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Sexual Predators Who Prey on Children: No Second Chances

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ABSTRACT

Child sexual abuse is an ugly reality that results in enormous consequences and costs to both its victims and society, and though steps have been taken that have attempted to address it, they have largely failed. More must be done. The position of the researcher is that those who sexually victimize children should receive a mandatory life sentence without the possibility of parole. Information used to support this position was obtained from numerous books, journal articles, and internet sites. Child sexual abuse victimizes children in the most personal of ways. While it's economic costs are higher than any other crime (Wright, 2009), its impact forces its victims and society to cope with lasting and profound physiological, psychological, emotional, developmental, and behavioral consequences. There is no accepted, standardized, and proven risk-assessment or treatment measures for those convicted of these crimes, and the legislation that has been passed attempting to address them has proven to be merely ceremonial. How to protect the most innocent in society is one of most critical decisions government must make. Because steps taken to date to protect society's children from sexual predators have failed significantly, those convicted of such heinous crimes should not be given a second chance to do so again.

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INTRODUCTION

Suppose there was a catastrophic disease in today's society that victimized one out of every five girls and one out of seven boys before they reached the age of 18. Suppose that same disease drastically affected those children's future health by increasing their risk of developing an addiction to drugs, of acquiring a sexually transmitted disease, and committing suicide. Suppose it caused its victims to experience drastic mood swings, have severe conduct and behavioral issues, and prevented them from establishing normal and appropriate relationships. Suppose the disease led to the victims not being able to have healthy and satisfying sexual relationships when they became adults. Suppose this disease was contagious, but lay dormant for years, resulting in some of its victims passing on its debilitating affects to others years down the road. Sadly, such a disease does exist in society today. That disease is child sexual abuse (Ward, Laws, & Hudson, 2003).

Crime, for anyone, can be traumatic. Children, unlike adults, are not as aware that there are people that will take advantage of their youth, their lack of knowledge, and lack of life experience, and victimize them in the most personal of ways. Due to their age and/or lack of physical strength, children are often helpless to prevent becoming victims of sexual abuse, and they do not have the maturity and understanding to appropriately cope with the aftermath. Children, for reasons such as fear of the offender and feelings of helplessness or shame, often do not tell of their abuse. Many children believe, or are led to believe, that the abuse is their fault or that there is something wrong with them since they were chosen. They do not comprehend that by

staying silent, they may be allowing other children, now or in the future, to also be abused by the same offender (Salter, 2003).

While almost all pedophiles are child molesters, not everyone who molests children are pedophiles. Pedophiles are sexually attracted to children, most often those under 13 years of age. Non-pedophile child molesters are primarily attracted sexually to adults but may molest children in order to meet emotional needs because of low self-esteem, other feelings of inadequacy, and/or an inability to establish or maintain appropriate adult relationships ("Pedophiles and Child Molesters: The Difference," n.d.). Freeman (2007) stated that "Child molesters often find comfort in the relationships formed with their victim, as children are perceived as less threatening than adults" (p. 753). According to Dr. Anna Salter, a psychologist and world renowned expert on child sexual abuse (CSA), the reason pedophiles molest children is much less complicated than the popular theory that pedophiles are compensating for verbal abuse suffered at the hands of their mother (a "mother complex") or any of the other excuses and theories often suggested. Many pedophiles simply have a deviant arousal pattern and molest because they are sexually attracted to children. Whatever their reasoning, the compulsiveness of these individuals can be extraordinary (Salter, 2003).

Salter (2003) reported that research in the late 1980s by Dr. Gene Abel and his colleagues stunned those in the professional community when 232 professed child molesters admitted that they had attempted over 55,000 incidents of molestation, which is an average of 237 each. These same men claimed they had successfully committed 38,000 incidents of molestation, which is an average of 164 each. Combined, these men reported to having over 17,000 victims, which is an average of 73 victims each. All

these victimizations were committed by only 232 men. These men were not lying or just bragging about their exploits, and numerous studies have confirmed what these offenders have claimed. Salter (2003) also mentioned another study by Dr. Pamela Van Wyk, who conducted a treatment program for incarcerated offenders. Each offender initially admitted to having an average of three victims each. When faced with having to pass a polygraph examination, the offenders admitted to having an average of 175 victims each. And another study found that offenders, when faced with a polygraph, revealed they had four to six times the number of victims than they first admitted to (as cited in Salter, 2003). Statistics show that the rate at which children are being sexually molested is not getting any better. A recent National Violence Against Women survey found that one out of every six women has been raped, and of those, 95-96% reported also being sexually victimized as children (Wright, 2009).

Unless society intervenes, sexual predators that prey on children will not stop molesting on their own (Salter, 2003). A mandatory life sentence, without the possibility of parole, should be mandated for those who sexually victimize children. Society can do more, much more, to protect children from those that will victimize and prey on them.

POSITION

Those who sexually molest children manipulate society in order to carry out their perverted acts, and this is but one reason a mandatory life sentence should be implemented for such people. They use many techniques to “fool” people in order to gain access to children. Their main one is to live a “double life,” working hard to establish the persona of the type person who would never do such a thing as molest a child. Society often imagines child molesters as hideous monsters who stalk children.

But outside of their inclination or propensity to molest children, they are no different from anyone else. Because they appear kind and respectable in public, many people cannot or will not believe there are people who commit such brutal and horrible acts. Psychiatrist Fred Berlin has noted that people often believe that a person who appears to have character and integrity cannot have deviant sexual interests. Unfortunately, this is not always the case. A person who obeys the law, shows compassion, and displays responsibility, may also compulsively molest. What is "different" about child molesters from the rest of society is simply this: they molest children (Salter, 2003).

In order to carry out their perverted acts, child molesters take full advantage of many of the character traits associated with their ideal victims. Molesters will exploit the fact that children are naturally curious about most things, especially sex, since it is often a taboo subject. The fact that most children are taught to respect and obey adults makes it that much easier for child molesters, particularly when they hold some position of authority. Not unlike adults, children have a need for attention and affection. Those from dysfunctional and broken homes, who have strong feelings of being neglected or alienated, are the most vulnerable. They will be sought out by molesters who, preying on the child's need for attention and affection, will treat them better than they are treated at home. Children going through a rebellious stage, with a desire to defy their parents, are also targeted by molesters who take full advantage of their rebellious attitude (Lanning, 2001). Many molesters choose emotionally disturbed children with a history of telling lies. Because of their history, when and if these children do tell of abuse, they are often not believed. One convicted offender, a young, charismatic, church deacon, chose just such victims. He later admitted that he had twice been told on, but no one

believed his victims. Church, community leaders, and many others defended the deacon because of their perceptions of who they thought he was. The deacon later confessed to having 95 other victims, all from groups he counseled or supervised. Being “normal” and holding a respectable position can provide cover for child predators for long periods of time at the expense of an unbelievable number of victims. When victims of CSA are not believed, the offender becomes emboldened, knowing he can then have almost unlimited opportunities to continue to victimize those children (Salter, 2003).

Predators that prey on children utilize many defenses to justify to society, and themselves, that what they have done is okay. Some of these include denial, minimization, and justification. With denial, usually their first reaction, child molesters may feign surprise or shock when confronted. If an admission is made, they will claim it was not sexual or that their intentions were misunderstood, saying something like, “it is a crime to hug a child?” Minimization involves the offender admitting to acts he is accused of, but minimizing both quantity and quality of them. He may admit to fondling or digital penetration as opposed to full sexual intercourse, or may claim an act occurred two or three times when it actually happened 30 times. Justification is used by many child molesters to try to convince themselves they are not evil, immoral, deviant, or even criminal. They portray themselves as loving and high-minded people at a time in history when their desires and actions are not yet acceptable (Lanning, 2001).

Additional defenses used by those who prey on children include rationalization, fabrication, and attack. Rationalization often involves the offender claiming the things he does shows that he cares for the children, and sex with children is not only not

harmful but beneficial for them. If he is in a parental-type role, he may claim it is better that he teach the child about sex rather than anyone else. The most common rationalization used by child molesters is blaming the victim with claims, such as the child initiated the sexual act and seduced him or the child is promiscuous. The more clever molesters employ fabrication to explain their actions, such as incest offenders claiming to teach the child the difference between “good touch” versus “bad touch,” or providing them sex education. Finally, attack can be used by child molesters to take the offensive. They may threaten, harass, or even bribe the victim and/or witnesses (Lanning, 2001)

Child sexual abuse has a profound and lasting physical and developmental impact on its victims. CSA, more than any other type of child abuse, has been identified as the contributing factor for numerous physiological symptoms suffered by it victims. Victims have been found to be disproportionally predisposed to eating disorders such as bulimia and anorexia. Due to the stress produced, victims of CSA have been found to display “gastrointestinal disturbances, migraine headaches, hypertension, sleep disturbances, aches, pains, and rashes that seem to defy diagnosis and/or treatment” (Rodriguez-Srednicki & Twaite, 2006, p. 30). One study found that sexually abused children had much higher than average rates of chronic depression and morbid obesity (Dallam, Heath Consequences of Childhood Maltreatment, 2001, para.1).

There are other serious physical consequences of CSA. One is a reduction of the volume of the hippocampus in the brain, which affects learning and memory (Bremner, 1999). Magnetic Resonance Imaging (MRI) scans have shown the intracranial and cerebral volumes of abused children to be significantly smaller than

control groups of non-abused children. These consequences have a negative affect on memory performance. During severly stressful events such as CSA, cortisol is released by the body as a survival mechanism to suppress the body's reaction to injury. Repeated often, this release can have a lasting negative impact on the immune system by reducing the size of the thymus gland, a primary organ of that system. Studies indicated that the thymus gland in abused children is significantly smaller than those of non-abused children (Dallam, 2001). CSA is also a known risk factor for Human Immunodeficiency Virus (HIV). It has been shown that a much greater percentage of HIV-infected women were the victims of CSA compared to non-abused women. CSA has also been linked to an increased risk of arthritis and breast cancer in elderly women and thyroid disease in elderly men (Dallam, 2001).

In addition to the physical consequences, the victims of CSA face a lifetime of trying to cope with resulting psychological and emotional problems. Victims are typically characterized by general fearfulness and anxiety related symptoms, poor social skills, social withdrawal, bouts of sadness, feelings of guilt and shame, and unusually high levels of anger. They have difficulty establishing satisfying peer relationships and may have specific phobias, including that of avoiding adult males. Insomnia, extreme and recurrent nightmares, and other sleep disorders are common. Dissociative symptoms such as periods of amnesia, excessive fantasizing, sleep-walking, black-outs, daydreaming, and imaginary friends have also been linked disproportionately with CSA. Confused and unable to understand the reasons for their victimization, victims often believe they are to blame for the abusive treatment they receive and will frequently have such low self-esteem that it leads to self-hatred (Rodriguez-Srednicki & Twaite, 2006)

A strong relationship between adult Borderline Personality Disorder (BPD) and CSA has also been confirmed through in-depth studies, such as those by Links, Steiner, Offord and associates (1988), and Zanarini, Gunderson, Marino and colleagues (1989) (as cited in Rodriguez-Srednicki & Twaite, 2006). In the 1988 study, 48% of the sexually abused children met the legal diagnoses for Post Traumatic Stress Disorder (PTSD). Of those sexually abused by their biological fathers, it was 75%. A later study by McLean & Gallop (2003) not only confirmed these findings but found the relationship among these disorders and CSA was even greater at 94%.

The lifelong behavior of victims is also impacted significantly by CSA. During childhood, they often suffer both physical and mental developmental delays and may experience difficulties behaving appropriately around their peers. They are often unable to appropriately adjust while at school and may become disruptive in the classroom. As a result, their academic performance is affected and can result in their being retained in a grade and/or cause them to drop out of school. When these victims become adolescents, they have a much higher probability of engaging in self destructive behaviors such as truancy and running away from home (Rodriguez-Srednicki & Twaite, 2006)

Victims of CSA frequently engage in inappropriate sexual activities. Excessive curiosity with sex, compulsive masturbation, promiscuity, and acts of indecent exposure are common. (Rodriguez-Srednicki & Twaite, 2006) Research has verified they more frequently engage in risky sexual behaviors such as promiscuity, premature sexual activity, failure to use condoms, and engaging in prostitution, all of which increase their risk of acquiring HIV and other sexually transmitted diseases (Wilson & Widom, 2008).

Numerous research studies (e.g. Miller, Downs, & Testa, 1993; Bachman, Moggi, & Stirnemann-Lewis, 1994; Chandy, Blum, & Resnick, 1996b; Collins, 1995; Peters & Range, 1995) have shown there is a distinct relationship between a history of CSA and illegal substance abuse among both women and men (as cited in Rodriguez-Srednicki & Twaite, 2006). As they get older, many sexually abused children find "they can artificially induce a more relaxed state by self-medicating with substances such as alcohol, cigarettes and drugs" (Dallam, 2001). One study by Riggs et al. (1990) found the risk of smoking and drug use doubles following victimization, and the likelihood of using alcohol triples (as cited in Dallam, 2001).

A significant relationship has also been found between various forms of Non-Suicidal Self Injury (NSSI), the direct and deliberate destruction of body tissue in the absence of suicidal intent, and the victims of CSA. The two most common reasons CSA victims engage in NSSI are to both to generate feelings when they have none and to stop negative feelings (Weierich & Nock, 2008). Several studies (e.g. Borowsky, Resnick, Ireland, & Blum, 1999; Beautrais, 2000; Martin, Bergen, Richardson, Roeger, & Allison, 2004; Ystgaard, Hestetun, Loeb, & Mehlum, 2004) have shown relationships between early CSA and both self-injurious and suicidal tendencies in children, adolescents, and adults (as cited in Rodriguez-Srednicki & Twaite, 2006). In a survey by Martin and colleagues (2004) of 2,485 adolescents, respondents with a history of sexual abuse were significantly more likely to admit having thoughts about killing themselves (73% of the CSA group versus 25% of the non-CSA group); making plans to kill themselves (55% vs. 12%); threatening to kill themselves (45% vs. 9%); and actually attempting to kill themselves (24% vs. 5%)(as cited in Rodriguez-Srednicki & Twaite,

2006). For some, these feelings develop to such a magnitude that they become intolerable and end with suicide attempts. Dallam (2001) reported that one study by Riggs et al. (1990) found that high school students who had been sexually abused were three times more likely to try to commit suicide, and another study by Garnefski and Arends (1998) found that the rate was ten times higher for boys. Dallam (2001) stated, "Abused children discover at some point that intolerable feelings can be most effectively terminated by a major jolt to the body. The most dramatic method of achieving this result is through the deliberate infliction of injury" (para. 2).

Because child sexual abuse involves an adult imposing their sexual desires on a child, the victims of CSA often come to associate such intimate acts with dominance, fear, and shame, instead of warmth, caring, and affection for a partner. As if sexual development was not difficult enough, the stigma and distorted feelings and beliefs resulting from CSA makes achieving a healthy, adult, romantic, relationship later in life exceedingly more challenging (Cleland, 2009). For many victims, a broad range of adult sexual issues can be attributed to CSA. Some grow up having a complete lack of interest in sex, while others feel compelled to compulsively engage in risky promiscuous sex with strangers and/or multiple partners. Some victims cannot achieve an orgasm during sex, others can only do so when intoxicated, and still others can only do so through the use of pornography; the latter often requiring pornography involving sadomasochistic or abusive sexual behavior.

Because many CSA victims have difficulty establishing normal, healthy adult relationships, they often end up in situations and relationships that are abusive and subject them to again being repeatedly sexually assaulted. Becoming an exotic dancer

or prostitute is quite common among victims of CSA, an unfortunate fact supported by substantial empirical literature (e.g. Chu, 1992; van der Kolk, 1989; Widom & Ames, 1994) (as cited in Dallam, 2001). A study by Ross, Anderson, Heber, and Norton (1990) found that 60% of prostitutes reported being sexual abused as children, with 70% claiming the abuse influenced their decision to become a prostitute (as cited in Dallam, 2001). Ninety-six percent of juvenile prostitutes in the study were runaways, and many indicated they ran away because of the sexual abuse they were experiencing. The studies discovered that just ten years of age was the mean age for the first victimization. Once out on their own, hungry and finding themselves with no place to stay, these runaways become prime candidates for pimps to recruit into prostitution.

In addition to the personal affects of childhood sexual abuse, the costs of sexual victimization, both economically and to society as a whole, are exorbitant. Costs for the criminal justice process alone include expenses for public education, law enforcement, the courts, and incarceration. A 1996 National Institute of Justice study placed the cost of sexual assaults at $87,000 per victimization, higher than any other crime (Wright, 2009). Society also bears CSA costs for psychological and medical care, child protection agencies, and the loss of productivity and earnings. As mentioned, many victims often engage in high-risk behaviors, such as alcohol, tobacco, and drug use. The effects these behaviors have on the health and well-being of the individuals are greater than any other preventable illnesses and create a huge economic burden on society as a whole. A report in 2001 attributed substance abuse to nearly 590,000 deaths and roughly 40,000,000 illnesses and injuries annually (Dallam, 2001). Although

exact numbers are not known, research has also indicated that one of the greatest costs to society is the cost of re-victimization, as many victims of sexual abuse continue the vicious cycle of abuse and become child molesters themselves (Lanning, 2001).

The commission of additional offenses by molesters following their release from custody is one of society's biggest fears. Recent prominent national cases, such as Jessica Lunsford in Florida in 2005, demonstrated the gripping fear sexual predators can cause, especially to parents with young children. According to a 2005 report, the recidivism rates of sexual offenders are near 15% within five years of release, near 20% after ten, and between 30%-40% after 20 years. These numbers, however, are conservative ("Recidivism: How Often Do Child Molesters Go on to Reoffend?" 2005).

When determining recidivism rates, most studies count only the offenses committed by released sex offenders after they have been rearrested and reconvicted. Since only a small percentage of offenses are reported and, of those, few result in conviction, trying to determine true recidivism rates is almost impossible. For example, if every released child molester re-offended, with the reporting rate for CSA being 12% and the conviction rate being 50%, the recidivism rate would be reported as only 6% ("Recidivism: How Often Do Child Molesters Go on to Reoffend?" 2005). Recidivism rates vary significantly across studies, mainly due to methodological differences. These differences include the types of data sources used, how recidivism is defined, and sample characteristics included. Because of the differing definitions on recidivism, differing follow-up periods, and the low reporting and conviction rate, official statistics should always be viewed with caution (Wright, 2009).

Although the importance of recidivism research cannot be underestimated, the documented studies on this issue have produced widely varied results. Some even use the highly questionable method of self-reporting by offenders in order to determine their recidivism rate. Taking all the various differences into account, one study by Doren (1998) estimated that 52% was a conservative recidivism estimate for extra-familial child molesters, and the results of a another 25-year follow-up study by Langevin et al. (2004) placed the recidivism rate for that same group at 70%, and incest offenders at 50% (as cited in Durkin & Digianantonio, 2007). Combined data from numerous recent studies showed that conservative estimates indicated that no fewer than 40% of child molesters reoffend (Wright, 2009).

The release of just one child molester back into society greatly increases the risk for another innocent child being victimized. To help address this, risk assessments are often done prior to release. Just the fact that these assessments are needed indicates the serious, real-life implications that possible release presents. Despite the importance of such decisions, the risk assessment process is plagued with problems. Two major ones have been identified. One is determining the proper risk assessment model to use based on the situation. The debate over which model is best has been going on for over 50 years, and it still continues today. The second is that while most models address the probability of an offense being recommitted, they do not address the imminence, frequency, or severity of the offender's risk. A great deal of reliance is placed solely on the judgment of the person conducting the evaluation (Marshall, 2006)

Probably the most relevant study of the reliability of clinical diagnoses to date was conducted by Levenson in 2004 (as cited in Marshall, 2006). This large study

compared one year's worth of cases in which at least two different diagnoses of each offender were made by separate clinicians. The study found that the reliability of these multiple-diagnostician diagnoses was not even close to acceptable standards (as cited in Marshall, 2006). In the past decade, a number of assessment instruments to predict the recidivism risk of sex offenders have been developed. According to Looman and Abracen (2010), comprehensive studies have found that none outperformed any other in consistency or reliability for the prediction of sexual reoffending in general, and not one of the assessment instruments were able to reliably predict recidivism for child molesters. Because there is no accepted standardized method, the prediction of an offender's recidivism risk is dependant on the offender, the many variables surrounding them, and the quality of the assessor and assessment process. Trying to predict what a person will do in the future is a next to impossible task. With the stakes so high with regards to sexual predators, for the sake of the children of this country, these predators should not be released.

COUNTER POSITION

Through the years, the treatment of sexual offenders has changed significantly. Treatment began in the 1960s with mainly individual behavioral therapy using shock treatments and adverse odors along with social skills training. It progressed to more group cognitive treatments that challenged both the offender's thoughts and beliefs that their actions were the victims fault and their denial that they were harming the victim. There are currently two primary categories of treatment types, psychological and biological, and they are often used in combination. Psychological approaches, using behavior and cognitive therapies, work to try to modify the offender's behaviors. The

biological, utilizing chemical (medication) or physical (surgical) castration interventions, deals with reducing or eliminating the sex drive of the offenders.

Behavior therapies are based on the premise that people's negative behaviors are conditioned, and they can be retrained and replaced with appropriate ones. Some use cognitive methods, which focus on helping offenders understand their problems and how to appropriately interact with others. Watching films depicting the effects of victimization and reading victim impact statements are used to teach offenders empathy. Relapse prevention therapy, which teaches offenders to recognize their own specific cues that lead to offending, is another popular strategy utilized to try to break the cycle of offending. It is believed that once these cues are known to the offenders, they will then be able to take the necessary steps to avoid or deal with them. With this strategy comes a lifelong commitment these sex offenders must accept, to recognize their cues and take the appropriate steps to deal with such situations, feelings, and behaviors (Wright, 2009).

As promising as the sex offender treatment methods may sound, their effectiveness must be further studied. Many meta-analytical studies, Hall (1995), Alexander (1999), and Hanson et al. (2002) have produced conflicting results, indicating recidivism rates among treated sex offenders anywhere between 12% and 19% compared to 17% to 27% for untreated offenders (as cited in Wright, 2009). These differences between those receiving treatment and those not are not significant. With the various methodological differences in the ways the studies are conducted and the definitions used for recidivism, predicting which child molesters will reoffend is next to, if not, impossible (Wright, 2009). Sex offender training must to go beyond the classical

relapse prevention approach of simply managing high-risk situations which has been the accepted primary treatment method for years.

Despite improvement in treatment methods, child molesters continually rely on an emotion-based style of coping and, because these individuals often lack self worth and emotional stability, this style of coping is detrimental (Serran, Moulden, Firestone, & Marshall, 2007). It has also been identified that the amount of training each therapist has and the characteristics of both the therapist and treatment center plays a vital role in the effective delivery of treatment (Craig, Browne, & Beech, 2008). Even centers specializing in sex offender treatment have been found to be naïve. One center, after "treating" a Catholic priest with a known history of molesting boys, and who had plead guilty to doing so, concluded that he plead guilty only to spare the church and even hired him as a member of their staff. After he was later charged with an additional 18 counts sexual assault, the center still refused to believe he was a child molester and that their diagnosis was wrong. In another case in 1989, two family therapy clinicians treating offenders who had molested their own children told the families that what had been done may indicate that they loved each other too much, thus redefining CSA within the family as showing too much love (Salter, 2003).

While treatment can produce some positive outcomes, it can only do so if the offenders understand that sexual acts with children are wrong. It is believed that those who comply with the requirements of treatment programs will be at a lower risk for recidivism. Treatment, however, must be a long-term process in order to be effective, and even then, recidivism rates have been shown to increase over time (Durkin & Digianantonio, 2007). Offenders must remain self-motivated and committed in order to

be successful. While motivation has been shown to improve during treatment, it has also been shown to drop substantially after the offender has been released back into the community (Craig, Browne, & Beech, 2008). While treatment and therapy methods have improved over the primitive methods used decades ago, treatment techniques and beliefs still have a long way to go. To date, no treatment method for sexual offending, including child molesters, has been identified as the agreed-upon definitive treatment method (Wright, 2009).

Referred to as “memorial laws” and named after tragic kidnapping, sexual assault, and murder cases, most current sex offender laws were enacted to try to protect society from re-victimization at the hands of released sexual offenders. Sex offender laws have come in three waves. The current wave began in Washington State with the passage of the Community Protection Act of 1990 containing 14 provisions meant to ensure the safety of communities against sexual predators. This was followed in 1994 by the Violent Crime Control and Law Enforcement Act, which included the Jacob Wettering Crimes Against Children and Sexually Violent Offender Registration Act, the first federal law to include sex offender registration and notification as well as a national registration database. Numerous other federal, state and even local laws followed, the most recent major one being the Adam Walsh Child Protections and Safety Act in 2006, which established new national standards in several areas. These policies, which have included civil commitment, residence restrictions, special identifiers on drivers licenses, community supervision, GPS tracking, and even mandatory chemical castration, have provided a means of treating, managing and supervising sexual offenders. Residence restrictions, the most common and well known, limit where

sex offenders can live, work, and loiter, with the hopes that by restricting their access to areas where children are known to congregate public safety will be increased (Wright, 2009).

The problem is that even with all their good intentions, sex offender laws are failing to protect communities from sexual predators. A study in one Arkansas county, by Walker, Golden, and VanHouten (2002), discovered that 48% of child sexual offenders lived within a 1,000 foot radius of schools, parks, and day care centers, compared to only 26% of non-child sex offenders who did, while another study by Weiner (2007) in New York City found that 85% of the highest risk offenders lived within five blocks of a school (as cited in Wright, 2009). Even with today's advanced technology, the intent of these laws for criminal justice agencies to establish and maintain a comprehensive database of information on sex offenders and to share that information throughout the country is still unmet. Current sex offender registries heavily rely on the self-reported information from offenders and, unless the time is taken to actually verify it, offenders can easily manipulate the system or even disappear entirely. Additionally, crucial information, such as known aliases, relatives, and frequented locations, which could be extremely beneficial in quickly locating a sexual predator, are not contained in many state registries ("Technology to Protect Children From Sexual Predators," 2007).

Despite the efforts of residence restriction and similar statutes, previously convicted child molesters have continued to access, victimize, and murder children as occurred in the well known Amber Hagerman, Elizabeth Smart, and Jessica Lunsford cases, all of which happened following the passage in 1994 of the Violent Crime Control

and Law Enforcement Act. Because of harsher restrictions imposed by sex offender legislation, many offenders simply flee to avoid having to comply, proven by the fact that of lower compliance rates in states with the most restrictive requirements. As a result, it has been claimed that instead of increasing public safety, sex offender legislation has actually decreased it and provided a false sense of security. These laws make it difficult for offenders to find adequate housing and employment, thus causing them difficulty in complying with the requirements of their treatment. Their emotional states suffer as a result, making them even more susceptible to reoffending (Wright, 2009).

Polygraph testing is another tool widely used to treat, manage, and supervise sex offenders. Numerous states have passed laws requiring those with two or more convictions to submit to periodic polygraph testing to ensure they are complying with the conditions of their release on parole or probation. The polygraphs three primary purposes are to verify reported full disclosures by offenders following sentencing, to confirm any denials or specific issues, and, as a maintenance instrument, to ensure treatment requirements are being complied with. The use of a polygraph, and even the threat of, has been reported to be an effective intervention tool in all these areas (Farkas & Stichman, 2002).

Opponents of the polygraph, however, point to issues raised with its validity, the potential to rely too heavily on it, and the lack of standardization requirements. An innocent person having a physiological reaction during the test due to the fear of being falsely accused and then falsely judged guilty creates the potential of a false positive examination result, which is a major concern. And just the opposite, a guilty person's lack of remorse or acceptance of guilt, resulting in a false negative, is also a serious

concern. Another issue raised is the possibility of offenders becoming desensitized to relevant questions after repeated examinations or learning to use countermeasures. A lack of standardization, both regarding testing methods and interpretations, has been found in many treatment programs. Ethical issues have also been voiced regarding the use of polygraph results in sex offender treatment, as there has not been a scientific agreement on their accuracy (Farkas & Stichman, 2002)

A new option used to attempt to control sexual offenders that many states have chosen is chemical castration. Though seen as repulsive to many, castration has proven successful in large-scale studies such as Heim and Hursch (1979) (as cited in Ward et al., 2003). So-called chemical castration is not truly castration, nor does it cause sterilization or any other permanent physical effects. Hormonal medications, such as Depo-Provera, are used to control the production of testosterone, which plays a major role in dictating male sexual behavior. FDA approved, these drugs theoretically control compulsive sexual desires. It must be noted that chemical castration only works for one type of sex offender, the paraphiliac, those with a preference for, or obsession with, unusual sexual practices, such as sex with children. It has been reported that weekly injections have dropped recidivism rates from 90% to as low as 2% (Meisenkothen, Description and Use of Depo-Provera, 1999).

The biological processes responsible for human sexuality, including feelings, fantasies, and urges, have been recognized and identified. What has not been recognized, and is still not clear, is the place biological agents, such as Depo-Provera, play in controlling these processes. Like other treatment methods to deal with sexual offenders, biological agents are not immune from many of the same problems in

assessing their successes or failures, such as inconsistent control group standards, lack of sufficient follow-up periods, and omission of recidivism rates. There are concerns with known relevant studies due to their sample sizes and lack of the validity of the measures used. A major concern with the use of chemical castration is the fact that although the drugs used have proven to control the production of testosterone, and sexual urges as a result, it is not known how, or even if, these medications have any impact on the offenders' sexual fantasies, preferences, or behavior, especially deviant sexual behavior. It has been found that sexually violent offenders generally do not have a higher level of testosterone production when compared to non-violent offenders. In fact, numerous cases of sexual predators with lower than average testosterone levels, who have committed considerable and repeated violent acts have been documented (Ward et al., 2003). Since many acts of CSA are the result of non-sexually triggered mechanisms and these drugs only help control sexual urges, it could be argued that the use of these drugs, unless the diagnoses is exact and has been tested, is simply wishful thinking. In addition, if such treatment was a condition of an offender's probation or parole, once that time has been served, there is no longer a reason for the offender to continue the treatments (Meisenkothen, California's Chemical Castration Statute, 1999).

Civil commitment statutes, another method designed to control sexual offenders, were first used in the 1930s. Mentally Disordered Sexual Offender statutes, as they were referred then, sought to identify sex offenders who were the most mentally disturbed and funnel them from prison straight into a treatment program, where they stayed until it was decided they no longer posed a risk to society. Since this time, many states have passed similar laws permitting the civil commitment to a mental facility of

sexually violent predators (SVP) determined to have a mental or personality disorder and also present a danger to themselves or others. The goal now, as it was 1930s, is to keep high risk repeat offenders confined in some manner, away from the public, until it has been determined that they have been rehabilitated. The civil commitment process is intended to supplement the incarceration process, not replace it (Wright, 2009). High-profile cases in recent years, the most prominent being that of Jessica Lunsford, involving released sexual predators who re-offended and molested and murdered a child, have made the process of civil commitment seem a more than sensible solution when deciding how to deal with these predators, especially the ones who admitted that they would do so again if and when released. It is said that recent advances in risk assessment methods have increased the likelihood that appropriate referrals for civil commitment are being made (Marshall, 2006).

Although civil commitment keeps dangerous sexual predators away from society, the process has many hurdles it must continually overcome. Even the best relapse prevention treatment can only be effective if an offender is open and honest about both his offending history and fantasies. Any and all omissions can, and will, impair or prevent the possible effectiveness of the treatment. People tend to not be “open and honest” when it comes to talking about sex or confessing to wrongs they have committed. Combining these two issues makes it doubly difficult to get the total truth from a child molester, especially when he is only talking about it because he was caught or is trying to get released. Due to limited resources in many states, only the worst of the worst (those offenders with long histories and/or those with serious mental disorders) are being referred for civil commitment, and these are the ones most likely to

resist treatment. The rate of progress among the population of sex offenders who have been civilly committed is a very slow. The main reason for this is the fact that a majority of these individuals suffer from various personality disorders, mainly Antisocial Personality Disorder. Those with antisocial traits seldom respond well to treatment because they lack remorse, a willingness to be candid during treatment, and a motivation to succeed, which are all traits essential for success. Also, since their criminal sentence has been served, a reduction in their prison time left cannot be used to motivate them to succeed. (Marshall, 2006)

As mentioned, civil commitment programs contain only the worst case offenders, increasing even more the likelihood of recidivism once released. For example, one of only two sexual offenders released from a program in Kansas reoffended within 18 months of his release, committing an even more violent sexual crime than he was previously convicted for. Another hurdle with civil commitment is trying to determine when the criteria that indicates that an offender no longer poses a threat, and no longer needs to be confined, are met. Arizona was forced by court order to release several committed offenders, without the support of their treatment providers, because it was ruled that the standard of “highly likely to reoffend” was no longer reached in their cases. The majority eventually had their releases revoked. (Marshall, 2006)

Another huge obstacle society faces to provide treatment programs, especially during tough economic times, is their costs. These programs drain $90,000-$120,000 per offender from taxpayers each year, nearly double or more the cost to house them in prison. These costs cannot be sustained, especially when a majority of these “patients” do not want to be there and are unwilling to actively participate in treatment. A major

hurdle to the success of civil commitment programs, one that actually reduces the likelihood of success, is the fact that many of the participants are unmotivated and often uncooperative because they are committed by court order and cannot be removed from the program (Marshall, 2006). One of the biggest argument against the civil commitment process is the fact that the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is used as a diagnostic tool in the civil commitment process, "was never intended as a system for classifying criminal behavior, and consequently does not provide meaningful diagnosis for most of the individuals who are candidates for the sexually violent predator commitments." (Janus & Prentky, 2008, p. 93)

CONCLUSION

Recent research has found that 38% of women, and up to 16% of males, were physically molested in some way prior to turning 17. Only 5% of these offenses were ever reported (Salter, 2003). Remember, recidivism rates are based on re-arrest and re-convictions. Child sexual abuse is a powerfully traumatic experience that "can teach a child he or she is worthless except as an object for the sexual gratification of others" (Rodriguez-Srednicki & Twaite, 2006, p. 51). The impact from these experiences can, and often do, last a lifetime.

Sex offender laws were designed to protect society from the repeated re-victimization by convicted sexual predators. A comprehensive study conducted by the Department of Justice, Bureau of Justice Statistics (2002) of inmates released from 15 states found that within three years, 67.5% were rearrested, with those convicted of sexual offenses having among the lowest re-arrest rate at 41.4% (as cited in Wright, 2009). The recidivism rate for sexual offenders may be one of the lowest of other

crimes, but a recidivism rate over 41% is unacceptable when, especially when, society's children and grandchildren may pay the price.

During an interview with one of his patients, a therapist had the customary process of circumcision described to him, in detail, by an offender. The offender told of how a knife is used to cut skin off the tip of a newborn baby boy's penis, without the use of anesthesia, and is celebrated by the family and society as a religious act. The offender then made the statement, "I bend over and kiss that same penis, and I am arrested as a child sexual abuser. Can you explain that to me?" (Saleh, 2009, p. 3). In the US and around the world, there are many organizations that go against the norms of society and not only practice and openly promote having sex with children, but advocate abolishing the laws that make doing so a criminal act. A few of these include, The Rene Guyon Society, North American Man/Boy Love Association (NAMBLA), Pedophile Information Network (PIE), Child Sensuality Circle, the Pedo-Alert Network (PAN), and Lewis Carroll Collector's Guide. Because of the support, validation, and material these groups publish justifying their beliefs and behavior, they pose a serious threat to society (Lanning, 2001).

In addition to the organizations just mentioned, the internet has made it easy for child molesters to gain access to children. Many have either seen or heard of the Dateline NBC show that conducts stings with law enforcement agencies to catch on-line sexual predators. Despite the show's popularity, there is never a shortage of offenders who enable the show to continue airing new episodes. A 2007 subcommittee report to the U.S. House of Representatives estimated that there are over 50,000 child predators on-line searching for children at any given time and stated that the exploitation of

children via the internet is at a crisis point. The report, citing statistics from the National Center for Missing and Exploited Children, indicated that of the images of child sexual abuse found on offenders' computers, 80% included children less than 12 years of age. Images of children younger than six years of age was found on 39% of those computers, and 19% of the offenders arrested on child porn charges had images of children younger than three years old (U.S. House, 2006).

Society assumes, or wants to believe, that it is able to recognize or identify a predator, that people are basically good, and those that are likeable can be trusted. Such beliefs and illusions made it easy for Ted Bundy to convince young women to help him, just before he murdered them. As has been discussed, child molesters can come from every walk of life and practice deception to gain access to their victims as well the confidence and support of those around them.

It is strongly believed, and has been affirmed repeatedly by legislation and court cases, that all persons have an important and fundamental right to control their own body and not have it violated by another. This can be especially true for children who are often helpless to defend and protect themselves. Among the most critical of decisions a government must decide is how to respond when that right is violated. (Wright, 2009) Despite the importance of such decisions, the policies America's various legislative bodies have developed over the years to address and prevent sexual reoffending have failed significantly. Of all the recent efforts to develop instruments and methods to predict whether a convicted child molester will reoffend, none have proven consistent and reliable, and none are able to predict recidivism for child molesters. With all the money put into this crisis, recidivism rates have not been reduced, children in

society are not safe, and society does not appear any closer to accomplishing either one. There are many theories on how to address this ugly and life changing victimization called child sexual abuse, from counseling, to civil commitment, to castration. Because none can claim to be truly effective, the only sure way to truly protect children from sexual predators is to prevent these predators, once caught, from returning to society where they can offend again and victimize other children. With an estimated 60% of all convicted sexual offenders living in local communities (Freeman, 2007) and posing a substantial risk to society, a change in approach is definitely needed. Until better methods to address this terrible threat to children has been discovered and proven effective over time, life in prison without the possibility of parole should be mandatory.

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