CASE REPORT

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Sex Offender Case Study: The Truth?

REFERENCE: Dwyer, S. M., Bockting, W. O., Robinson, B., and Miner, M. H., "**Sex Offender Case Study: The Truth?,**" *Journal of Forensic Sciences*, JFSCA, Vol. 39, No. 1, January 1994, pp. 241–245.

ABSTRACT: At a prominent university clinic that has treated sex offenders for 15 years, an offender and his wife appeared for therapy and faked engagement in treatment for two years. Details given in this case study serve as an extreme example of the manipulation, collusion, and deception that often occurs in sex offender treatment programs. This case study gives cause to reflect on the individual's denial system, society's criminal justice system, and the difficulty for therapists in ascertaining the truth.

The purpose of this paper is to report our experience with a patient who may have simulated pedophilic symptoms.

KEYWORDS: psychiatry, sex offender, manipulation, malingering, deception, simulated pedophilic symptoms

In most sex offender treatment programs, treatment is extensive for offenders and members of their support systems, such as their nuclear family and their family of origin. The families usually cooperate with therapy in order to help the offender. As indicated in this case, however, both the family and the offender conspired/collaborated to fake treatment. Reasons for this occurrence are not clear to date. The offender and family members may have felt the court was punishing them too severely. Or they may have hoped to avoid jail for their husband/brother/son, and believed they could finish a "treatment course" quickly and be on with their lives. To date, no other cases, such as this one are reported in the literature.

Presenting Problem

Mr. John Doe appeared at our clinic, admitting that he had been sexual with his 8-year-old daughter, but denying that he had sexually abused his two pre-pubescent sons. He and his new wife of several months stated that he had denied the abuse for a year, but that now he was willing to confess he had been sexual with his daughter numerous

Received for publication 19 April 1993; accepted for publication 27 May 1993.

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times. He described the various kinds of sexual acts and touching that had taken place, short of intercourse. His new wife concurred with the story and even though a warrant for John's arrest had come three days before the wedding, decided to marry him anyway.

John stated he was angry with his ex-wife and during weekend visitations he sexually abused his daughter. He was not sure if the sons had witnessed any of this behavior, but he believed they had not.

Assessment Interviews

As is customary in our clinic, approximately seven one-hour interviews were conducted with John assessing his amenability to treatment. Detailed sex histories, marital histories, family-of-origin histories and accounts of the sexual abuse were obtained. Mrs. Doe was also interviewed several times. In the final in-take session the treatment process was explained, including its difficulties and their obligations as patients. Both Mr. and Mrs. Doe accepted all conditions for treatment. The therapist did note that both appeared "too good to be true," and said they probably would progress through treatment rapidly.

Diagnostic Instruments

Both Mr. and Mrs. Doe completed an extensive battery of testing that included the following: Minnesota Multiphasic Personality Inventory (MMPI), Derogatis Sexual Functioning Inventory (DSFI), Dissociative Experiences Scale (DES), Tennessee Self-Concept Scale, Health History Questionnaire, Couple's Conflict Management Styles Checklist, Locke-Wallace Marital Adjustment Test, LoPiccolo Sex Inventory. In addition, Mr. Doe completed the Multiphasic Sex Inventory (MSI) as well as a plethysmograph measuring sexual arousal patterns.

The testing responses were valid. Both MMPI scores were normal with no elevations. The couples' conflict management scale indicated a couple agreeing on everything, which was noted as very unusual. The Tennessee Self-Concept Scale indicated a male who felt unusually good about himself, but was not really open to the treatment process, again leading to some questioning about why he would be seeking treatment. His MSI indicated his primary interest was in pedophilia and his pre-plethysmography report indicated high arousal to minor females ages 8 to 16. He also had arousal to adult females. The test indicated possible suppression of sexual arousal to minor males, eight years old, as well as a tendency to violence paired with sexuality. These same patterns appeared again on the post-plethysmography testing.

The Psychopathy Check List (PLC) indicated that while the patient did not meet the diagnostic criteria for an antisocial personality disorder, he did appear to be self-absorbed, have little empathy or concern about the effects of his behavior on others, and capable of manipulating people and systems for self gain.

Other written testing indicated the usual sex offender patterns of passivity, anger, low self-esteem, and nonassertiveness. No material emerged indicating that sex offender treatment would not be helpful or would be contraindicated.

Therapeutic Process

For two years Mr. Doe attended a weekly two-hour sex offender group where he talked explicitly of abusing his daughter, his sexual fantasies, his personal problems, and his marital problems. He also attended one-hour bi-weekly family sessions. In these sessions several family members were involved along with other support persons, that is, people he could call on after treatment completion. Multiple assignments were given to Mr. Doe to complete, which he usually did. Assignments were frequently of a written

nature such as journaling, detailed maintenance plans, reading material and making some behavioral changes in relationships.

Mrs. Doe attended a partners' group every other week, or as it was scheduled. She also had occasional individual appointments and attended all the required educational components with her husband.

Therapy Progress

For two years therapy moved very slowly, if at all. Part of this was attributed to John's lack of affect, lack of feelings, and lack of social skills. He was confronted numerous times about his poor progress. After two years of minimal progress, all of the Does' therapists believed that he was concealing a major secret, although he denied this vehemently and repeatedly. At this time Mr. and Mrs. Doe were assigned to another family therapist, because the original therapist felt "stuck" and unable to offer more. The original therapist also suggested that Mr. and Mrs. Doe contact a lawyer for help regarding the major medical bills incurred by his children, for which the courts held him responsible.

It was during the contact with the attorney that Mr. Doe, who was still trying to prove his innocence regarding the sexual abuse of his sons, stated that he never had abused his daughter. He claimed to have invented this story to cooperate with the court system, avoid jail time, complete treatment, eventually get out of the judicial system and get on with his life. John said he had lied for two years in treatment regarding the abuse. "I didn't do any of it," he told his attorney.

Mr. Doe took two polygraph tests; he failed one, but passed a repeat test. He still continued to lie to his therapists and to his group members. His defense attorney was obliged to honor the confidentiality of the client-attorney relationship. After getting our assurance that we would not immediately terminate Mr. Doe from the program and jeopardize his probation, his lawyer encouraged John to inform us about his "newly proclaimed innocence."

At this point the clinic and Mr. Doe's attorney suggested that a second plethysmograph be completed. The second plethysmograph lab results indicated that Mr. Doe was sexually aroused by minor females, aged 5 to 16, as well as adult females, and the results were questionable regarding minor males. Basically, the two plethysmograph laboratory results were similar and the conclusions virtually identical.

Reviewing Reports

Over 400 pages of documents on Mr. Doe and his children had been gathered from the time the accusations began and were reviewed. These documents indicated that the children continually told contradictory stories to all authorities involved. With almost every contradictory story another genital exam was performed on the children, to search for physical evidence of the allegations. Documents indicated that Mr. Doe's ex-wife (the mother of the children) repeatedly changed hospitals and "doctor shopped," while the children continued to exhibit bizarre behavior during their treatment for sexual abuse. With numerous hospitals, doctors, social workers, and psychologists involved, the data became increasingly confusing and contaminated. Reports indicated that the children may have been sexual with one another, but this issue was never addressed. It is not clear if their mother was informed of this sexual activity between siblings or not.

Several social workers who were involved with the family indicated that "mom is obsessed with sexual abuse and has been for years." Others believed that a therapist, from another clinic, treating the children was "feeding into the sexual abuse idea." A third clinic's therapist wrote, "(I have) concerns that the kids might have been brain-

washed and that mom might be mentally ill." Yet another worker indicated concern when "mother talked about the children's sexual abuse issues in front of 15 strangers in a social service waiting room." On the other hand, there were numerous professionals who believed all three children had been sexually abused.

Conclusions

At this time Mr. Doe is pursuing legal action to clear himself of all sexual abuse charges. This will be a lengthy process and the details will not be known for some time to come.

There have been several studies addressing the frequency of false claims of abuse [*1*] but, to our knowledge, a case has never been reported in which a patient intentionally attempted to produce false symptoms of a paraphilia [*2*].

Both Mr. and Mrs. Doe reported spending numerous hours and days in local libraries seeking information on sex offenders, what they say, what their families frequently say, and how all parties act in order to "play their role" well.

Repeated changes in doctors, hospitals, and therapists made it difficult to obtain accurate, reliable, and clear assessments of damage inflicted on the children. The most that could be gathered from the documents was that these children were under stress, but what the stressors were was never clear due to the contradictory and confusing reports. It is known that all young children show behavioral disorganization under stress [*3–5*]. The stressors must be made clear before a diagnosis of abuse is made, because this behavioral disorganization could be mistaken for symptoms of sexual abuse. In this case, it is our opinion, that before the stressors were identified, it was decided that the children had been sexually abused. Children often have pervasive transductive reasoning, which causes them to reason from one particular idea to another without logic [*3,6*]. Again, this transductive reasoning should have been consistently checked out to see if perhaps the children were connecting some nonsexual events to sexuality and naming it/them sexual abuse.

Due to the divorce, our therapists were never able to evaluate the children or see them in therapy. This remains a major gap in our information base. In retrospect, perhaps we should not have violated the philosophy of our program, which states we do not treat sex offenders unless all relevant family members are available to us for some sessions.

The truth, as to whether Mr. Doe sexually abused his children, may never be known. We believe that this "offender" either simulated symptoms of pedophilia, opposite sex, incest, severe, for two years during therapy or was, in fact, a pedophile who lied and denied his paraphilia on at least two occasions: when he was first accused and again after two years of therapy. We believe his most likely diagnosis is that of malingering: the act of imitating symptoms of a psychiatric disorder (pedophilia) for external incentives [*2*].

The patient's decision to pursue legal remedies to overturn his past pleas of guilty and to prove his "innocence" precipitated his discharge from our sex offender treatment program. In the weeks before his discharge, the patient frequently expressed his desire to use his remaining therapy time to convince the therapists and peers in his treatment group of his innocence. He became quite angry when he was told that we did not feel that this was an appropriate use of his therapy time. He also apologized to the therapists and group members for deceiving them.

On leaving the program, the patient expressed his relief at no longer having to participate in therapy and his anger at the therapists for abandoning him and not believing him. Although the truth as to whether the patient sexually abused his daughter and two sons may never be known, the therapists in our clinic continue to review this case and will follow his court proceedings in the hopes of learning how to recognize such decep-

tions in the future. Questions still linger in our minds, such as: was this a case of exchanging an admission of guilt for a more lenient sentence? Should a convicted defendant be forced to admit guilt to obtain a more lenient sentence? And a further empirical question is raised: What do treatment providers know about the effects of bribery and other forms of coercion on the outcomes of psychotherapy [*7*]? Can mental health experts—or anyone else—legitimately "validate" child sexual abuse? What standards should be used to evaluate the adequacy of clinical procedures used by "validators" to assess alleged victims of child sexual abuse [*8*]?

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