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Profiling the Sexually Violent Predator: An Examination of the Current Literature Regarding Candidacy for Surgical Castration

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Abstract

This literature review examines the current practice of the surgical castration of Sexually Violent Predators (SVPs) in the United States, drawing from American and European research collected using PsycInfo and LexisNexis. It seeks to determine if psychologists have the evaluative tools necessary to determine who would be a good candidate for surgical castration. The findings suggest that the knowledge derived from forensic psychology is limited in this area and requires extensive amounts of additional research before a profile can be fully compiled. Nevertheless, the author found the profile of the ideal candidate for surgical castration must at least be a SVP who is accurately labeled as likely to reoffend using a guided clinical approach to risk assessment, and is motivated to reform prior to the employment of this treatment.

Introduction

Surgical castration has become a newly viable option for sex offenders who pose a threat to the general public. Many of these sex offenders are socially restricted by Sexually Violent Predator (SVP) Laws, limiting their abilities to fulfill their sentences, leave mental treatment facilities, and live without constant government surveillance (La Fond, 2005). For them, surgical castration may be the most effective way of gaining freedom from the court system and limiting paraphiliac inclinations and behaviors (Weinberger, Sreenivasan, Garrick, & Osran, 2005). Hence, the last decade has seen a rise in legislation permitting or mandating the use of surgical castration in treating SVPs (Norman-Eady, 2006; Scott & Holmberg, 2003).

The surgical castration of sex offenders is a highly charged subject of public policy debate. Because the sex offender has been framed in the popular mind as an unpredictable, incurable, and incomprehensible public enemy, factual evidence surrounding the ethicality, constitutionality, and efficacy of the procedure is obscured. Additionally, research on this issue is rare, given the unpopular subject matter, and hard to conduct, given the extreme confidentiality required and safety issues that arise (La Fond, 2005). Consequently, further research is needed in this area. As

surgical castration becomes a more widely used method of treatment, the following salient question remains: do psychologists have the evaluative tools necessary to determine who would be a good candidate for surgical castration?

Method

In attempting to answer this question, an examination of the current relevant research in this area was conducted. PsycInfo was used to search material related to the surgical castration of sex offenders. Search terms included, but were not limited to, “castration,” “sexually violent/deviant predator,” “sexually violent/deviant offender,” “SVP law,” and “risk assessment.” Additionally, LexisNexis was used to access the relevant law texts, supreme courts cases, and other legal literature.

Employing the information gathered in reviewing the literature, this paper will explore the profile of the Sexually Violent Predator, the legislation applied to such persons, and the rates of recidivism associated with these offenders. This study will then move into an assessment of the surgical castration procedure, the legality and ethicality of the procedure, and the alternative treatments available. Following the analysis of the castration option, there will be a review of the relevant research that has been conducted on the efficacy of the procedure in preventing recidivism, and the problems with the research that has been performed thus far. Finally, using the collected research and considering the limitations presented, a profile of the sex offender that would most benefit from the surgical castration procedure will begin to be formulated, first by focusing on the reoffender identification process and then by distinguishing the factors that predict a successful surgical castration.

This literature review will aim to show that, though the current research has provided a few markers in determining who would be most fit for the castration option, the question of what criteria imply good candidacy for this procedure is ultimately left unanswered by previous work. Given these findings, it is concluded that psychologists are not yet adequately equipped to create or employ a profile of the ideal candidate for surgical castration. It is clear, however, that SVP status established through an actuarial and/or guided clinical approach to risk assessment, as well as an active desire on the part of the SVP not to reoffend and resultant free election to receive the surgery, are necessary prerequisites for surgical castration.

Discussion of findings

What Defines a Sexually Violent Predator?

Consideration for castration is contingent upon the offender falling under the legal definition of a Sexually Violent/Deviant Predator (terminology varies by state). This is a highly selective classification, determined by either a judge or jury. A composite of the necessary criteria for placement into this sub-group of sex offenders is as follows:

- 1) the person has been convicted of offenses determined by the state to constitute a sexually violent crime; 2) the person suffers from a diagnosed mental disorder [or mental abnormality, personality disorder, behavioral abnormality, sexual psychopath personality, serious emotional disturbance, etc]; and 3) as a result of that disorder, the person is likely to engage in sexually violent offenses. (Weinberger et al., 2005; definitions vary by state)

As of 2005, seventeen states had adopted this or similar legislation (Washington State Institute for Public Policy, 2005). Given the hybrid nature of the SVP criteria – which, in fact,

incorporates both legal actions and psychological classifications – it is at times unclear as to who should be assigned this label. A sex offender may meet the legal criteria, but not the diagnostic criteria, or vice versa. Additionally, states vary in their willingness to include different levels of sex offenses in the SVP criteria. Regardless, the SVP classification is reserved only for those sex offenders who are regarded as most dangerous, usually due to the extreme nature or frequency of the crimes that they have committed.

The SVP classification originated when a series of laws were enacted across the United States that allowed for the continuing confinement of sex offenders after they had served their prison sentences fully. The SVP Laws allow states to hold sex offenders “in secure institutions until they [are] safe to be released” (La Fond, 2005). The first of these laws, the Washington SVP law, states that “Sexually Violent Predators generally have anti-social personality features which are not amenable to existing mental illness treatment modalities and those features render them likely to engage in future sexual behavior” (Wash. Rev. Code §71.09.010-115, 2003). The important feature listed here is the likelihood of that person to reoffend. This documented likelihood is what justifies the continued institutionalization of the sex offender, implying that they pose a public threat, have not been sufficiently rehabilitated through their incarceration, and remain in need of further treatment. Thus, the SVP incarceration laws serve two purposes: 1) to keep the sex offender in captivity, and 2) to allow for more time to treat the psychological disorder associated with the sexually violent behavior.

Surgical Castration: Purpose and Procedure

Given the Sexually Violent Predator laws, many sex offenders pursue alternative means of rehabilitation in order to demonstrate their recovery, in hopes of limiting their time in institutions. As of 2003, only California, Florida, Iowa, Louisiana, and Texas offer surgical castration to sex offenders seeking to be released from continued institutionalization (Scott & Holmberg, 2003). Though this review only examines the practice in the United States, it is of note that several countries in Europe also allow for castration as a means of treating sex offenders (Seto, 2008; Weinberger et al., 2005). The surgical procedure is offered as a means to decrease the initial duration of the prison sentence (Batchoo, 2007) or, in most cases, as a way to limit the amount of time spent in post-incarceration institutionalization (Weinberger et al., 2005).

The idea behind implementing laws that allow for surgical castration is that if a man cannot produce the hormones necessary to maintain a normal sex drive, he will not be driven to perform violent sex acts. The general belief that sex offenders lack impulse control has caused various legislative bodies to conclude that punishment by imprisonment is an insufficient or inefficient response to sex offense, and hence view castration as an alternative or additional method of addressing violent sexual crimes (Witt & Conroy, 2009). Thus, the aforementioned states sponsor castration as a way to reduce recidivism in SVPs. After collecting anecdotal data from the California SVP population, Weinberger et al. (2005) believe that, “Persons committed under these [SVP] laws or in the pre-commitment process may view surgical castration as their only realistic option for release” (17).

The surgical castration procedure, also called *orchiectomy*, consists of a bilateral removal of the testes, which almost completely inhibits the production of androgens, particularly testosterone (Seto, 2008; Weinberger et al., 2005). This limits, to some degree, the male’s sexual drive as well as his sexual performance. The surgery is performed on an outpatient basis, using only local anesthesia. Side effects of this procedure include:

Changes in metabolic processes; loss of protein; augmentation of pituitary functions; augmentation of creatinine found in urine; changes in fat distribution in the body; diminution of the calcium content of bones after a period of time; hot flashes and sweating; multiple diffuse somatic complaints; and diminishment of beard and body hair[...]depressive reactions, suicidal tendencies, emotional liability, and indifference to life. (Stone, Winsdale, & Klugman, 2000; Winslade, Stone, Smith-Bell, & Webb, 1998)

Additional problems with the procedure include its ethicality (see Scott & Holmberg, 2003, for a discussion of the viability of informed consent given by the imprisoned sex offender), as well as the recipient's susceptibility to self-imposed androgen supplementation for the purpose of regaining sexuality post-operation (La Fond, 2005; Seto, 2008; Weinberger et al., 2005).

It is important to note that surgical castration is not a standardized treatment for preventing reoffense (Seto, 2008; Weinberger et al., 2005). Though there is no accessible statistical data available on how often this surgery is used in comparison to other therapies available, it is widely accepted as a comparably extreme approach to the problem, and hence not employed as often as other legal or medical approaches to the SVP.

There are other options available to sex offenders in various states, some overlapping with the five that allow for surgical castration. With the exception of Texas, all states that allow for the surgical castration of sex offenders also sanction chemical castration as an alternative (Scott & Holmberg, 2003). Chemical castration, the most comparable alternative to surgical castration, consists of a perpetual, regulated injection of antiandrogenic hormones into the body (Miller, 2003). Chemical castration falls short of surgical castration in that hormone supplements may be attained to reverse the effects of the antiandrogens, and are seemingly more effective on chemically castrated individuals than on surgically castrated ones (Weinberger et al., 2005). Similarly, while a sex offender receiving chemical castration must be subjected to regular hormone treatments, surgical castration requires no continuing commitment on behalf of the offender.

In addition, there are non-medical therapies available, many of which are cognitive-behavioral, that involve redirecting sexual preference through olfactory conditioning, masturbatory satiation, cognitive restructuring, victim empathy, social competency, stress and anger management, and relapse prevention (La Fond, 2005). With respect to these alternatives, surgical castration has the advantages of being permanent and almost immediate.

Examining the Recidivism Research

In attempting to identify the Sexually Violent Predator that would most benefit from surgical castration, it is important to first consider a general picture of sexually violent reoffense, as well as how this information is collected and examined. Recidivism rates are compiled using several different measures. The most accessible sources of data are official records, which detail arrest, conviction, and incarceration rates. Depending on which of the three data collection methods the researcher chooses to adhere to, the recidivism rates for a given population may appear higher or lower. Another method is victim survey, which shows that arrest rates do not sufficiently account for the high incidence of reoffense, but are rather unhelpful in determining specific information about the nature of the offender. Victim surveys, usually in the form of self-reports, are the most widely practiced method of observing post-castration recidivism rates; however, despite the extensive measures taken to ensure confidentiality, these surveys are susceptible to response bias (La Fond, 2005).

Sex offenders, using the broadest definition, engage in recidivism significantly less than the average criminal. La Fond (2005) argues that, “official law enforcement records indicate that sex offenders, as a group, are *not* especially dangerous. In fact they commit *fewer* new crimes than many other types of criminals” (46). The United States Department of Justice states that only 43% of sex offenders released from prison commit any another offense, whereas 68% of non-sex offenders commit other crimes (Bureau of Justice Statistics, 2008). A crucial caveat, however, is that recidivism rates for sex offenders vary not only because of the wide-ranging and imprecise methods of data collection, but also as a result of the inconsistent definitions of the term “sex offender” (Shajnfeld & Krueger, 2006). When one looks solely at those sex offenders classified as SVPs, the recidivism rates skyrocket. Most researchers estimate SVPs’ reoffense rates to be somewhere within the 70-80% range (Hanson, 1998). Since SVPs are a more precisely defined subgroup, these estimates tend to be more consistent from study to study.

Recidivism rates following surgical castration are much lower than those of SVPs who do not receive the surgery. Most studies show rates in the 0-10% range (Weinberger et al., 2005). The largest scale study was conducted in Germany in 1963 by Langelüddecke . With a participant pool of 1036, 84% of whom had committed at least two sexual offenses, 2.3% reoffended after electing for surgical castration. The follow-up period varied from six weeks to twenty years. By comparison, a control group of 685 similarly violent sex offenders showed a 39.1% recidivism rate (Langelüddecke, 1963). Another prominent study that took place in Germany in 1989 involved 99 convicted and castrated sex offenders, followed up after eleven years, and found a 3% recidivism rate, in comparison to a 46% recidivism rate in the 35 person control group (Wille & Beier, 1989). Similar rates were found in other studies (Norway: $n = 102$, follow up time: 1-10 years, recidivism rate: 2.9%, no control group; Cornu, 1973; Denmark: $n = 900$, follow up time 6-10+ years, recidivism rate: 1.1%, no control group; Sand, Dickmeiss, & Shwalbe-Hansen, 1964; Sturup & Wolfgang, 1972). The aforementioned 10% recidivism rate was found during a small study of 21 participants in Denmark in 1991, with a follow up time of 15+ years, and a control group of 22 with a 36% recidivism rate (Hansen, 1991). The only study conducted in the United States took place in California in 1952. Sixty castrated participants, 27.5% of whom were convicted at least once for a sexual offense, were followed up with after 2 months to 13 years. None reoffended. There was no control group for this study (Smith, Brown, & Beck, 1952).

The recidivism rates for surgically castrated sex offenders are relatively consistent, usually falling between 2-3%. The two outliers in this study, the 0% and the 10% were the smallest studies conducted. The variation in sample sizes, control groups, number of sex offenses previously committed, and in particular the diversity of follow up time, accounts for the spread of recidivism rates. Additionally, because the studies took place in different countries and at different times, sex offenders and the severity of their offenses may have been classified differently, and reoffense rates may have been gathered and calculated using different methods.

A major problem, aside from the variation in definitions and data collection methods, is that because those who received the surgery elected for it, there is no random sampling involved; therefore, recidivism rates for castrated SVPs may be biased (La Fond, 2005). The variable groups and control groups were self-selected. Without random sampling, one cannot determine whether it is the castration itself, or the disposition of the person who elects to be castrated, that produces the low recidivism rate. This likely biases the data by automatically lowering the post-castration recidivism rates, given that those individuals who received the surgery had willingly elected to do so, and thus most likely had little intention of reoffending to begin with, in comparison to those who refused the surgery. Subjects who sought recovery and chose alternative therapies over surgical castration may have also displayed a lower bias, given that

sexual castration is a relatively drastic measure. However, the recidivism rates and apparent bias would be expected to be lowest with surgical castration, despite the fact that biases from other treatments may also lower recidivism rates. Hence, when claims are made that surgical castration has the lowest recidivism rate of any other treatment method (Rosler & Witztum, 2000), there may be a bias in effect that disallows for these conclusions to be concretely drawn.

Identifying The Reoffender and Profiling The Candidates

Identifying sex offenders that could benefit from the surgical castration option is a two-step process: the first step is to predict whether the convict in question is likely to reoffend, and the second is to evaluate his motivations for receiving the surgery. It is important to note that courts constitute the official authority on whether a sex offender is labeled a SVP as well as whether the offender is offered surgical castration therapy. Clinicians, who tend to be psychologists, psychiatrists, or social workers, usually have a strong influence on the decisions made in court. In fact, Janus and Nudell (2000) note, "The testimony of clinical psychologists is given great weight in sex offender commitment proceedings and the accuracy and reliability of their testimony is of paramount importance to the correct resolution of the case" (13). Therefore, these practitioners both evaluate the danger posed by a sex offender and provide suggestions for what actions should be taken to rehabilitate the offender. There are several methods currently used to predict which sex offenders are likely to reoffend. La Fond (2005) separates these methodologies into three distinct approaches: clinical, actuarial, and guided clinical.

The clinical method consists of a psychiatrist or psychologist interviewing the convicted sex offender and looking for cues that would suggest the possibility of reoffense. Risk is evaluated based on a collection of factors, and is largely left to the subjective judgment of the clinician. This method has proved rather ineffective when used on its own, and is being phased out by many forensic practitioners (Hanson & Bussiere, 1996; La Fond, 2005).

The second method is the actuarial approach, which uses other, sometimes seemingly unrelated, factors in the convict's behavioral patterns to calculate the statistical likelihood that he may reoffend (La Fond, 2005). The most widely validated actuarial instrument is the *Violence Risk Appraisal Guide (VRAG)*, which places subjects into one of nine levels of risk of violent behavior. Interrater reliability ($r = .90, .95$) has consistently been found to be highest on this test (Barbaree, Seto, Langton, & Peacock, 2001; Jackson, Rogers, & Shuman, 2004). Another common test, the *Static-99*, is an actuarial instrument used to predict future sex offenses. A subject is placed into four different levels of risk, ranging from low risk to high risk (Jackson et al., 2004). Interrater reliability ($r = .90$) for this test has been found to be relatively high (Barbaree et al., 2001). There is, however, no comprehensive method of employing solely this procedure to evaluate risk without running a distinct possibility of false positives, which is unacceptable in a situation in which such extreme bodily modification is being considered. Witt and Conroy (2009) report that actuarial risk assessments "often place many more subjects in the high-risk category than the relatively small number that state systems typically wish to commit" (59). Even with this heightened risk of false positives, 95% of "SVP experts" report using the actuarial method when assessing the likelihood of reoffense (Jackson & Hess, 2007).

The final method is called the guided, or structured, clinical approach, which essentially combines the two aforementioned methods. In fact, the guided clinical approach unites the risk assessment from the scores acquired through actuarial testing with an evaluation of the remaining risk factors present. In describing this method, Jackson et al. (2004) write, "The clinician uses his or her clinical judgment in conjunction with the identified risk factors in formulating a prediction of risk" (119). The most promising tool within this methodology relating to sex offenders seeking

prison release appears to be the *Sexual Violence Risk-20* (SVR-20), which accounts for factors related to sexual violence and sex offenders (Jackson et al., 2004). Instruments such as SVR-20 have been shown to have higher reliability and predictive capabilities than mere clinical judgment, the first method presented (Mercado & Ogloff, 2007). Though it has been regarded by some as the most accurate (Hanson, 1998), the guided clinical method is still in the beginning stages of gaining widespread credibility.

Of these three methodologies, none is effective enough to warrant confident statements regarding the danger posed by an individual SVP. Jackson et al. (2004) found that, using typical risk assessment tools in order to predict future sexual violence, clinicians correctly assess likelihood to reoffend for approximately 50% of SVPs. Other, earlier estimates, were set as high as possessing 75% accuracy (McNeil, Sandburg, & Binder, 1998) and as low as 33% (Monahan, 1981). Additionally, after performing extensive research, Rogers and Jackson (2005) found that “no individual method of SVP evaluation offered an appreciable advantage in predicting sexual violence” (523). These low accuracy ratings, along with the lack of exemplary methodology, may be the cause or the result of why many surveys have shown spotty usage of these techniques in risk assessment. Witt and Conroy (2009) claimed “it would be difficult to contend that the administration of specially designed risk assessment instruments represents the approach used by the majority of practitioners in the field” (66). Unfortunately, many other less reputable or reliable factors, often emotion based, are considered when clinicians or other professionals in the field make decisions involving risk assessment and treatment (Mercado & Ogloff, 2007).

Though vast improvements in the field of risk assessment have been made over the past three decades (Jackson et al., 2004), this area of study requires significant additional research. The methodologies psychologists and psychiatrists currently employ in order to determine the danger posed by a sex offender and to determine his eligibility for castration and other therapies lack validity and effectiveness. It should be of concern that such drastic measures, such as the orchiectomy procedure, are taken based on data that has been shown to produce high error rates and is frequently haphazardly collected. It is no wonder, then, that Mercado and Ogloff (2007) declare that “SVP courts must insist on good science” (386).

The second task in evaluating surgical castration candidacy is to determine whether the sex offender has the right motivations in pursuing castration. Because surgical castration is used as a means of limiting time in the penitentiary or institution (Batchoo, 2007; Weinberger et al., 2005), it is essential that the sex offender seek the surgery out of a desire to reform, and not merely to be allowed back into the public sphere. This is especially true given the fact that many SVPs who receive the surgery are still able to perform sexually. Wille and Beier (1989) reported that 33.3% of their subject pool in the aforementioned study could maintain an erection such that they could engage in sexual activity. Additionally, in the study performed by Hansen (1991) in Denmark, the 10% of the subject pool that reoffended (two men) had been able to access testosterone via injections to supplement the loss of androgens associated with the castration procedure. This data suggests that there are ways for some SVPs, even after receiving the surgical castration procedure, to engage in sexual acts, and therefore to reoffend. Given this knowledge, an analysis of underlying motivations should be performed in examining possible candidates for castration. Thus, the profile of the ideal candidate for surgical castration is a SVP who is accurately deemed likely to reoffend, preferably determined using the guided clinical approach, and is motivated to reform prior to the usage of this treatment.

Conclusion

Though there has been a sufficient amount of research done on the rates of recidivism in surgically castrated SVPs, little information has been collected to provide a comprehensive method with which to identify the sex offenders that are most fit for the procedure. Due to the highly confidential nature of the information collected, few case studies are available to gain a closer view of the sex offender who re-offends even after receiving this treatment.

Though it is clear that psychologists do not have adequate evaluation techniques to determine which SVPs would be good candidates for surgical castration, the treatment itself has proven to be widely effective. However, a large gap in the legal system's employment of this technique suggests that there are not sufficient prognostic tools at the disposal of forensic clinicians. Thus, much research is needed to improve the implementation of this recidivism prevention method, including studies performed with the intention of enhancing risk assessment methodologies and of identifying which SVPs most require surgical castration.

Needless to say, the stakes of this research are quite high. Given the extreme nature of the operation performed, a false positive identification of a candidate would be dangerous and unjust. Providing this treatment to a sex offender who would not otherwise reoffend seems inhumane, while allowing a sex offender who has no desire to recover from his violent sexual tendencies to receive this treatment would be incredibly dangerous upon his release. In the delicate yet promising method of addressing sexual reoffense described here, effectively profiling the ideal candidate is an essential step to successfully ensure the safety of both the sex offender and the surrounding community.

Rayna Edwards is currently a member of the class of 2010 at Wesleyan University, majoring in Psychology and Religion. She plans to continue conducting research in the areas of cultural psychology and sexuality studies after graduation. She would like to thank Professor Sarah Carney, Gwynne Hunter, Mattie Liskow, Christi Richardson, Sophia Sadinsky, and Lauren Sonnabend for their efforts in supporting this research. Correspondence may be addressed to rgedwards@wesleyan.edu.

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