of control over the task of desistance. We called this *Agency*. The third was about the optimism the statement showed about the possibility that this change (desistance) could come about. We called this *Optimism*. An example of the first was 'Inclusion, fitting in and having a place amongst the world of everyone else.' An example of the second was: 'My life doesn't really make sense, lack of control. I don't really think I'll make it.' An example of the third was: 'Positive beliefs about the future, about living productively.'

A recent paper (de Vries, Robbe, Mann, Maruna, & Thornton (2015) names similar variables as significant desistance factors. The three factors that relate to our work are: 1) having a 'place within a social group or network' (Belonging); 2) 'an enhanced sense of personal agency' (Agency), and 3) 'Hopeful, optimistic and motivated attitudes to desistance' (Optimism) (de Vries, Robbe, et al. 2015, pp. 26-28). In another recent paper, Majer, Olson, Komer & Jason (2015) found that self-efficacy was positively related to motivation for change in ex-offenders. Given that there are well-established psychological instruments that measure these variables, they may provide scope for testing convergent and discriminant validity."

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