Court-Mandated Treatment and Required Admission of Guilt in Cases of Alleged Sexual Abuse: Professional, Ethical and Legal Issues

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ABSTRACT: Mandated mental health treatment of persons accused of sexual abuse of children poses several professional, ethical, and legal issues. There is variation in treatment methods with limited empirical data of efficacy. Treatment is often court mandated, which raises ethical issues regarding informed consent, particularly voluntariness of participation, since participation may be coerced with threats of parental rights termination. Confidentiality in such programs cannot be assured and counselors may serve in potentially unethical dual roles of counselor and reporter of disclosures. The requirement that participants admit having abused the child may violate Fifth Amendment protection against self-incrimination. State-granted immunity from prosecution allows, but should not coerce, participants to admit guilt.

The number of child abuse allegations has risen dramatically in the past three decades. Besharov (1986) noted there were 150,000 reports of abuse and neglect in 1963, but 1.5 million in 1984. In 1987 there were over two million (Besharov, 1990) and by 1993, 2.8 million (Besharov & Dembosky, 1996). Of these reports of alleged abuse and neglect, 47% were for neglect, 22% for physical abuse, 11% for sexual abuse, and the remaining 20% for medical neglect, emotional abuse, or unknown form of mistreatment (Petit & Curtis, 1997).

With these increasing numbers of reports, the number of court cases in which child abuse and neglect is alleged has also increased. A child abuse allegation may arise in all judicial arenas, including the criminal courts, family-domestic courts, or juvenile courts. Often, when a sexual abuse allegation is made, the alleged abuser is referred to mental health treatment. The number of programs for persons accused of sexually mistreating a child has increased in the past two decades, paralleling the increase in the number of child sexual abuse allegations. Alexander (1994) reported that the number of sex offender treatment programs increased from 643 in 1986 to 1974 in 1994. Such programs are referred to as "sex offender treatment programs," "perpetrators' treatment," or "offending-parent treatment."

Referral to such programs often occurs prior to an adjudication being made. Participants are often required to admit abusing the child to successfully complete treatment, even when they may not have been adjudicated as guilty and, if adjudicated, may still profess innocence. There are several ethical and legal questions associated with this situation. Perhaps the most troubling focuses on voluntariness of participation, that is, whether a therapeutic relationship between the participant and therapist can exist when participation is not genuinely voluntary and the person cannot give truly informed consent.

There is a lack of confidentiality in such programs due to mandated reporting laws and the therapist may be in a potentially unethical dual relationship of counselor and reporter to State authorities. There are several legal issues inherent in treatment of alleged sexual offenders, including the right to refuse mental health treatment, Fifth Amendment right against self-incrimination, and Fourteenth Amendment rights regarding the preservation of family integrity. The requirement that the accused person admit to having abused the child in such programs presents a possible violation of constitutional rights. These issues will be addressed following the discussion of sexual offender treatment programs.

Effectiveness of Sex Offender Treatment Programs

The overall goal of all sex abuse treatment programs is to prevent recidivism or reoffending. A review of the literature reveals great variation in the methods, modalities, and objectives of such programs. According to Levine and Doherty (1991) many psychotherapists assert that an abusive parent cannot be treated successfully, and the family cannot be restored to normal functioning, unless the abuser admits the violence (or violation) and apologizes to the child-victim, especially in cases of sexual assault. Therapists holding this view maintain that an admission of this nature has a dual therapeutic purpose — it may aid in restoring family relationships and may relieve child abuse victims of guilt and responsibility for acts of abuse (pp. 98-99).

Survey of a number of treatment programs reveals widespread support for Levine and Doherty's generalization (e.g., Gelinas, 1988; Giarretto, Giarretto, and Sgroi, 1978, Haugaard & Reppucci, 1988, Walker, Bonner, & Kaufman, 1988). Brown (1989) describes a program in which convicted sex offenders can receive psychotherapeutic treatment in a family development center rather than in prison if specific criteria are met. Objectives of the program include increasing cognitive and affective awareness of the harmful effects of incest on victim(s), learning to help victim(s) recover from the abuse (e.g. apology letter), and developing insight into personal dynamics contributing to sexual abuse. Lack of adequate progress results in an administrative hearing and possible removal from the program. Brown acknowledged that there was a lack of research-based treatment models because outcome is difficult to measure.

Groth (1978) includes an assessment of the offender's attitude in the psychological evaluation which is to be forwarded to legal authorities to assist in determination of the risk of reoffending. The therapist is given guidelines for assessing the offender's reaction to the offense, his subjective feelings regarding the offense (such as remorse, embarrassment, justification, etc.), his efforts at restitution, and his impression of appropriate disposition (p. 37). At the same time, Groth reported that no precise set of predictor variables were available in terms of repetition or dangerousness.

Chaffin (1992) describes a program for intrafamilial sexual abusers referred involuntarily either by child protective services and/or the criminal justice system. Participants are "required to specifically admit to molesting either a daughter or step-daughter" (p. 253). The program requires a detailed admission of the behavior, admitting full acceptance of responsibility, developing empathy for the victim,

understanding the motivational factors supporting the behavior, and modification of cognitive distortions and rationalizations.

Similarly, Friedman (1991) indicates that "in many cases it will be seen as appropriate for the offender to write a letter of apology to the victim" (p. 36) and adds that the primary consideration must be for the welfare of the victim. The letter can be rewritten as the offender progresses from self-centered expressions to acknowledgment of full responsibility. Friedman appears to have overlooked his own earlier observation that treatment professionals should not perform assessment under the assumption that the client is guilty if that client professes innocence. Such a mental framework, he notes, would bias the evaluator's clinical judgment and skew the interpretation of test results.

Required admission objectives — disclosure of the abuse, recognition of the effects on the victim, development of victim empathy, restitution — were listed by Bonner (1995) as part of a treatment program for adolescent sex offenders. The admission of having abused is required in spite of the fact that such treatment programs lack empirical support. Bonner noted that "there is a significant need for empirical research on the efficacy of treatment with adolescent sex offenders." He concluded that, until more data are available, clinicians will continue to be uncertain as to which techniques are the most effective with adolescent sex offenders.

The origins of a program requirement to admit guilt are not clear, although it appears that this requirement is based on the premise that there is credible evidence that sexual abuse has occurred, that the person has been adjudicated, and that the alleged child molester is indeed guilty. But in many cases of alleged child sexual abuse, no physical evidence of abuse exists and the only evidence consists of statements of the child or supposed behavioral indicators of abuse. Within the past several years, an increasing volume of research has shown that the commonly used techniques for interviewing children are poor and that many reports of abuse are artifacts of suggestive and coercive interviewing techniques. (See Ceci & Bruck, 1995, and Adams, 1995 for a discussion of this).

Other sources of false allegations include allegations of sexual abuse that occur in divorce and custody disputes (Call, 1994; Wakefield & Underwager, 1991a), erroneous interpretation of "behavioral indicators" of abuse (Adams, undated), and inaccurate conclusions resulting from incomplete and faulty investigative methods (McGough, 1995). Unfortunately, the unwarranted assumption that "children never lie about sexual abuse" has predominated in the mental health field for at least a decade and only recently has been subject to scientific and legal scrutiny. Operating on the basis of this erroneous assumption, many professionals conducted highly biased interviews and investigations (Adams, 1995; Ceci & Bruck, 1995; Gardner, 1991, *State v. Michaels,* 1994). Several convictions have been overturned due to the fact that investigations and interviews were conducted improperly.

Given the possibilities that the interviewing and investigative methods may have been seriously flawed, some persons referred to sex offender treatment programs may not, in fact, be guilty. Wakefield & Underwager (1991b) caution that, in providing treatment to persons accused and/or convicted of child sexual abuse, the

situation can be complicated by a number of factors. When a person is accused of sexual abuse, the accusation is either true or it is not true and the accused may admit or deny the accusation. An accused person may be required to enter a treatment program as a sexual abuser long before there is a determination by the justice system about the accusation. Successful completion of treatment, whether or not the allegation is true, is often defined by the requirement that the accused admit guilt.

Admission of guilt, however, is not a universal requirement as a condition of successful completion of sex offender treatment programs. Langevin and Lang's (1985) first goal was to improve adjudicated sex offenders' behavioral management, i.e., motivating them to want to control their sexually anomalous behavior. Treatment was not aimed at changing sexual preference, but was directed toward assisting the program participant in controlling his sexual behavior (p. 417). The authors concluded that "many therapies have been tried but no effective method of treatment has yet evolved" (p. 416-417).

A respectful attitude toward participants in sex offender treatment programs was advocated by Marshall (1996b), who did not focus on empathy other than to say that it could be addressed along with other program objectives. Building self-esteem and developing self-efficacy are higher priorities for Marshall (1996a, 1996b). Laws (1989, 1995) describes a sex offender program with a cognitive-behavioral approach, utilizing a relapse prevention model. The results of this approach are described as "encouraging," although use of the same approach in California was termed "less optimistic." Pithers (1997), who is critical of programs that use confrontive and humiliating methods, describes a program which used such offensive methods of drama therapy that the participants requested an injunctive hearing through the assistance of the American Civil Liberties Union (ACLU) to prohibit use of that technique.1

To summarize, the literature describes mixed approaches and results of sex offender treatment programs. Comparison across studies is complicated by the fact that subject groups differ, criteria for inclusion or completion vary, and data are lacking. Furby, Weinrott, and Blackshaw (1989) conducted a meta-analysis of 55 sex offender treatment programs and concluded that there was no compelling evidence that treated sex offenders did better than untreated ones. More recent meta-analyses, however, are more encouraging. Alexander (1994) evaluated 673 sex offender treatment outcome studies and statistically analyzed 74 of those studies. Subjects in these 74 studies who received treatment had a lower recidivism rate than nontreated control group members. No mention is made of a required admission of guilt in this meta-analysis.

In spite of the fact that outcome data are limited and inconsistent, many programs continue to require that participants admit they have abused the child, whether or not they did abuse the child, and regardless of whether or not a legal proceeding has found that abuse occurred. But authors who describe their treatment approaches do not address the ethical and legal issues inherent in provision of such treatment, the possibility of an erroneous adjudication, and issues of Constitutional rights protection.

Ethical Issues in Court-Mandated Treatment

Court-ordered mental health treatment of the alleged sexual offenders raises three major ethical issues for mental health practitioners — informed consent, confidentiality, and potentially unethical dual relationships. The ethical principles require that the client's right to provide "free and informed" consent must be safeguarded by treatment professionals. Greenland (1988) notes that informed consent has become the hallmark of ethical treatment and research. He observes that, traditionally, ethical guidelines have served a three-fold purpose — to protect patients from exploitation; to uphold the rights of the patients to make decisions about their own lives and to have access to information that is important to their welfare; and to foster, by the professional's own behavior, desirable social attitudes and actions.

Greenland (1988) observes that, while these ethical standards are or should be mandatory to voluntary clients and research participants, their application to involuntary patients and prisoners — who are not strictly free to enter into a consensual therapeutic relationship — is problematic. The maintenance of ethically sound therapeutic relationships is likely to be compromised in prisons and prison-like institutions (p. 375). While professionals might argue that sex offender treatment programs are neither prison-based nor prison-like, the fact that such programs are court-ordered shifts the weight toward the legally-mandated end of the scale and away from voluntary counseling or therapy.

Informed Consent

Haas and Malouf (1989) note that informed consent involves three components — being informed, making a voluntary decision, and being competent to give consent. Mental health professionals must inform their prospective clients of the risks and benefits of the proposed treatment, the potential financial and psychological costs of the treatment, and the risks that may result from possible disclosures (e.g., in court or to legal authorities) of information potentially damaging to the recipient of the services (pp. 43-44). In court-mandated treatment, there is a question as to whether clients have been adequately informed of the possible risks of failure to complete such programs successfully, the risks of possible termination of parental rights, and the requirements of counselors to report on the client's level of participation. For parents who are court ordered to sex offenders' treatment, coercion is quite prevalent, with the threat being permanent loss of parental rights. In *Santosky v. Kramer* (1981), the removal of the child from the parents is seen as a penalty as great as, if not greater than a criminal penalty. Full information on these possible outcomes may be lacking in some programs, thereby compromising the client's ability to give truly informed consent.

Thompson (1990) observes that some court-mandated clients are clearly coerced to go to a counselor or therapist. He notes that some professionals believe that therapy cannot take place if clients believe they are forced to participate and, on that basis, refuse to treat such clients. An ethical dilemma exists which is, unfortunately, not addressed carefully in professional training.

Peterson (1992) states that, in order for informed consent to occur, a non-coercive

relationship with mutual power between the mental health practitioner and the client must exist. He points out that an "unequal power balance in the relationship and the omnipresent threat of consequences to the client makes full consent impossible" (p. 124). In court-mandated treatment, the person is likely to be under distinct coercion and therefore cannot provide informed consent. The weight granted to the opinions of the treatment provider could create an unequal power balance and therefore compromise voluntariness. In addition, in the treatment of incarcerated prisoners, the threat of punishment or the removal of privileges is so great as to make "free and informed" consent an unattainable ideal in the treatment of prisoners (Bancroft, 1981).

An additional problem is that ethical guidelines regarding informed consent usually require that participants be free to withdraw their consent at any time without prejudice or negative repercussions. But, when treatment is court ordered, the freedom of clients to withdraw consent to participate is abridged since they would be placed in a seriously compromised legal position by withdrawal from such a program. In fact, participation in sex offender treatment programs may never be truly voluntary since the particular elements of voluntariness and information are likely not fulfilled.

Confidentiality

A second ethical issue is confidentiality. Haas and Malouf (1989) state that, in a philosophical sense, the maintenance of confidentiality protects the client's right to privacy, which is a fundamental human right. A mental health professional, as a vital part of the therapeutic relationship, has a duty to uphold client confidence. But mental health professionals are also bound by state laws requiring them to report suspected child abuse. When there is an allegation of abuse, the duty to report supersedes the duty to uphold confidence and "confidentiality cannot be absolutely assured" (Levine & Doherty, 1991, p. 109). When the clinician is required to report suspected abuse, the therapeutic relationship is compromised and is likely to dissolve along with confidentiality, at least at the moment that a reasonable suspicion of abuse arises.

Dual Relationships

Clients who are court mandated to sex offender treatment present a third ethical dilemma — the question as to who is the client. Is the client the court system or the state agency, or is it the referred person? For whom is the mental health professional working? Who retained the services? Did the client independently select a therapy provider or was treatment with this particular professional required by the court? While mental health practitioners may tell the individual that he or she is the client, this assertion might be in question, regardless of whether the referred person did abuse the child as alleged. While it may appear that the therapist is working for the client, the therapist is often working to fulfill the objectives and requirements of the court or a state agency.

Langevin and Lang (1985) point out that a person seeking help for a genuine sexual problem involving children may encounter the mental health "double agent," who serves as both helper-therapist and informer for the law (p. 410). The fact that the

individual was court mandated to treatment may, from the onset, predispose that individual to resent and distrust the therapist, further hindering the establishment of a genuine therapeutic relationship. Langevin and Lang note that the law does not encourage therapeutic relationships, but that is not its intended purpose. In fact, any verbalizations, disclosures, actions, or lack of same may be revealed to the court. Many clients in sexual offender treatment are still naive to the fact that none of their program participation is guaranteed confidentiality from the court. Therapists who provide treatment under such circumstances may find themselves in precarious ethical, and consequently, difficult professional positions.

In some cases, the court has differentiated between court-ordered psychological evaluations and court-ordered therapy and has moved to preserve the integrity of the psychotherapeutic relationship. In a California case (*In re Eduardo A.*, 1989), the court established that there is a major difference between a psychological examination ordered by the court as a tool to garner information regarding parents' mental and emotional condition and referral for psychotherapeutic treatment. The court concluded that the legislature had intended to abrogate the patient-psychotherapist privilege in the former, but not in the latter type of court order. The court also noted that crucial to "psychotherapeutic treatment is a patient's readiness to reveal his thoughts, dreams, fantasies, sins and shame. It would be unreasonable to expect a patient to freely participate in such treatment if he knew that what he said and what the therapist learned could be revealed in court" (Patton, 1990, p. 514). The court determined that there were a sufficient number of other sources from which data on the parent's progress could be gleaned in order to determine the best interests of the child at subsequent judicial review hearings, so as not to rely on psychotherapeutic disclosures in making that decision.

Legal Issues in Court-ordered Mental Health Treatment

There have been recent legal developments regarding the right of individuals to refuse mental health treatment as well as court rulings on the requirement of admission of guilt from persons in sex offender treatment. Related to this is the possibility of the state granting immunity to persons in treatment.

The Right to Refuse Mental Health Treatment

There has been a steady development of case law supporting the right to treatment for persons confined primarily in mental institutions (Alexander, 1988; Gutheil, 1986). About the time that significant changes were being made in protecting the right of mental health patients to treatment, it was asserted that mental health patients also had the right to refuse treatment. It was then reasoned that patients in state mental hospitals and inmates in correctional institutions both have the right to refuse treatment. In some cases, the mandatory participation in mental health treatment was considered to be punishment in disguise. Advocates insisted that some mental health treatments, such as psychotropic drugs, psychosurgery, and aversive therapy can cause irreversible bodily damages. In this situation, there is a right to refuse such mental health treatment.

Under common law, any medical (or other) procedure that is not consented to by a person is a "battery." The right to refuse mental health treatment is considered by

some authors to involve First Amendment rights. Correctional treatment designed to change the mind or thought processes of inmates can be rightfully refused as violating their First Amendment right to free speech. Recent case laws have established the right to "mind freedom" and "privacy of the mind" (Alexander, 1988, p. 93). Ordinarily, courts are reluctant to interfere with this right unless the state advances a compelling interest (Vetter & Rieber, 1980). In sexual abuse treatment programs that require admission of guilt, one goal is to change the mind and thought processes of persons referred to those programs. On this basis, it could be argued that program participants should have the right to refuse that portion of treatment, whether or not they are adjudicated.

Other authors have considered the right to refuse mental health treatment based on the premise that informed consent is prerequisite to treatment. Informed consent requires that a person consent to a medical (or mental health) procedure but must also be given information on the possible risks and likely benefits of the procedure. Mental health treatment is defined as any treatment designed to alter the behavior or mental functioning of an individual. The reason for explanations to recipients of services is to respect their right to autonomy or self-determination.

The United States Supreme Court has indicated that even felons, i.e., persons convicted of crimes, do not automatically lose all of their rights. In 1973, the Supreme Court affirmed that prisoners retain all rights enjoyed by free citizens except those necessarily lost as an incident of confinement (*Pell v. Procunier,* 1973). If convicted felons still retain the right to refuse mental health treatment, then certainly it would seem that either adjudicated or non-adjudicated referees to sex offender treatment programs should retain the legal right to refuse either the entire treatment or a portion of the treatment.

Court Decisions Regarding Requirement of Admission of Guilt and Parental Rights Termination

In many treatment programs, ultimate success or failure in the program is contingent on whether or not the accused person admits to having abused the child. In many cases the program provides feedback to the court as to whether the referred individual has successfully completed the treatment program. Often, failure to admit to having abused the child is considered to be a treatment failure, regardless of other factors such as favorable evaluation, regular attendance, or completion of assignments. The feedback may then be considered by the court as "failure to make acceptable progress on treatment standards" and on this basis parental rights may be terminated.

Patton (1990) notes that the requirement to participate in psychological counseling as part of a family reunification plan raises a host of Fifth Amendment questions. Parents have a multitude of interests implicated in child dependency cases, one of which is fundamental liberty. The parents' liberty interests involve not only their personal freedoms, but also the right to raise their own children. According to Patton, "The United States Supreme Court has consistently underscored the historical importance of family in rearing children" (p. 486). The parents' interest in family integrity is of fundamental importance. Children also share in the "reciprocal rights of parents and child to one another's companionship" (Patton, p. 488). The

Supreme Court in *Santosky v. Kramer* (1981) found that parents have a "fundamental liberty interest" in the "companionship, care, custody, and management of their child," which is protected by the Fourteenth Amendment. That case also determined that part of the child's interest is shared with the family and that parents' and child's rights should not be presumed to be adversarial.

Patton (1990) notes that there is growing legal disagreement among the states as to whether forcing a parent to confess to child abuse in court-ordered therapy as a condition for family reunification violates the parents' privilege against self-incrimination. He observes that "There is really no dispute regarding the coercive nature of requiring parents to confess in court ordered therapy as a condition for regaining child custody. . . . the dependency court can coerce parents into following its directions by ordering that a removed child will not be returned unless the parents follow through on a reunification plan" (p. 515).

Patton (1990) notes that some courts, such as those in California, have determined that it is fundamentally unfair to put parents to the Hobson's choice of remaining silent in court-ordered therapy, resulting in loss of their child, or confession to abuse, resulting in loss of liberty. Understanding that court-ordered confession is coercive, the second question arises, i.e., whether such court-ordered confessions are an unconstitutional penalty. Patton reasons that the dilemma parents face — to remain silent in therapy and lose child custody or to confess child abuse and provide the prosecutor in a criminal case with damaging evidence — certainly appears to place parents in the penalty case context.

In *In the Interest of A. W., a Child,* the Iowa Court of Appeals held that it was not reasonable for the Department of Human Services to require the child's father to admit that he abused the child in order for the Department to offer services where it was clear that the father would not make such an admission. In that case, the social worker from the Iowa Department of Human Services testified that it would be therapeutic for the natural father to admit that he sexually abused the child and that the Department considered the father to have been the perpetrator of the sexual abuse upon the minor child, in spite of the court's findings that the evidence was not sufficiently specific to identify the perpetrator. Indeed, for six months of therapy, the only purpose of the Department was to "get him to 'admit' that he was the perpetrator" (p. 476). In the appeal decision, the child protective agency was required to show what reasonable efforts, without requiring the father to admit the abuse, were necessary to allow the child to be returned to the custody of a parent or parents. In *In the Interest of H. R. K.* (1988), the Iowa Court of Appeals found that termination of parental rights based in part of parents' failure to complete a sexual abuse treatment program which required them to first admit to charges of sexual abuse did not deny parents due process, but termination was supported by clear and convincing evidence even absent contested evidence of sexual abuse.

The issue of parental rights termination is highly emotionally charged. The threat of losing one's child for failing to admit abuse is arguably a potent penalty that should trigger full Fifth Amendment protections (Levine & Doherty, 1991). In particular, the *Santosky v. Kramer* (1982) Supreme Court decision bears on the issue of possible termination of parental rights as a result of abuse. In *Santosky v. Kramer* (1982), the court found that parents have a fundamental liberty interest in the

"companionship, care, custody, and management of their child," which is protected by the Fourteenth Amendment of the Constitution and that fundamental interest does not evaporate simply because they have lost temporary custody of their child to the state. A natural parent's desire for and right to the companionship, care, custody, and management of his or her children is "an interest far more precious than any property right" (p. 758).

The *Santosky v. Kramer* court ruled that the nature of the process due in parental rights termination proceedings turns on a balance of three factors — the private interests (of the parents and children) affected by the proceedings, the risk of error created by the state's chosen procedure, and the countervailing governmental interest supporting use of the challenged procedure. A parental rights termination proceeding interferes with the parents' fundamental liberty interest. The private interest of the parents which is affected was described as "commanding and the threatened loss is permanent."

The court concluded that the child and the child's parents "share a vital interest in preventing erroneous termination of their natural relationship" (p. 760) and, at the fact-finding, the state cannot presume that a child and his parents are adversaries. Before the state may sever completely and irrevocably the rights of parents in their natural child, due process requires that the state support its allegation by at least clear and convincing evidence. Moreover, the state, in the fact-finding stage, must prove that the child has been "permanently neglected" (p. 748). Furthermore, the state must establish, among other things, that for more than a year after the child entered state custody, the agency "made diligent efforts to encourage and strengthen the parental relationship" (p. 748).

Santosky v. Kramer addressed the very real possibility that the court which hears a child protection matter runs a risk of error. Regarding the second factor, the risk of error created by the state's chosen procedure, the majority opinion observed that, in child protection hearings, "numerous factors combine to magnify the risk of erroneous fact-finding" and indicated that the "standard of proof" serves the primary function of minimizing the risk of erroneous decisions. The majority opinion therefore elevated the standard of proof in parental termination hearings in an effort to "alleviate the possible risk that a fact-finder might decide to deprive an individual (parent) based solely on a few isolated instances of unusual conduct [or] . . . idiosyncratic behavior." The argument could be made that failure to admit abuse, particularly when there is improper investigation and no adjudication, would fall into the category of "a few isolated instances of unusual conduct."

The *Santosky v. Kramer* opinion continued its cautions about possible erroneous fact finding, stating that "courts in child protection matters possess unusual discretion to under weigh probative facts that might favor the parent. Because parents subject to termination proceedings are often poor, uneducated, or members of minority groups, such proceedings are vulnerable to judgments based on cultural or class bias." Furthermore, "the state's ability to assemble its case almost inevitably dwarfs the parents' ability to mount a defense. No predetermined limits restrict the sums an agency may spend in prosecuting a given termination proceeding." The state's attorney has full access to all public records concerning the family. The state may call on experts in family relations, psychology, and

medicine to bolster its case. Furthermore, the primary witnesses at the hearing will be the state's own professional caseworkers whom the state has empowered both to investigate the family situation and to testify against the parents. Indeed, because the child is already in agency custody, the state has the power to shape the historical events that form the basis for termination. The state's unusual ability to structure the evidence increases the risk of an erroneous finding.

Moreover, the majority opinion reasoned that, with regard to the third factor to be balanced, the state has two interests, the first being *parens partae,* which favors preservation, not severance, of the natural familial bonds. The second interest is in finding an alternative permanent home for the child, which arises only when it is clear that the natural parent cannot or will not provide a normal family home for the child. The Supreme Court found that the standard of proof in proceedings which may result in parental rights termination must be "clear and convincing evidence."

Following *Santosky v. Kramer,* the application of the "clear and convincing evidence" standard can readily be seen. In *In the Interest of Chad* (1982), the Supreme Court of Iowa found that the mother's parental rights *could not* be terminated, since there was not clear and convincing proof that the mother substantially, continuously, or repeatedly refused or neglected to comply with the duties engendered by the parent child relationship. On the other hand, in *In the Interest of K. L. C.* (1985), the mother's parental rights were terminated because the mother lived a transient existence, placed her children at imminent risk of harm from lack of supervision and sexual abuse, evidenced a long history of failure to fulfill counseling requirements, and failed to provide a minimal degree of care with food, clothing, and shelter.

Similarly, in *In the Interest of C. and K.* (1982), the mother's rights were terminated, with clear and convincing evidence that the children could not be returned to the mother's custody due to her "indolence and woeful lack of inherent capacity." The mother had deplorable personal hygiene, was most indiscriminate about whom she slept with, and moved no less than six times in a five-month period. Even after a myriad of services was provided to the mother to assist her in nurturing the children, she could not demonstrate even rudimentary parenting skills. Similar bases for termination of parental rights were found in *In the Interest of K. M. R.* (1990), an Iowa Appeals Court that terminated parental rights after showing a five-year history of child and spousal abuse, as well as the father's previous conviction of child endangerment and the mother's conviction of conspiring to commit a forcible felony.

Based on *Santosky v. Kramer*, termination of parental rights should only take place when there is clear and convincing evidence, over an extended period of time, that parents are unable to provide care for the child. Another case (*In the Interest of M. R.* 1983), found that evidence of past abuse and deprivation is not, by itself, enough to terminate parental rights; there must be a showing of present abuse and deprivation, the conditions and causes of which are likely to continue. To base termination of parental rights merely on the parents' failure to admit that they abused the child would not appear to be consistent with the "clear and convincing evidence" standard of proof.

Several cases have addressed the issue of required admission of guilt in sexual

offender treatment programs. In *Montana v. Imlay* (1991), the defendant appealed an order revoking his suspended sentence. Imlay was convicted of fondling a seven-year-old girl, a charge which he consistently denied, and was sentenced to five years in the Montana State Prison. All but 35 days of the sentence were suspended and the defendant was placed on formal probation, under certain conditions, including the fact that he was required to enroll in and complete a sexual therapy program. The defendant had scheduled and attended a number of counseling sessions with a counselor for the sexual therapy, but was finally advised that he did not qualify for the treatment program because he would not admit that he was guilty of the crime of which he had been charged and convicted. No other treatment program would accept the defendant for treatment, based on the fact that he would not admit that he had committed the offense. When the defendant was unable to complete the sexual therapy program, his suspended sentence was revoked and he was ordered imprisoned at the Montana State Prison for the remainder of his five-year term. The state alleged that the failure to complete a sexual treatment program was grounds for revocation of the defendant's suspended sentence. The issue raised before the court on appeal was whether or not the defendant could, as a condition of a suspended sentence, be compelled to admit he was guilty of the crime of which he was accused and convicted.

In the appeal, the Fifth Circuit Court of Appeals found that *Imlay* met all conditions set by the court, except for admitting that he committed the crime for which he was convicted. In a previous case cited by the court *(Thomas v. United States,* 1966), the district court judge advised the defendant that if he confessed his guilt the court would take his confession into consideration in determining the length of his sentence, but that if he persisted in his denial of guilt, that denial would also be taken into account. The sentence was vacated by the court, based on the conclusion that the alternatives presented to the defendant violated his Fifth Amendment right not to witness against himself.

The Court of Appeals pointed out that, "It must be remembered that, at the time of his allocution, Thomas had been finally and irrevocably adjudged guilty. Still open to him were the processes of motion for new trial, appeal, petition for certiori, and collateral attack. Indeed, appeal is now an integral part of the trial system for finally adjudicating the guilt or innocence of a defendant. The District Court, it was determined, had put Thomas "between the devil and the deep blue sea." On the one hand, Thomas could admit guilt (in a case where he contended that he was not guilty), abandon his Fifth Amendment right not to witness against himself, and forego all post-conviction remedies. In the process, he would be committing perjury (by making statements that were false); he could then confess to the crime of perjury, with intendant legal action. On the other hand, Thomas could have chosen, as he did, not to confess to a crime which he contended his did not commit, exercise his Constitutionally guaranteed rights, but in the process receive a longer prison term. The case became cited as the *"Thomas rule."*

Other cases in accord with *Thomas* are *Scott v. United States* (1969), *United States v. Laca* (1974), *United States v. Wright* (1976). In *Poteet v. Fauver* (1975), the United States Court of Appeals concluded that augmentation of a post-conviction sentence based on refusal to admit guilt violated the due process clause of the Fourteenth Amendment of the United States Constitution.

In *Imlay*, the Appeals Court concluded that, even though the defendant had already been convicted of the crime that he denied, the legal system still has opportunities to challenge the conviction. These rights were considered to be important rights guaranteed to every defendant under the criminal justice system, which "would be rendered meaningless" if the defendant could be compelled to admit guilt as a condition of his continued freedom. The court found that "the better reasoned decisions are those decisions which protect the defendant's constitutional right against self-incrimination, and which prohibit augmenting a defendant's sentence because he refused to confess to a crime or invoke his privilege against self-incrimination (p. 592).

Immunity from Prosecution in Court-ordered Therapy for Suspected Child Abuse

In some cases, the state will offer to grant immunity to persons accused of sexual abuse, thereby facilitating their participation in mental health treatment programs. In *In re J. G. W. and J. L. W.* (1988), the father brought an action seeking to have a therapist removed from the case because she required that he first admit to abusing the children. The father repeatedly denied abusing the children. Relying on an earlier high court decision (*In re J. A. and A. W.,* 1987), the Minnesota Supreme Court found that by approving the therapist's requirement of admission of abuse as a precondition of regaining visitation with the children, the trial court had attempted to compel testimony in violation of the father's Fifth Amendment rights against self-incrimination. The therapist was precluded from requiring an admission of sexual abuse as a precondition to establishing visitation, unless a grant of immunity by the state was available to resolve the conflict. In the earlier case, the court further stated that if the state wished to encourage treatment, it could cease criminal prosecution and apply for a grant of immunity for the parents, thereby allowing the parents to participate in treatment without fear of prosecution (*In re J. W. and A. W.*, 1987, cited by Levine & Doherty, 1991).

A key word in this discussion is "allowing," that parents are *allowed* to participate without fear of prosecution. The grant of immunity would allow the parents to participate and would allow them to admit abuse, if indeed they did abuse the child. However, this does not consider the possibility that the parent did not abuse the child. Allowing the parent to participate and possibly admit abuse should not be confused with requiring or coercing the parent to participate and admit abuse, particularly when the parent continues to assert innocence and no adjudication has been made. Granting immunity so that parents may should not, in any way, be construed to mean that they *must* make an admission.

Patton (1990) maintains that offering immunity is the only remedial accommodation capable of protecting the parents' privilege against self-incrimination, while at the same time promoting the best interests of the child by providing an incentive for full parental cooperation in family reunification efforts. The immunity granted must cover both use and derivative use of the statements made in order to be coextensive with the privilege against self-incrimination and thus meet constitutional requirements. Courts have described testimony given under use immunity as "the essence of coerced testimony," and established that such testimony cannot be used for impeachment or any other purpose. In order for a grant of use immunity to

facilitate parent rehabilitation and family reunification, no threats from the court-ordered therapy should exist. The threat of loss of custody and care of one's child would constitute the ultimate legal threat.

Summary and Conclusions

The treatment requirement to admit having abused the child has been examined in terms of professional, ethical, and legal concerns. While required acknowledgment of misconduct or admission of guilt is fairly common among treatment programs, the requirement is not universal. Obvious bias exists in treatment, as well as in many legal arenas, when it is assumed that all allegations of abuse are valid and persons who do not admit they abused the child are "in denial." There are no empirical data indicating that a requirement to admit guilt is therapeutically efficacious.

Ethically, several dilemmas exist in court-mandated sex offender treatment, including questions about whether a participant can truly give informed consent when court ordered and with the threat of loss of parental rights. The counselor-client relationship is further compromised by the lack of assurance of confidentiality when treatment providers are required to report patient disclosures to the court. Professionals providing court-ordered sex offender treatment may find themselves in potentially unethical dual relationships.

Several legal issues pertain to sex offender treatment and the required admission of guilt. There are questions as to whether the failure to admit abuse constitutes "clear and convincing evidence" of parental unfitness. The Supreme Court in *Santosky v. Kramer* concluded that parental rights should not be terminated solely on the basis of "a few isolated instances of unusual conduct [or] . . . idiosyncratic behavior." It is argued that failure to admit abuse, considered in the totality of information about parental abilities, would fall into the category of "a few isolated instances of unusual conduct."

If the person did commit the abuse and is court mandated to treatment, the Fifth Amendment protection against self-incrimination would be in effect. But if the person did *not* commit the abuse, and is court mandated to treatment and required to admit abuse, that person is put in an impossible situation. An innocent individual who is required to admit abuse is being legally required to commit perjury. If an innocent person continues to profess innocence, those assertions are "truthful negation," and not "denial." Very real risks of judicial error should be considered in light of factors identified in *Santosky v. Kramer.* A grant of immunity from prosecution may "allow" participants to admit guilt, if they are guilty, but should not serve as another mantel for judicial coercion.

References

Adams, J. (1995). Interviewing children in suspected sexual abuse cases. *Oklahoma Family Law Journal, 10*(4), 105-111.

Adams, J. (undated). *Behavioral indicators of alleged child sexual abuse and hearsay testimony based on these indicators.* Manuscript submitted for publication,

October, 1997.

Alexander, M. (1994, November 11). *Sex offender treatment: A response to the Furby, et al. 1989. Quasi meta-analysis II*. Presented at the ATSA Conference, San Francisco, CA.

Alexander, R. (1988). Mental health treatment refusal in correctional institutions: A sociological and legal analysis. *Journal of Sociology and Social Welfare, 15*(3), 83-99.

Bancroft, J. (1981). Ethical aspects of sexuality and sex therapy. In S. Block & P. Chodoff (Eds.), *Psychiatric Ethics* ()(). Oxford, England: Oxford University Press

Besharov, D. J. (1990, Spring). Gaining control over child abuse reports. *Public Welfare,* 34-41.

Besharov, D. J. (1986). Unfounded allegations — a new child abuse problem. *The Public Interest, 83,* 18-33.

Bonner, B. L. (1995). Adolescent sex offenders: current treatment approaches. *The Quarterly, 8*(4), 5-9.

Brown, J. L. (1989, August). *Treatment of incest offenders in a community correctional facility.* Paper presented at the American Psychological Association Annual Convention, New Orleans, LA.

Call, J. A. (1994). False allegations of sexual abuse in custody and visitation disputes. *Oklahoma Family Law Journal, 9*(2), 76-87.

Cecil, S. & Bruck, M. (1995). *Jeopardy in the Courtroom: A Scientific Analysis of Children's Testimony* (). Washington, DC: American Psychological Association.

Chaffin, M. (1992). Factors associated with treatment completion and progress among intrafamilial sexual abusers. *Child Abuse and Neglect, 16,* 251-264.

Friedman, S. (1991). *Outpatient Treatment of Child Molesters* (). Sarasota, FL: Professional Resources Exchange, Inc.

Furby, L., Weinrott, M. R., & Blackshaw, L. (1989). Sex offenders recidivism: A review. *Psychological Bulletin, 105,* 3-30.

Gardner, R. A. (1991). *Sexual Abuse Hysteria: Salem Witch Trials Revisited* (). Cresskill, NJ: Creative Therapeutics.

Gelinas, D. J. (1988). Family therapy: characteristic family constellation and basic therapeutic stance. In S. M. Sgroi (Ed.). *Vulnerable Populations, Vol. 1* ()(). Lexington, MA: Lexington Books.

Giarretto H., Giarretto, A., & Sgroi, S. M. (1978). Coordinated treatment of incest. In A. W. Burgess, A. N. Groth, L. L. Holmstrom, & S. M. Sgroi (Eds.). *Sexual Assault*

of Children and Adolescents ()() (pp. 231-240). Lexington, MA: Lexington Books.

Greenland, C. (1988). The treatment and maltreatment of sexual offenders: Ethical issues. In R. A. Prentky & V. L. Quinsey (Eds.). *Human Sexual Aggression: Current Perspectives* () (pp. 373-378). New York: The New York Academy of Sciences.

Groth, A. N. (1978). Guidelines for the assessment and management of the offender. In A. W. Burgess, A. N. Groth, L. L. Holmstrom, & S. M. Sgroi (Eds.). *Sexual Assault of Children and Adolescents* ()() (pp. 25-42). Lexington, MA: Lexington Books.

Gutheil, T. G. (1986). The right to refuse treatment: paradox, pendulum, and the quality of care. *Behavioral Sciences & the Law, 4,* 265-277.

Haas, L. J., & Malouf, J. L. (1989). *Keeping Up the Good Work: A Practitioner's Guide to Mental Health Ethics* (). Sarasota, FL: Professional Resource Exchange, Inc.

Haugaard, J. J., & Reppucci, N. D. (1988). *The sexual abuse of children.* San Francisco, CA: Jossey-Bass Inc.

Langevin, R., & Lang, R. A. (1985). Psychological treatment of pedophiles. *Behavioral Sciences & the Law, 3,* 403-419.

Laws, D. R. (Ed.). (1989). *Relapse prevention with sex offenders.* New York: Guilford Press.

Laws, D. R. (1995). Central elements in relapse prevention procedures with sex offenders. *Psychology, Crime & Law, 2,* 41-53.

Levine, M., & Doherty, E. (1991). The Fifth Amendment and therapeutic requirements to admit abuse. *Criminal Justice and Behavior, 18*(1), 98-112.

Marshall, W. L. (1996a). Assessment, treatment, and theorizing about sex offenders: Developments during the past twenty years and future directions. *Criminal Justice and Behavior, 23,* 162-199.

Marshall, W. L. (1996b). The sexual offender: Monster, victim or everyman. *Sexual Abuse: A Journal of Research and Treatment, 8,* 317-335.

Marshall, W. L., & Pithers, W. D. (1994, March). A reconsideration of treatment outcome with sex offenders. *Criminal Justice and Behavior, 21,* 10-27.

McGough, L. S. (1995). For the record: Videotaping investigative interviews. *Psychology, Public Policy, and Law, 1,* 370-386.

Patton, W. W. (1990). The world where parallel lines converge: The privilege against self-incrimination in concurrent civil and criminal child abuse proceedings. *Georgia Law Review, 24*, 473-524.

Peterson, M. R. (1992). *At Personal Risk: Boundary Violations in Professional-Client Relationships* (). New York: W. W. Norton and Company.

Petit, M. R., & Curtis, P. A. (1997). *Child Abuse and Neglect: A Look at the States* (). Washington, DC: Child Welfare League of America (CWLA).

Pithers, W. D. (1997, March). Maintaining treatment integrity with sexual abusers. *Criminal Justice and Behavior, 24,* 34-51.

Thompson, A. (1990). *Guide to Ethical Practice in Psychotherapy* (). New York: John Wiley and Sons.

Vetter, H. J., & Rieber, R. W. (Eds.). (1980). *The Psychological Foundations of Criminal Justice (Vol. II)* (). New York: John Jay Press.

Wakefield, H., & Underwager, R. (1991a). Sexual abuse allegations in divorce and custody disputes. *Behavioral Sciences & the Law, 9,* 451-468.

Wakefield, H., & Underwager, R. (1991b). Sex offender treatment. *Issues in Child Abuse Accusations, 3,* 7-13.

Walker, C. E., Bonner, B. L., & Kaufman, K. L. (1988). *The physically and sexually abused child.* New York: Pergamon Press.

Cases Cited

In re Eduardo A., 1989. 209 Cal. App. 3d. 1038, 261 Cal. Rptr. 68.

In re Kristen B. and Sarah Marie B. 1986. 232 Cal. Rptr. 36 (Cal. Appl 4 Dist.).

In the Interest of A. W. 1990. 464 N.W.2d. 475.

In the Interest of C. and K., Children. 1982. 332 N.W.2d. 76.

In the Interest of Chad, A Minor. 1982. 318 N.W.2d. 213.

In the Interest of H. R. K., R. M. A. C., Jr., Children. 1988. 433 N.W.2d. 46 (Iowa App.).

In the Interest of K. L. C, K. L. C., K. K. B., Children. 1985. 372 N.W.2d. 223.

In the Interest of K. M. R., and D. C. R., III, Minor Children. 1990. 455 N.W.2d. 690.

In the Interest of R. W. B., A Child. 1976. 241 N.W.2d. 546.

Montana v. Imlay. 1991. 48 St. Rep. 588.

Pell v. Procunier. 1973. 417 U.S. 817.

Poteet v. Fauver. 1975. 517 F.2d. 393 (3rd Cir.).

Santosky v. Kramer. 1982. 455 U.S. 745.

Scott v. United States. 1969. 419 F.2d. 264 (O.C. Cir.).

State v. Michaels. 1994. 642A.2d. 1372 (N.J.).

Thomas v. U.S. 1966. 368F. 2d. 941 (Fifth Circuit).

United States v. Laca. 1974. 499 F. 2d 922.

United States v. Wright. 1976. 533 F. 2d 214.

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