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Should States Require Special Certification for Psychologists Who Work with Sex Offenders?

September 11, 2006

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## Abstract

Psychological evaluation and treatment of sex offenders affect public safety. Some have recommended that state legislatures and/or state psychology licensing boards implement special rules or laws restricting which psychologists can do this work. Although perhaps well intended, these recommendations would do more harm than good. If implemented, such rules and laws would unnecessarily restrict the practice of psychology without benefiting public safety. Ordinary psychology licensing laws and rules and existing ethical guidelines, are sufficient to guide competent practice and, when necessary, to sanction psychologists who practice incompetently.

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Psychologists in several states (including my own state of Florida plus Texas,<sup>2</sup> Idaho,<sup>3</sup> and Illinois<sup>4</sup>) have reported that legislatures and/or boards of psychology have acted to restrict which licensed psychologists can legally evaluate and/or treat people who have been convicted of sexual offenses. Such restrictions would be reasonable and necessary only if (1) licensed psychologists have been harming or failing to protect the public and/or harming or failing to protect convicted sex offenders, (2) routine ethical requirements that psychologist practice within their expertise cannot save us from this danger, (3) some specifiable set of criteria can be shown to distinguish special psychologists from the ordinary licensed psychologists who have been endangering us, and if (4) there is an empirically demonstrated technology for evaluating and/or treating sex offenders that only special psychologists can know and use. Under this analysis, requiring special certification for evaluating and treating sex offenders is not warranted.

### Baby You Can Drive My Car

The practice of psychology, like the driving of a car, is a privilege, not a right. States restrict who can drive a car in order to protect the public. A person must pass a written test to show knowledge of traffic rules and laws, and he or she must pass a driving proficiency test to show the ability to safely drive a motor vehicle. People who pass the tests are granted a license to drive. Those licensed drivers who repeatedly harm other people or their property are likely to lose their drivers' licenses. And drivers who repeatedly violate rules and laws related to driving may lose their drivers' licenses even if they have not harmed others. Driving rules and laws are designed so that dangerous drivers can be recognized before they have caused harm, and such drivers can lose their licenses in order to prevent harm to others.

Similarly, people who complete educational training and pass tests can become licensed to practice psychology in a given state. Psychologists who harm other people or fail to take reasonable steps to protect others may face sanctions including restrictions on their licenses or loss of their psychology licenses, and in some cases they may face civil or criminal penalties as well.

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<sup>2</sup> Mary Alice Conroy, personal communication, 3/4/06.

<sup>3</sup> Linda Hatzenbuehler, personal communication, 3/4/06.

<sup>4</sup> Kirk Witherspoon, personal communication, 3/2/06.

People who want to operate a motorcycle or a large truck may have to pass special tests, beyond an ordinary driver's license, to show that they can do so safely. That is understandable because the skills necessary to operate a motorcycle or a large truck are clearly different than those necessary to operate an ordinary car. On the other hand, states typically do not require a special driver's license to drive a pickup truck, an SUV, or a car with manual transmission. Those skills are not that different from the skills necessary to drive an ordinary car, and standard procedures for gaining and maintaining a driver's license suffice for protecting the public from potentially dangerous drivers of pickup trucks, SUVs, and cars with manual transmission.

#### But Should You Evaluate and Treat Sex Offenders?

This analogy is useful in considering whether psychologists who evaluate and/or treat people who have been convicted of sexual offenses should be required to complete specialized training. Try this one-item quiz: Providing psychological services to someone who has not been convicted of a sex offense is to providing psychological services to someone who has been convicted of a sex offense like driving a car with automatic transmission is to (a) driving a car with manual transmission or (b) driving a large, commercial truck. Key: should a specialized license or certificate be required?

To answer this little quiz, it is useful to consider whether psychologists should have a specialized license or certificate to provide psychological services to other identifiable groups of people, such as those accused of, or convicted of, theft, murder, arson, child abuse, domestic violence, etc. Other candidates would be people who are divorcing or otherwise have disputes about child custody, or people who allege personal injuries. And perhaps there should be a specialized license or certificate to provide psychological services to people who have – or may have – specific disorders such as psychosis or Posttraumatic-Stress Disorder or Gender Identity Disorder. And why not require specialized licensure or certification to provide certain types of psychological services, such as aversion therapy or cognitive-behavioral therapy or psychodynamic psychotherapy?

Why have there been concerted – and in some states successful – efforts to create sex-offender-certified psychologists but not arson-certified psychologists or murder-certified psychologists or psychosis-certified psychologists or psychodynamic-certified psychologists? I believe that three conditions have to be met for special certification to be legally mandated: (1) Some people assert that psychologists are endangering the public, (2) some people – perhaps the

same people – assert that if only psychologists had specialized training or skills they could protect the public, and (3) contrary views are not presented, or are not presented as loudly or clearly or to the right people (legislators or psychology board members) at the right time.

Demands to be tough on sex offenders come from the general public. Legislatures often react to high-profile cases such as a stranger abducting, raping, and murdering a child by quickly enacting legislation designed to never let such a tragedy happen again (LaFond, 2005). As LaFond describes, such efforts are doomed to fail because it is impossible to prevent any such tragedy from ever occurring again. Because such dramatic events are, fortunately, rare events, focusing society's resources disproportionately to stop abduction-rape-murders by strangers leads to fewer resources being devoted to preventing other sex offenses. Legislatures that react promptly to societal demands to “do something” following a high-profile, scary but rare event typically waste money without making the public safer (LaFond, 2005).

Demands to be tougher on people who evaluate and treat sex offenders typically do not come from the general public, but from a single voluntary professional association (DeClue, in press; see also Notes 1, 2, 3). The Association for the Treatment of Sexual Abusers (ATSA) states prominently in their 2005 Practice Standards and Guidelines that “ATSA does not certify or license practitioners to practice in any discipline and Clinical Membership does not confer the privileges of either certification or licensure to practice in any field” (Association for the Treatment of Sexual Abusers [ATSA] Professional Issues Committee, 2005, p. 1), but some ATSA members have been pushing state legislatures and licensing boards to require special certification. People are ready to be scared by sex offenders (LaFond, 2005), and in state after state some people have been telling legislatures and boards of psychology that sex offenders are different than other people, that they need specialized treatment, that specialized treatment works to reduce recidivism, and that any psychologists who do not recommend and/or provide that specialized treatment are endangering the public.

*Are sex offenders different from other people?* Other than the fact that they have been found guilty of a sex offense, no. There is no typical profile of a sex offender on any consistent pattern on psychological tests or battery of tests (Campbell, 2005; Doren, 2002; LaFond, 2005; Lalumière, Harris, Quinsey, & Rice, 2005). There is some evidence that “anomalous neurodevelopment, whether of genetic or environmental origin, does increase a male's risk of problematic sexual behavior, especially pedophilia” (Blanchard, Cantor, & Robichaud, 2006, p.

99), but “more detailed conclusions are difficult to justify.” Sex offenders are indistinguishable from non-sex offenders and non-offenders via psychological or physiological measures. The only reliable way to tell who has been convicted of a sex offense and who has not is to check criminal records.

*Are sex offenders like other sex offenders?* Not particularly. People who have been convicted of sex offenses differ from each other in all the usual ways that people differ from each other, and in the way they offend, victim choice, and frequency of offending. This has contributed to criticism of prescribing a unitary “sex-offender treatment” for anyone and everyone who has been convicted of a sex offense (Campbell, 2005; Lalumière *et al.*, 2005). Thoughtful people do not expect that a psychopath with a lifelong history of violent, including sexually violent, offenses would respond to the same type of treatment in the same way that a schizotypal first-offender incest perpetrator or a mentally retarded, preferential pedophile would.

Recommendations regarding treatment should draw from the broad body of psychological knowledge, including, but not limited to, what is known about people who have been convicted of sex offenses.

We turn briefly to what is known about sex-offender assessment and treatment.

*What do we know about sex-offender assessment?* There is general agreement about the answer to this question. Hanson (1998; Hanson, Morton, & Harris, 2003) articulates this well: Unguided clinical assessment of a person’s risk to sexually re-offend is typically little, if any, better than chance. In contrast, risk assessments using actuarial instruments or structured professional judgment, both of which guide the evaluator to rely on empirically determined risk factors, have the potential to achieve moderate levels of accuracy (e.g., Hanson & Morton-Bourgon, 2004). Lalumière *et al.* (2005, p. 4) write that “psychologists know a great deal about the personal characteristics that distinguish or fail to distinguish rapists from other offenders and from other men. They also know that some convicted rapists are more likely than others to commit sexual offenses once again, and they can identify those men reliably.” LaFond (2005, p. 58) concurs: “There is ... a small group of sex offenders who are very dangerous and do have a lasting proclivity to sexually reoffend. Important strides have been made in accurately identifying who they are, [which can] enhance our ability to apply current crime-control strategies to those sex offenders who are at greatest risk of reoffending. Limited resources can then be concentrated on

the most dangerous sex offenders, thereby maximizing our chances of preventing sexual violence.”

A psychologist who evaluates a person who has been convicted of a sex offense should be very familiar with the research on sexual recidivism, but he or she should, of course, also be familiar with general psychological assessment, tests and measurement, individual differences, developmental psychology, etc. Year after year the volume of research on general recidivism and violent recidivism exceeds that regarding sexual recidivism. So it would not make sense to require that a psychologist performing a sexual-offense risk assessment must have special certification, but a psychologist performing a violent-offense risk assessment need not. In sum, any psychologist conducting a risk assessment should be knowledgeable about the relevant research, but there is no need to require special certification of psychologists who assess risk of sexual re-offense.

*What do we know about sex-offender treatment? Does sex-offender treatment reduce recidivism? Do some sex-offender treatments work better than others? Do we have an empirical basis to assign certain treatments to particular offenders? There is considerable controversy about these questions. The widely recognized “most ambitious and scientifically sound study to date on whether treatment reduces sexual recidivism” found “no positive effect for treatment” (LaFond, 2005, pp. 77-78; see also Lalumière et al., 2005, pp. 176-179, 194; Marques, 1999; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). It was found that people who completed treatment did better than people who dropped out of treatment, but “volunteers who had sought treatment and received it had very similar recidivism rates ... to those who also had volunteered for treatment but did not receive it.” LaFond, 2005, pp. 77-78; see also DeClue, 2002). Another well-designed study yields similar results. Hanson, Broom, and Stephenson (2004, p. 94) report their overall findings: “The treatment program examined in this study did not appear to be effective in reducing recidivism. Although some analyses slightly favored one group or the other, the differences between the treated and untreated groups were virtually zero after controlling for year of release, follow-up time, and static risk factors.”*

Meta-analyses of sex-offender treatment that include studies with sub-optimal research designs tend to show that people who complete sex-offender treatment recidivate at slightly lower rates than people who were not treated (Lösel and Schmucker, 2005), but the difference

could be explained by the markedly higher rates of recidivism for people who drop out of treatment or are kicked out (Lalumière et al., 2005).

There is currently some difference of opinion about what to make of recent studies that do show differences in detected recidivism between treated sex offenders and untreated controls, because those studies all have significant design limitations. LaFond (2005, pp. 79-80) distinguishes between “the agnostic view” that “simply put, the effectiveness of adult sex offender treatment has yet to be demonstrated” and the “cautiously optimistic view” that “the balance of available evidence suggests that current treatments reduce recidivism, but that firm conclusions await more and better research.” Even the cautious optimists acknowledge that there have been “few high-quality research studies” to support their optimism, the apparent positive effects of treatment might not be caused by treatment at all, and the “treatment effects in reducing sexual recidivism were not large in absolute terms (7%)” (LaFond, 2005, p. 80). That is, treated people were 7% less likely to be detected for committing a new sex crime than those who had not been treated.

And there are cautious pessimists. Lalumière et al. (2005, p. 172) have reviewed the treatment of sex offenders in great depth, and “we believe that there are too few well-controlled studies of sex offender treatment to conduct an informative meta-analysis.” They note that the small observed differences between treated and control groups could be accounted for by such factors as

- Comparison groups that included an unknown number of men who would have refused or dropped out of treatment had it been offered,
- A longer follow-up period for the comparison group,
- Exclusion of offenders from the treatment group but not the comparison group,
- Disproportionately high-risk offenders in the comparison group, and
- Disproportionately low-risk offenders in the treated group.

Lalumière et al. (2005, pp. 178-179, 188) “conclude that the balance of available evidence suggests that current treatments *do not* reduce recidivism, but that firm conclusions await more and better research” and “there is no clarity about whether anyone has demonstrated a specific effect of treatment in lowering sexual offender recidivism. The situation is even worse with respect to rapists in particular. There is simply no convincing evidence that treatment has ever caused rapists to desist or even to reduce their offending behavior.”

I count myself among the cautious pessimists regarding the effectiveness of sex-offender treatment. Researchers have yet to show that sex-offender treatment reduces recidivism, or that certain types of sex-offender treatment reduce recidivism more than other types of treatment, or that we currently have an empirical basis for assigning particular offenders to particular treatment modalities. Unless and until we have answers to these scientific questions, it makes no sense to make policy decisions requiring that psychologists who treat sex offenders must undergo specialized training and experience and meet certification requirements beyond those necessary for licensure as psychologists.

### Summary

As with other decisions that psychologists make, including other decisions routinely made by forensic psychologists, decisions made by psychologists evaluating and/or treating sex offenders can affect public safety. Psychologists who evaluate and treat sex offenders should practice within their area of competence, as should all psychologists. That is a routine part of our ethical code, state licensure laws, and the administrative rules of state boards of psychology. Although some rare, scary sexual offenses grab the public's attention and, potentially, that of state legislatures and boards of psychology, sex offenders are not unique in posing a risk to public safety. All of us psychologists need to do our jobs well, not just those who evaluate or treat sex offenders.

There is a growing body of research relevant to the evaluation of sex offenders, as there is for other areas of psychology, including other types of risk assessment. Research regarding sex-offender treatment continues to accumulate (though there is disagreement about how currently available research should guide current practice). Competent evaluation and treatment of sex offenders requires knowledge and understanding regarding the relevant research, but the same is true for every other area of professional psychology.

It is neither empirically nor logically justified to require special certification for psychologists who evaluate and treat sex offenders. Ordinary psychology licensing laws and rules and existing ethical guidelines, are sufficient to guide competent practice and, when necessary, to sanction psychologists who practice incompetently.

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