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Medico-Legal Collaboration Regarding the Sex Offender: Othering and Resistance

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We examined medico-legal collaboration regarding dangerous sex offenders where state legislators have adopted statutes that determine the criteria for commitment to and discharge from civil commitment programs. The application of these statutes relies on medical diagnoses of pathologies such as paraphilia, anti-social personality disorder, and pedophilia along with prognoses for cure or recidivism. In our study, we examined court opinions from commitment hearings and observed a trial in federal court on the constitutionality of these commitments. We found that one result of this medico-legal collaboration is the marginalization or othering of sex offenders by essentializing, dividing, shaming, and impeaching them. We also found that this group attempted to resist othering by rhetorical strategies such as providing evidence of change in character, distinction within the othered group, and proof of internal controls over unacceptable impulses. Finally, we discovered that such othering relies heavily on medical expertise, even though some medical practitioners may disagree with, or be hesitant in, their roles in this medico-legal collaboration.

KEYWORDS: medico-legal collaboration, sex offender, civil commitment, medical diagnosis and prognosis, legal statutes, resistance, othering

When sex offenders have completed their prison sentences but are considered still too dangerous to be released into the community, legal representatives must decide how to control them externally, and medical experts are called upon to teach them how to manage their sexual impulses internally. Ideally, in a medico-legal collaboration, the medical and the legal communities partner to better address a health-harming social condition, such as exposure to violence. After all, the law, according to Austin Sarat and Thomas Kearns (2000), "is inseparable from the interests, goals, and understandings that deeply shape or comprise social life" (p. 6). Likewise, Elisa Sobo and Martha Loustaunau (2010) remind us, "The ways in which we perceive and interpret health and illness, and seek and deliver care" are "inextricably bound up with cultural norms, beliefs, and values, as well as by social structure and environmental conditions" (p. viii). The World Health Organization (2003), for example, provided *Guidelines for Medico-Legal Care for Victims of Sexual Violence*, which proposes that health workers achieve an understanding of local rules and laws applicable to sexual violence and that policymakers ensure that services for such victims are coordinated and funded.

Within the United States, 20 states plus the federal government rely on medico-legal collaboration to address the need for confinement and treatment of dangerous sex offenders through indefinite civil commitment. More specifically, legal representatives create the criteria by which offenders are civilly committed as well as discharged from such commitment, and medical experts provide the diagnoses to support these criteria and measure the risk of each offender reoffending. In this medico-legal collaboration, however, we find that success in treating sex offenders so that they are safe to discharge into the community may not be achieved, and the medico-legal partnership might not be equal. Moreover, this medico-legal collaboration and resulting discourse support this civil commitment by marginalizing or "othering" the offender in contrast to the "normal" citizen.[1] And so, in this article, we not only explore othering as the result of this medico-legal collaboration but also hope to extend the work on

[1] Throughout this article, we use "othering," "stigmatization," "subordination," and "marginalization" somewhat interchangeably. We do recognize that some scholars distinguish among these terms. Steven Brown, Jo Deakin, and Jon Spencer (2008), for example, found that the 969 people who responded to a questionnaire distributed in the UK believed that *marginalization* of sex offenders rather than community integration best secured public safety. Richard Tewksbury (2012) determined that *stigmatizing* or labeling sex offenders "leads to internalization of negative

othering by rhetoric of health and medicine (RHM) scholars. Such RHM scholars include Catherine Gouge (2018), who argues that biomedicine failed to "productively engage" patients who resisted physician orders because these patients' divergent behaviors did not conform to the expected norms (p. 119). Also, Jennifer Malkowski (2014) provides evidence that counterpublics, such as the subculture of gay men who actively desire to contract the human immunodeficiency virus, had limited means and opportunities to explain their intentions to health professionals.

As we explain in this article, the rhetorical devices used to other the sex offender include essentializing, dividing, shaming, and impeaching. Moreover, some sex offenders may attempt to resist being othered by denying their criminal history, rejecting the medical diagnoses and prognoses that support their commitment, and blaming an unfair system or complicit victim for their situation—all usually unsuccessful persuasive strategies. Some sex offenders may also more successfully oppose what seems like perpetual othering by providing evidence of change, distinction within the othered group, and internal control over unacceptable impulses. The effectiveness of these rhetorical resistance strategies, however, depends partly on the credibility of the individual as challenged by legal criteria for commitment and discharge, and such practices as risk assessment conducted by therapists and medical forensic experts.

Thus, medico-legal collaboration in the case of civil commitment creates a disciplinary rhetoric that not only initiates this othering but also shapes resistance to it. As explained by Amy Koerber (2013) in her study of infant feeding, "Individuals might resist certain elements of disciplinary rhetoric, but they never escape the grid of disciplinary power altogether" (p. 107). In terms of our study, on the one hand, sex offenders who deny their criminal history are confronted by a powerful multidisciplinary grid that has compiled and interpreted the number and seriousness of their crimes. On the other hand, sex offenders who testify to internal change in character and have the support of their therapists have learned to speak within that multi-disciplinary grid. In our study, we investigate how these two powerful disciplinary groups, medical experts and legal stakeholders, work together to manage such a socially despised group, and how members of that group have attempted to resist othering in one courtroom setting.

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feelings" (p. 614). Finally, Joy Johnson et al. (2004) define othering as a process that reaffirms dominant and subordinate social positions. However, these terms, it seems, are highly related.

Moreover, we discover how in the case of sex offenders, legal othering relies heavily upon medical diagnosis and prognosis, even though those diagnoses and prognoses are at times uncertain or even disputed by practitioners, and such othering may be based as much on emotion—such as fear, disgust, and shame—as on professional insight.

We begin by exploring the catalyst for the creation of civil commitment programs as well as the problems in maintaining them, with a particular focus on perhaps the least successful of them all, the Minnesota Sex Offender Program (MSOP) (see, for example, Sex, 2017). We explain the theoretical perspectives on othering and resistance that we draw upon and extend in this article. We also describe our data sources: a number of court opinions resulting from Minnesota civil commitment hearings and our observation of the constitutional challenge to MSOP occurring in federal court in Spring 2015. Finally, we focus on how two groups of civilly committed sex offenders who testified in that federal trial attempted to resist their othering: the sex offenders who committed their offenses exclusively while juveniles, and the sex offenders who had been diagnosed with pedophilia. We conclude by extending scholarly knowledge on othering and resistance and by commenting on how with this medico-legal collaboration, the medical collaborators were somewhat pressured to be conclusive when in some cases they were uncertain or hesitant.

Civil Commitment and Disciplinary Discourse

As a result of medico-legal discourse and collaboration, a few of the civil commitment programs in the United States have successfully treated and integrated sex offenders back into the community; many, however, do not achieve enough success in treatment to ensure public safety.[2] Although all programs certainly rely on statutes to provide the legal criteria for civil commitment for an indeterminate period and eventual discharge and on current medical practices to evaluate and treat psychological abnormalities, the norm can still be a de-facto life sentence for the offender. Judge Audrey Fleissig, for example, ruled that Missouri's Sex Offender Rehabilitation and Treatment Services program "suffers from systemic failures regarding risk assessment and release that have resulted in the continued

[2] For a description of civil commitment programs that are marked as successful given their discharge and recidivism rates, see Rule 706 Expert Report and Recommendations, *Karsjens v. Jesson*.

confinement of individuals who no longer meet the criteria for commitment, in violation of the Due Process Clause" (*Van Orden v. Schafer*, 2015, p. 844). The Minnesota Sex Offender Program has also faced due process challenges asserting that civil confinement of sex offenders is unfair and arbitrary, and although civil commitment efforts might meet a specific government interest, those efforts are not applied in the narrowest way as required by the Constitution. Thus, for extensive periods, civilly committed sex offenders may be deprived of their liberty rights as guaranteed by the Fourteenth Amendment and the Due Process Clause.[3] In addition, MSOP currently has the highest per capita number of sex offenders civilly committed and the lowest number of offenders discharged back into the community.

Certainly, the public fear and pressure on medico-legal collaboration to control, if not solve, sexual violence, and the perceived recidivism among these sex offenders, play a role in not only othering but also establishing barriers to successful resistance to othering. As Eric Janus (2006) notes, the sexual predator appears to the public to be "the worst of the worst," a widespread characterization of those offenders who appear so dangerous that "they seem to be pathologically different from the rest of us" (p. 2). Likewise, Dany Lacombe (2008) proposes the "figure of the sex offender has become emblematic of society's greatest fears: an immoral, impulsive predator who amuses himself by tormenting, sexually torturing and killing the most vulnerable among us," an offender who because of some psychological flaw cannot help himself (p. 55).

Given this characterization, a well-publicized crime by a sex offender often serves as a catalyst for the medico-legal collaboration in creating or extending a civil commitment program. The public's reaction to the crime can result from moral panic as, according to Stanley Cohen (1980), when a group is viewed as a "threat to societal values and interests" and therefore should be "segregated and isolated" (pp. 9, 18). Moral panic might then start a chain reaction wherein media describe a risk, the public believes that the risk is real and immediate, and lawmakers respond with extreme action, or in the case of civil commitment, the medical and legal communities

[3] For an in-depth examination of how civil commitment programs may curtail the constitutional liberty and due process rights of sex offenders, see Brandt and Prescott (2015, February 1); Brandt and Prescott (2015, February 7); Brandt and Prescott (2015, June 21); Janus (2006); Janus and Brandt (2015).

collaborate to essentialize and confine sex offenders (see also Jenkins, 1998; Schuster & Propen, 2015; Propen & Schuster, 2017). In other words, moral panic and othering are highly related in terms of group identification, marginalization, and containment. Thus, the first sexual predator legislation was passed after the well-publicized arrest of repeat offender Earl Shriner, as Cyd Cipolla (2011) explores in her assessment of the Washington Community Protection Act (WCPA) of 1990. During the Shriner case, public and medico-legal discourse concluded that sex offenders like Shiner could never be cured and therefore must be confined indefinitely. The Washington state legislature passed WCPA in response to this discourse to shift from the forensic-psychology intervention model to a model that identifies and then contains a small group of violent sexual predators. And so, Cipolla concludes, "Both the psychiatric community and the legal community agree that men like Shriner are potentially incurable" (p. 105).

In Minnesota, the legislature seemed more optimistic in relying on the medical community to properly identify and treat dangerous offenders so that the public could be safe. But as in the state of Washington, a well-publicized and much-discussed case led the Minnesota legislature to strengthen its civil commitment criteria.

The Case of Minnesota

The planned release in 1997 of Dennis Darol Linehan from a Minnesota prison served as a catalyst for medico-legal collaboration in creating a state statute in which two identities of sex offenders could be committed—the Sexually Dangerous Person (SDP) and the Sexual Psychopathic Personality (SPP)—both of which depended on medical diagnoses and prognoses as well as criminal histories. Among other violent crimes, Linehan killed a 14-year-old girl during an attempted rape. In the midst of the debate about what to do with him, Linehan ironically identified himself as the "poster child" for civil commitment or "a parent's worst nightmare" (Oakes, 2008, n.p.). Then, with the 2003 kidnapping and murder of female college student Dru Sjodin by Alphonso Rodriguez, Jr., Minnesota Governor Tim Pawlenty discouraged any future discharges of SDPs and SDDs from MSOP even though Rodriguez himself, a Level-3 sex offender (considered most likely to reoffend), had never been civilly committed (see, for example, McEnroe, 2001). From that point on, the state required Minnesota county attorneys to review, with the help of medical experts, all Level-3 sex offenders at the

end of their confinement to prison for possible civil commitment for an indeterminate time (see Minnesota Statute 2016, § 253D.09(a)). The number of civilly committed sex offenders increased almost six-fold after the Rodriquez case (see Bierschbach & Mannix, 2015, n.p.). Moreover, the state criteria for discharge from civil commitment became more difficult for an offender to meet than the criteria for initial commitment (see Minnesota Commitment and Treatment Act, 2016, § 253D.30; § 253B.18).

As a result of this political and public pressure, the current population of MSOP is now over 720, with only one successful full release and eight provisional discharges from the program in its 20-year history.[4] More than 40 offenders have died from disease or old age in the treatment facilities in Moose Lake and St. Peter, MN, and in 2016, the oldest offender in MSOP was 94, and several were over 70 (Fritz, Brandham, & Oldham, 2016, June 28). For this reason and others, we agree with Corey Yung (2013) who, in the *AMA Journal of Ethics: Virtual Mentor*, concludes that civil commitment represents "a quintessential example of a poorly conceived scheme designed to unify concepts from the fields of law and medicine" (p. 873). Specifically, Yung accuses legislators who have supported such programs as attempting to rely on the authority of mental health professionals to "lend credence to legal regimes on shaky doctrinal ground. The result has been a set of programs that *fail from both a medical and legal standpoint*" (p. 873, emphasis added).

Theoretical Perspectives and Methodology

Rhetorical perspectives on othering and resistance to such othering help illuminate the medico-legal collaboration regarding the ongoing dilemma of how to manage and treat sex offenders. The medico-legal discourse is anchored in continued debate about threats to public safety and the likelihood of recidivism—whether sex offenders can be cured and why this

[4] Provisional discharge includes confinement to a secure group home, GPS monitoring, individual and group therapy, no contact with victims or those who match the profile of previous victims such as children, and such. To be provisionally discharged from MSOP, a client must initiate a petition, which is then reviewed for possible support by his therapy team and a forensic risk assessment expert. The petition is next considered by the Special Review Board, which consists of one attorney, one psychiatrist or psychologist, and one other mental health professional; the Board decides whether the client meets the criteria for discharge. Appeals may then be reviewed by a state Supreme Court Appeal Panel, which consists of three judges, and the Commissioner of Human Services votes to either oppose or not oppose the petition.

propensity to sexually offend occurs. To a great extent, then, such a medico-legal collaboration is demanded by the public to protect and maintain social expectations of safety.

Scholarship by RHM scholars about othering has included perspectives on subcultures that have seemed suspect to the general population. Containment rhetoric, as explored by these scholars, relies not only on disciplinary discourse but also social discourse, both of which establish and maintain boundaries between the normal and the abnormal. Michelle Smith (2010), for example, defines containment rhetoric as "a way to describe and define rhetorical imaginings that contain the threat of a group considered Other" (p. 129). Smith examines the containment rhetoric regarding the Amana groups—communal, religious, and communistic societies on the Iowa prairie—and her work identifies how the basic incompatibility of the othered group with general society is argued and established. In addition, Malkowski (2014) concludes that containment rhetoric emerges "as a means by which the character of a group can be discursively recrafted to undermine its perceived viability and/or threat" to so-called normal society (p. 214). Regarding rhetorical resistance, Koerber's work (2013) suggests that for those who "take meaningful action within the grid of meaning that is established through disciplinary power," there "remains some uncertainty about the precise nature and limitations of such actions" (pp. 106–107). Thus, Smith identifies othering as containment rhetoric, distinguishing between the normal and the abnormal; Malkowski suggests that the discourse about an othered group marks it as dangerous; and Koerber suggests that we need to extend our knowledge about resistance to othering. Primarily, it is this scholarship and conversation that we hope to extend.

Othering and Resistance

Providing a foundation for our scholarly contribution are basic perceptions about othering. Sune Qvotrup Jensen (2011), for example, defines othering as "*discursive processes by which powerful groups, who may or may not make up a numerical majority, define subordinate groups into existence in a reductionist way which ascribe problematic and/or inferior characteristics to these subordinate groups*" (p. 65, emphasis in original; see also Krumer-Nevo, 2002; Peternelj-Taylor, 2004). The abnormal is established by the normal, and such establishment reflects the values that the empowered "normal" wishes to maintain. Moreover, the abnormal can be defined as dangerous, threatening to cross

boundaries of containment to harm the most vulnerable of the population. As Sara Ahmed (2000) defines this fear of the othered, the outsider "stranger only appears as a figure of danger by coming too close to home" (p. 37; see also Kristeva, 1982; Butler, 1990; Ingebretsen, 2001). Again, we propose that medico-legal discourse encourages society to rely on the law to enforce such containment, and on medicine to identify those who must be contained.

As often noted in the discourse about the sex offender, particularly the pedophile who many consider the most dangerous and emblematic of all sex offenders, there seems no cure and therefore no avenue to move back safely into normal social life. As scholars such as Dale Spencer (2009) note, "This outsider is [considered] an irredeemable evil monster, stricken with a perverted disease for which there is no cure" (p. 225). In our study, we interrogate this aspect of the discourse by examining how medico-legal collaboration defines the mental illness that drives such offenders, and how individual practitioners within civil commitment facilities must predict whether each offender can be safely released into the community. Given this challenge, it might indeed seem better to confine indefinitely these offenders to guarantee public safety, because not doing so would risk creating more victims, consequently calling into question the existence and judgment of the commitment facility as well as the medico-legal collaboration. Thus, Minnesota's civil commitment laws and individual MSOP practitioners seem to err on the side of placing more, rather than fewer, offenders outside of open society's boundaries.

Enhancing this understanding of othering is the work of scholars who have explored the presence and function of emotion in the legal arena. As Susan Bandes declares, quite simply and forcefully, "Emotion pervades the law" (p. 1). Certainly fear drives civil commitment laws. As we see in the case of MSOP clients, however, attempts to shame the client and to evoke disgust for that client help reinforce this othering.[5] Shame often results from crippling guilt about certain acts. And as Martha Nussbaum (2004) relates about the emotion of othering, "Societies ubiquitously select certain groups and individuals for shaming . . . marking them off as 'abnormal' and demanding that they blush at what and who they are" (p. 192). If the abnormal is expected to feel shame for certain actions, actions that confirm

[5] Sex offenders civilly committed to MSOP are called clients, and so frequently we refer to them as such within this article.

abnormality and inherent traits, the so-considered normal population may feel disgust for the offender, an emotion that Nussbaum associates with fear of contamination. Thus, disgust as an emotion creates a dichotomy to distinguish the categories of the disgusting and the pure, which can limit the ability for the othered to resist othering. Finally, according to Mona Lynch (2002), the disgusting are "subject to measures that seek to quarantine, separate, and even destroy them to defuse their powerfully contaminating forces" (p. 540). If these social boundaries are carefully drawn and maintained, those considered disgusting cannot cross them, and by accepting their own nature as so defined, the shamed offenders might not attempt to cross these boundaries.

One aim of our analysis is to examine how a group of othered persons might resist containment rhetoric and marginalization as well as the disgust imposed upon them and shame expected of them. We choose this aim because until now the discussion of othering relating to the medico-legal collaboration surrounding civil commitment has not revealed specifically or in depth how these groups might resist othering. One exception is Richard Tewksbury's (2012) study, which found that marginalized individuals cast out of dominant society may manage their stigmatization by displacing "the stigma onto others or simply rejecting the stigma," by "celebrating one's difference," by seeking "empowerment through overcoming the label," or by distinguishing among group members (pp. 609–610). However, Tewksbury rightly qualifies his observations about resistance to marginalization by cautioning that these findings have "to date not addressed the case for sex offenders" (p. 609). Again, of the many groups who have experienced othering by way of the dominant cultural norms throughout history, sex offenders might be the most difficult to defend and redeem. These offenders, for example, might be particularly challenged to resist stigmatization through the means that Tewksbury shares, leaving open our opportunity to extend knowledge about resistance to othering within the medico-legal grid.

Civil Commitment Court Opinions

To explore thoroughly the nature of the medico-legal collaboration in creating civil commitment statutes and programs, we first reviewed 33 civil commitment court opinions from Minnesota between 1994 and 2016. (See Appendix A for a list of these court opinions as well as some specific legal

documents and reports we used throughout this article.) We did so to see how medical diagnoses and prognoses regarding Sexually Dangerous Persons (SDP) and the Sexual Psychopathic Personality (SPP) were used to support a county attorney's petition for civil commitment or to refute a MSOP client's argument for avoiding such commitment. Of the 33 court opinions we reviewed, 25 opinions came from the Minnesota Court of Appeals and eight from the Minnesota Supreme Court; 25 opinions concerned civil commitment to the MSOP, and eight concerned discharge from MSOP.

Although the process of civil commitment starts with the county attorney's petition, the case must proceed to medical experts' diagnoses and prognoses of the abnormalities that bring the offenders into court and predict any recidivism after treatment. Within Minnesota's civil commitment statutes, the SDP is defined as one who is 1) "engaged in a course of harmful sexual conduct" and therefore created a "substantial likelihood of serious physical or emotional harm to another"; 2) a person who has "a sexual, personality or mental disorder"; and 3) a person who is "likely to engage in harmful sexual conduct in the future" (Minnesota Statute 2016, § 253D.02, Subd. 16). The SPP is defined as one who, as a result of a mental or emotional condition, 1) has engaged in a "habitual course of misconduct in sexual matters"; 2) has an "utter lack of power to control" his or her "sexual impulses"; and 3) as a result of this inability to control behavior is "dangerous to other persons" (§ 253D.02, Subd. 15).

In *In re Civil Commitment of Stone* (2006), for example, two medical experts, Dr. Linda Marshall and Dr. Peter Meyers, agreed that Adnan Allen Fakaraldin Stone met the criteria for civil commitment in Minnesota as an SDP based both on their diagnosis of Stone's several mental disorders as well as their assessment that his young victim, now experiencing nightmares and separation anxiety, was suffering long-term emotional harm. Moreover, these two court-appointed experts concluded that each of the commitment factors for an SDP had been further met because of Stone's age, lack of family support, history of violent behavior, current stress in his living arrangements, and demonstrated incapacity to learn from his mistakes. Finally, these experts used base-rate statistics to argue for the high likelihood of Stone's reoffending with a "twenty-five-year recidivism rate ranging from thirty-nine to fifty-two percent" (*In re Civil Commitment of Stone*, 2006, n.p). Although the state rehearsed Stone's criminal history in court, it depended on the expertise of Drs. Marshall and Meyers to convince the

court that Stone met the legal criteria for commitment. And again, these medical experts not only diagnosed Stone's mental problems but also those of his victim, and they predicted that Stone was likely to reoffend if not civilly confined. Their prognosis involved not so much his likelihood to be cured but his likelihood to reoffend. (See Appendix B for the categories and subcategories that emerged from our examination of the 33 civil commitment court opinions.)

The Federal Trial of *Karsjens v. Jesson*

In addition to our assessment of the civil commitment court opinions, one of us observed in its entirety the six-week federal trial on the constitutionality of MSOP in the 2015 civil suit of *Karsjens v. Jesson*, with particular attention to the sex offenders who were called to testify. We conducted this observation to see how, by medico-legal collaboration, sex offenders were othered and how these offenders resisted othering. In doing so, we discovered that the most convincing forms of resistance might include providing evidence of change, showing distinction within the othered group, and having firm control of unacceptable sexual impulses. We also confirmed how medical expertise functioned to add certainty to legal criteria for civil commitment and discharge, even if those experts disagreed.

In the *Karsjens* case, fourteen civilly committed sex-offender plaintiffs engaged in a class action suit against individuals acting on behalf of the State, such as Lucinda Jesson, the Minnesota Department of Human Services Commissioner, and Jannine Hébert, MSOP Executive Clinical Director. The plaintiffs argued that the statutes that governed MSOP were unconstitutional on their face and that MSOP was unconstitutional as it applied those statutes, again for lack of due process and for curtailment of liberty rights. In the *Karsjens* trial, Judge Donovan Frank heard arguments in U.S. District Court, District of Minnesota. Our observer took notes on all the testimony, attempting to capture the exact words used by witnesses and the opposing parties. On one day, a videotape of one witness's testimony enhanced these observations, and on another day, the transcript from the court reporter became an important source.[6] (See Appendix C for

[6] To avoid constitutional challenges to civil commitment laws based on due process rights and prohibitions, such as *ex post facto* sentencing and double jeopardy, the courts have decided that treatment by psychologists as well as frequent risk assessment by forensic experts must be part of any civil commitment program (see *In re Blodgett*, 1994; *Kansas v. Hendricks*, 1997). Judge Frank,

the categories and subcategories that emerged from these observations.) In reviewing these data, we noted the rhetorical strategies that MSOP medical staff might use to argue for the continuing need for sex offenders to be confined and treated in their facilities, the strategies that those testifying offenders used to resist their othering, and the various interpretations of the statutes that governed civil commitment offered by the plaintiffs and defendants and supported by medical expertise.

The Juvenile-Only Offender

In our examination of the medico-legal collaboration in othering the sex offender, we looked specifically at the testimony of juvenile-only sex offenders, the first group of MSOP clients called by the plaintiffs in the *Karsjens* trial. The plaintiffs called two such offenders to testify, seemingly to prepare a foundation for rethinking the medico-legal boundaries separating these offenders from society. In contrast, in the 33 Minnesota civil commitment cases that we reviewed, the primary concerns were with victims, some of whom testified in the hearings. In *In re Martinelli* (2002), for example, the conclusion that Alexander Mark Martinelli had an utter lack of control over his sexual urges was based on his grooming of boys, even when he was on probation for similar offenses. Also, Minnesota Court of

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however, concluded that the Minnesota statutes governing civil commitment as well as MSOP in applying these statutes violated the due process constitutional rights of MSOP clients, particularly their fundamental liberty rights. Ultimately, the defense appealed Judge Frank's decision to the U.S. Court of Appeals for the Eighth Circuit, which found that Judge Frank had used the wrong standard of proof in determining his decision and that the ability of MSOP clients to petition for discharge met constitutional requirements. In response, the plaintiffs wrote a "petition for writ of certiorari" to the U.S. Supreme Court, arguing not only for the appropriateness of the standard of proof that Judge Frank had used but also for a necessary constitutional remedy: annual risk assessment of every MSOP client to determine whether that client still met the legal and medical criteria for civil commitment. Janus (2006) and other scholars have concluded that civil commitment creates a "reduced-rights zone" for sex offenders (p. 32). Within their writ of certiorari to the U.S. Supreme Court, the plaintiffs echoed this concern that civil commitment creates

> constitutionally impermissible sub-classes of rights holders—those who have a fundamental right to liberty and those who do not. This approach means that any group perceived as potentially dangerous to the public—the mentally ill, people with alien status, or those previously convicted of chronic criminal behavior, for example—could find themselves with diminished constitutional rights when facing civil commitment or detention. (p. 4)

On October 2, 2017, however, the U.S. Supreme Court declined to hear the case, a decision that effectively upheld the appellate court's decision.

Appeals Judge Shumaker expressed concern that Darrin Scott Rick was likely to engage in such conduct in the future after he sexually abused five developmentally challenged children (*In re Civil Commitment of Rick*, 2007).[7] In the *Karsjens* trial, however, the four expert witnesses (a licensed psychologist, a licensed clinical social worker, a board-certified clinical psychologist, and a forensic psychologist) were engaged by the judge to assess MSOP and to testify during the trial according to Federal Rules of Evidence Rule 706 (2011). These experts were particularly concerned about this subgroup of MSOP clients. Sixty-seven juvenile-only offenders were civilly confined to MSOP at the time of the trial, and they had never committed crimes as adults. Just as Linehan became the "poster child" for civil commitment, E. T. and C. B., whose cases and testimony we describe in this article, became the "poster boys" for the unjust othering of these young offenders and for challenging the medico-legal collaboration that divided the high-risk from the low-risk sex offender.[8] In particular, the use of medical

[7] Although in civil commitment hearings the voice of the victim is prominent and usually represented by the state, in the *Karsjens* trial that voice was subsumed by concern for public safety. Only one victim was called to testify in the *Karsjens* trial, T. M., who along with his wife had been sexually assaulted. T. M. ended his testimony by challenging Judge Frank: "If you're really convinced that you want to let them people [MSOP clients] out, then why don't you take them home with you? Why should we be the guinea pigs?"

[8] Even though the names of those sex offenders we specifically describe or address in this article are a matter of the public record and are revealed in some court opinion citations and media coverage, we have elected not to use the full names of the sex offenders in our text. Also, because all MSOP clients who testify in *Karsjens* were male, and only one female was civilly committed to MSOP at the time, we use the masculine pronoun in referring to a sex offender throughout this article. Finally, we include more detail of the personal and criminal histories of those MSOP clients who testified in the footnotes.

At the time of the *Karsjens* trial, E. T. was 25 years old. E. T.'s birth father was incarcerated, and his birth mother had abandoned him in a Las Vegas motel room shortly after his birth. His grandmother raised him briefly, but then she abandoned him at a day care center. His adoptive mother made him sleep in a closet on a towel for days as punishment for misbehaving. E. T. reported multiple incidents of having been sexually abused before his teenage years. At the age of ten, E. T. himself sexually abused his younger sisters, both of whom had developmental disabilities, and as a consequence, he spent most of his teenage years rotating through institutions where he displayed behavioral problems such as fighting and stealing. During the *Karsjens* trial, the plaintiffs revealed that E. T. never received a diagnosis necessary to civilly commit him, and in the summer of 2017, E. T. was fully discharged from MSOP.

C. B. was 19 years old at the time of his civil commitment hearing. When he was five and a half years old, C. B. was admitted to a hospital in Helena, Montana, after he smashed a child's fingers and threatened to set a house on fire. His parents admitted that C. B.'s uncle had sexually abused C. B. At the age of 15, C. B. sexually propositioned an 11-year-old girl and threatened to kill the child's father when confronted by him. In the same year, he was taken into custody after his 11-year-old sister reported that he had been sexually abusing her for the past three years.

diagnoses and forensic risk assessment were called into question for this group.

Othering by Essentializing

One rhetorical strategy to justify civilly committing sex offenders is to essentialize them with a medical diagnosis that meets the legal criteria for many sex offenders. As the Association for the Treatment of Sexual Abusers (ATSA) states, although the Minnesota statutes distinguish between the SDP and the SPP, both are considered a "high risk subgroup of sex offenders" (2010, n.p; for similar statutes and definitions, see Washington, 2001; D'Orazio et al., 2009; Wisconsin, 2017). Therefore, some diagnoses, such as paraphilia and anti-personality disorder, clearly fit the legal criteria and are commonly used, including among the 33 court opinions we reviewed.[9]

In *In re Martinelli* (2002), for example, Dr. Thomas Alberg concluded that Alexander Mark Martinelli's history of impulsive sexual behavior and the number of his criminal offenses indicated that Martinelli suffered from paraphilia or hebephilia (strong interest in pubescent children) as well as an anti-personality disorder. The court agreed that Martinelli so lacked control over his behaviors that he should be civilly committed (see also *In re Linehan,* 1996; *In re Kindschy*, 2001; *In re Civil Commitment of Navratil*, 2011). However, as Robert Prentky et al. (2006) concluded, this diagnosis of paraphilia becomes "one highly heterogeneous group" or "wastebasket for sex offenders" (p. 367). Equally common is the diagnosis of antisocial disorder, generalized as "a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood" (American, 2000, p. 645; in the Minnesota court opinions, see, for example, *In re the Civil Commitment of Spicer,* 2014; *In re Civil Commitment of Thomas*, 2015). Such diagnoses essentialize sex offenders rather than distinguishing them by their histories and behaviors in order to design

Over the next three years, C. B. was ordered to undertake sex offender treatment in three different programs for juveniles, none of which he completed.

[9] California's High Risk Sex Offender and Sexually Violent Predator Task Force concluded sex offenders subject to civil commitment often suffer from paraphilia: "Paraphilic disorders are diagnosable conditions characterized by deviant sexual urges, fantasies or behaviors involving humiliation of others, sexual activity with children and/or sexual activity with other non-consenting persons, and they occur over a period of at least six months" (Los Angeles County District Attorney's Office, 2016, n.p.; see also, Grossman, Martis, & Fichtner, 1999).

appropriate and individualized treatment. And so, these diagnoses cast a broad net for civil commitment in treatment programs where medico-legal collaboration may also leave open and even shed doubt upon whether treatment works.

During the *Karsjens* trial, for example, Dr. Amanda Powers-Sawyer, an independent researcher and practitioner, testified about her risk assessment of E. T. for possible discharge from MSOP. Dr. Powers-Sawyer recommended full discharge for E. T. based on her 40-hour interview with and assessment of him. However, Dr. Anne Pascucci, a forensic risk evaluator at MSOP, recommended against even provisional discharge for E. T. after she administered such risk assessment tools as the Stable-2007 and the Static 99R, even though the latter was never validated for juvenile-only offenders.[10] Moreover, E. T. refused to take a full-disclosure polygraph to measure to what extent he had admitted to his prior sex offences during his treatment. To offer a prediction or prognosis as to whether a sex offender will reoffend is extremely difficult. Although the risk assessment tools seem objective, that objectivity can present an obstacle to individual assessment, as in the case of E. T. And yet, to support the legal criteria for civil commitment, MSOP medical experts were asked to offer some assurance first that they could measure degree of risk and second that from that measurement they could offer reassurance against recidivism, an assurance doubted in the case of E. T. by Dr. Powers-Sawyer.

In regard to E. T., Dr. Pascucci continued her testimony by describing E. T.'s past offenses, including his planning to break into the girls' dormitory at a youth facility to "rape a low-functioning female" and "an escape from his room into the female pod areas," all of which "showed an escalation in his predatory nature." Based on these behaviors, Dr. Pascucci concluded that E. T. was "hyper-sexual" and displayed "a moderate degree of psychopathy," again placing E. T. within the othered group of dangerous sex offenders. Dr. Powers-Sawyer countered that E. T. did not have a sexual disorder but instead was living with post-traumatic stress disorder and

[10] The validity and applicability of such risk assessment tools was a focus of debate throughout the *Karsjens* trial. During the trial, the plaintiffs revealed that Stable-7000 was only validated among those sex offenders living in the community, and again Static-99R was never deemed valid for use on juvenile-only offenders (see also, the Static-99R, Clearing House, 2015; and Stable-2007 Assessment, 2015).

hyperactivity. In the case of E. T., the experts seemed to battle over diagnoses, one to justify and one to cast doubt regarding civil commitment. And so, we discovered that as displayed in the *Karsjens* trial, medico-legal collaboration regarding civil commitment often places demands on individual practitioners to apply legal criteria, demands about which they could have basic disagreement.

Moreover, it became clear during the disagreement between Drs. Powers-Sawyer and Pascucci and others that the legal criteria for discharge from civil commitment were often unclear and misunderstood. The legal criteria to be met by the MSOP medical staff when recommending or rejecting discharge from the program were as follows: "The committed person's course of treatment and present mental status indicate there is no longer a need for treatment and supervision in the committed person's current treatment setting," and the conditions of the provisional discharge plan must "provide a reasonable degree of protection to the public and will enable the committed person to adjust successfully to the community." These two criteria came under the required rubric that "a person who is committed as a sexually dangerous person or a person with a sexual psychopathic personality shall not be provisionally discharged *unless the committed person is capable of making an acceptable adjustment to open society*" (emphasis added, Minnesota Commitment and Treatment Act 2017, § 253D.30, Subd. 1). However, during the trial, the plaintiffs revealed that the Minnesota Supreme Court had recently questioned just how MSOP medical experts might predict with confidence that a person would adjust to open society. The court concluded that the primary discharge criteria should simply be: "A person committed as a psychopathic personality must be discharged if no reasonable relation exists between the original reason for commitment and the continued confinement" (*Call v. Gomez*, 1995, n.p.). The question became whether MSOP practitioners such as Dr. Pascucci could continue to rely on their risk assessment tools to predict acceptable adjustment.

In the case of C. B., the other juvenile-only offender to testify in the *Karsjens* trial, his continued civil commitment was supported overall by medical diagnosis. In his commitment hearing, medical experts testified that C. B. displayed the "sexual, personality or mental disorder" of a SDP and noted that his 32 separate sexual contacts with children as young as six years old led to his diagnosis of paraphilia, hypersexuality, bipolar spectrum disorder, and conduct disorder (*In re Civil Commitment of Bolte*, 2008,

n.p.). In their initial report and subsequent testimony, the Rule 706 experts confirmed that the "common theme" for individuals in the MSOP juvenile-only subgroup was "that they were problematic children with histories of abuse—sexual and otherwise—and neglect" (Rule 706 Expert Report and Recommendations, p. 11). Although these juvenile-only offenders had "engaged in a range of problematic sexual behavior, [as well as] other developmentally common behaviors," they were often viewed as reoffending because they had been labeled as sexual offenders at an early age (pp. 11–12). Had these juvenile-only offenders been properly assessed, argued the Rule 706 experts, they would not have met either the medical or legal criteria for civil commitment. Particularly alarming, said the Rule 706 experts, was that these juvenile-only offenders were being socially crippled by their confinement at MSOP, having been prevented from receiving academic training, obtaining job experience, developing appropriate intimate relationships, and learning to live independently. Implicitly reinforcing these ideas during his testimony, E. T. displayed no confidence in his diagnosis or treatment plan at MSOP. He said that he "had no grasp of what was going on in his life," now feeling "hopeless" despite treatment because he was "not going anywhere" and therefore had an "I don't care attitude."

Othering by Dividing Sex Offenders from Normal Society

Despite the recidivism prediction for E. T. and C. B. to meet the medico-legal requirements as a SDP or SPP, during the *Karsjens* trial the Rule 706 experts testified that the re-offense rate for juvenile-only offenders was low, probably less than 3% (see also Douard, 2008–2009; Harris & Socia, 2016). Moreover, the statistical probability of recidivism is uncertain even for adult offenders. Thus, in *In re Civil Commitment of Ince* (2014), the Supreme Court of Minnesota found that the term "highly likely" to reoffend, as required in the state statutes governing civil commitment of SDPs and SPPs, "cannot be defined by a numeric value" (n.p.; see also *In re Civil Commitment of Spicer*, 2014; Grossman, Martis, & Fichtner, 1999; Hanson et al., 2002; Quinsey et al., 1993). Once othered as abnormal or a threat to the moral values within society, it was difficult for these young offenders to overcome their marginalization. And so C. B. testified that MSOP treatment "makes the mold to fit anybody." According to C. B., the result of such

marginalization or division from society was that "all his hopes and dreams have been taken away," and he added that the "only way to get out [of MSOP] is to die." He was "burnt out" from the "repetitive treatment," treatment not designed for him, and so he had "no hope for a normal life."

In his testimony, C. B. complained about the repetitiveness and uniformity of MSOP treatment phases. In MSOP, phase one of treatment focused on rule compliance and treatment readiness; phase two involved sex offender treatment through group therapy and individual counseling; finally, phase three continued therapy with more living privileges and instruction on internal controls that could prevent recidivism. MSOP clients such as C. B. complained that they had to earn their way into phase two sex offender treatment and that every client began with phase one, regardless of their offenses or participation in prior sex offender treatment programs. Also, MSOP clients could spend decades in phase two if therapists found that they did not meet the criteria for progression. In Gouge's (2018) examination of the reasons why patients might not follow physician advice, she found, "Because compliance or adherence is still so widely considered to be the ethical response to treatment advice, the possibility of making sense of noncompliance/adherence as anything other than a problem to be solved is often foreclosed" (p. 116). In other words, C. B., among MSOP's over 720 clients, would be expected to progress through all prescribed phases of treatment before returning to society. In the *Karsjens* trial, this lack of individualized treatment was a common complaint among MSOP clients.

Othering by Shaming and Impeaching Sex Offenders

Gouge (2018) also notes that biomedicine alternates between "a blame- and shame-oriented preoccupation," which, because of a focus on compliance, does not recognize the reasons why people diverge from prescribed lines of treatment (p. 119). She notes that patients might misunderstand treatment plans, not have the necessary access to resources to follow such plans, be oriented in opposing ways to such treatment, experience conflict with their own goals for health, or otherwise have legitimate reasons for nonadherence. We confirm and extend Gouge's observation in the very different setting of MSOP. In cross-examination in the *Karsjens* trial, for example, the defense both shamed and impeached E. T. and C. B. to justify the continued need to separate them from society. Moreover, any approach to resisting their othered status was viewed as problematic, largely because

it challenged the normalized values and discursive structures of medical prognosis, risk assessment, and compliance.

Shaming in the courtroom is directly linked to impeachment. Questioning the truthfulness of a witness is usually based on, as Steven Lubet (1992) notes, exposing "some inherent trait or particular characteristic of the witness" that renders "testimony less credible" (p. 530; see also Federal Rules of Evidence Rule 607, 2011). The defense used the most common forms of character impeachment in the case of E. T., which include "conviction of a crime, defect in memory or perception, and past untruthfulness" (Lubet, 1992, p. 530; see also Mauet, 2000). Thus, if a person is shamed about his or her untruthfulness about past offenses, that person loses credibility and ability to resist othering in the courtroom. Whereas E. T. or C. B. might not be guilty in the sense usually assigned to adult sex offenders, the defense insisted in open court that they reflect upon their criminal records and admit that their sexual impulses were basically and consistently abnormal.

To engage further in such impeachment strategies in cross-examination, for example, the defense asked the MSOP medical staff to reveal in detail E. T.'s treatment notes. Here again in this medico-legal collaboration, medical experts became important supports for maintaining the constitutionality of the Minnesota state statutes governing commitment within MSOP. E. T.'s treatment notes recorded that, among other behaviors, he had "sexually acted out to get money and material things." Dr. Elizabeth Barbo, a clinical psychologist and Director of MSOP's Community Preparation Services (CPS), testified that even when E. T. was finally moved to CPS, the last stage before discharge, he was still "hostile and angry," engaging in rule breaking, and spending money "compulsively." Dr. Barbo also stated that E. T. declined family therapy and the polygraph, steps necessary to prove he was facing up to his offenses and was ready to be discharged. Therefore, the defense proposed in their closing arguments that E. T. "still deflects responsibility for his behaviors and past offenses" (Defendants' Closing Argument, pp. 129–130). To justify E. T.'s confined commitment, the defense depended on othering him through impeachment and shame, a form of self-blaming, by exposing how he might have been less than truthful about his past offenses and his present cooperation in MSOP treatment. Here again, Nussbaum's (2004) warning seems appropriate: "The shamed person feels a pervasive sense of inadequacy, and no clear steps suggest themselves to remove that inadequacy. The tendency may often be simply to retreat and shut down" (p. 209).

Resistance by Distinction

To resist these rhetorical strategies of othering—essentialization, division or marginalization from "normal" society, and shaming and impeachment—C. B. testified that he disagreed with the medical diagnosis that supported his civil commitment. That is, he felt he was different or distinct from other MSOP clients. Because he feared for his personal safety at MSOP, and he did not identify with what was "wrong" with all those other offenders, C. B. described his fighting with peers as a "safety thing" rather than a result of pathology. As a young person, he did not want to be vulnerable or a "target" among those "predatory peers," a fear also expressed by E. T. Moreover, C. B. described how his own sexual behavior was different from that of his MSOP peers. He witnessed, for example, MSOP clients masturbating while watching the television show *Toddlers and Tiaras* and concluded that such response "just feeds into their deviance" because there is "something seriously wrong with them," a problem that he did not share.

Resistance by Internal Change

Moreover, both E. T. and C. B. also asserted their distinction among othered sex offenders by claiming a fundamental character change from when they first offended. Now 27 years old, C. B. testified that he could "prove" that he was now "different from who he was before." Also, regardless of the details of the criminal history the defense raised, E. T. claimed, "That's who I was then, not who I am now." He was a different person, not someone who needed MSOP to control externally his abnormal desires but instead someone who could now make acceptable decisions. After his move into CPS, E. T. testified that he felt "most positive," "more normal," and "more happier." In essence, E. T.'s and C. B.'s resistance to othering rested primarily in their argument that they now were safe to function among the so-called normal community.

In a sense, in presenting this testimony of E. T. and C. B., the plaintiffs were refuting for E. T. and C. B. what Ahmed (2000) would call stranger fetishism, a form of othering, that "*invests the figure of the stranger with a life of its own insofar as it cuts 'the stranger' off from the histories of its determination*" (p. 5, emphasis in original). Once othered, it seems, moving into normal society could be exclusively the decision of the dominant group. However, according to Cindy Peternelj-Taylor (2004), "those who might be labelled other at any given point in time is not a constant factor but is continually

evolving" (p. 133; see also Göbbels, Ward, & Willis, 2012). In claiming change in their core identities and testifying that they could safely move into the boundaries of normal society, E. T. and C. B. resisted their othering through "refusing to be devalued" (Jensen, 2011, p. 66). In response to social alarm about sex offenders, the medico-legal collaboration creates a profile to fit the image of the abnormal and looks for key features in those marked as abnormal, making resistance to othering quite a challenge. Past behavior linked to a medical diagnosis and prognosis become part of that othering. But in his testimony in the *Karsjens* trial, former Executive Director of MSOP Dennis Benson said that the current method of handling these 67 juvenile-only offenders was "like swatting at a mosquito with a 15-pound mallet."

If any offender could develop the internal controls necessary to resist re-offense within society and to refuse to be devalued, it would be the juvenile-only offender. In particular, if the goal of civil commitment was to treat and possibly "cure" the sex offender, then the juvenile-only offender had the most potential to reach that goal. The uncertainty of medical experts such as Drs. Powers-Sawyer and Pascucci, however, represented a failure on the part of the medico-legal collaboration, in particular the medical experts, to develop a uniform strategy to determine the diagnosis and prognosis in regard to this offender. And so, given the potentially convincing appeal for discharge of these juvenile-only offenders, an appeal that would support unconstitutionality claims of how the state statutes were applied in MSOP, the defense went on to display the sex offender on the other end of the spectrum: the sex offender diagnosed with pedophilia.[11]

The Sex Offender Diagnosed With Pedophilia

The fear and disgust that sex offenders diagnosed with pedophilia evoke contribute greatly to the impetus to essentialize and marginalize all sex offenders. Ahmed (2000) describes this fear and disgust as the social insider recognizing the danger to the embodied innocence of the child, a child who "becomes a figure of vulnerability, the purified body that is most endangered by the contaminating desires of strangers" (p. 34).

[11] In Judge Frank's final decision and opinion in the *Karsjens* trial, he noted the Court's "growing concern" that MSOP was not treating juvenile-only offenders properly. In particular, he found that E. T. was "not an extreme outlier, but rather is representative" of what the Rule 706 experts warned was problematic in MSOP's handling of these juvenile-only offenders (p. 34, fn. 20).

Moreover, as Brown, Deakin, and Spencer (2008) remind us, "[T]here is a dominant narrative of the child sex offender which is deeply embedded and one that concludes that the sex offender is 'irredeemable'" (p. 271). Thus, marginalization of the pedophile depends not only on the urgency to protect the most vulnerable of victims but also on the belief that treatment cannot cure the pedophile, supporting any medico-legal notions about curtailing the recidivism of this offender except by indefinite confinement.

After reviewing the psychological work on defining and treating the pedophile after World War II, Elise Chenier (2012) concluded that, "Pedophilia, it seems, cannot be cured, yet we remain stubbornly committed to the notion that without treatment adults (principally men) who sexually desire people under a certain age cannot control their desire for sexual contact with children and youth and will repeatedly act upon it" (p. 174). This belief adheres to the pedophile and yet extends beyond this sex offender to many others. When interviewed by the Minneapolis *Star Tribune* newspaper, for example, Richard Williams, a civilly committed sex offender in MSOP with a diagnosis of SDP and SPP, rejected the idea of curing any sex offender as "someone with a disease"; instead, "sex crimes result from underlying feelings of rejection and resentment that can be 'managed,' but never cured" (quoted in Serres, 2016, February 22, n.p.). Internal, rather than or along with external, management became an essential claim for sex offenders in the *Karsjens* trial, but that claim was refuted in the 33 Minnesota civil commitment court opinions we reviewed regarding those diagnosed with pedophilia.

In *In re Civil Commitment of Lonergan* (2011), for example, one psychologist reported that the appellant's denial of the facts leading up to his diagnosis of pedophilia "would serve as a significant barrier to completion [of treatment] and future release" (p. 475). Thus, the treatment for a pedophile is often considered by the courts and the medical experts as "problematic" and possibly ineffective, given a "powerful attachment" to "deviant interests and an unwillingness to change" (*In re Kindschy*, 2001, p. 728). In these cases, the courts often noted that pedophiles, along with many other sex offenders, might deny not only their medical diagnoses but also their offenses, tending to blame their victims instead (see, for example, Schultz, 2005; *In re Civil Commitment of Jackson*, 2003; *In re Civil Commitment of Williams*, 2007; *In the Matter of the Civil Commitment of Travis*, 2009).

It might be unusual to label denial as a form of resistance because such denial is easily refuted by criminal history and medical diagnosis of this abnormality. The denial of these facts, however, became one of the only means that pedophiles had in possibly resisting their othering as a result of medico-legal collaboration. Thus, some of these offenders attempted to impeach the credibility of the defense's retelling of their criminal histories. Of course, such attempts failed, because, as Koerber (2013) concludes in her study of very different forms of resistance, they were limited by the grid of disciplinary power that determined pedophilia was abnormal and seldom, if ever, cured. Such a diagnosis determined that the problem was inherent, not the result of childhood sexual abuse as in the case of the juvenile-only offenders. The problem was not a result of opportunity, as in the case of the child-molester, because the pedophile actively sought young victims. Moreover, the social pressure placed on the legal-medico collaboration to protect the community from such feared predators would greatly limit any discussion of their discharge from MSOP.

Thus, given medico-legal discourse in regards to the pedophile, it should come as no surprise that the *Karsjens* trial addressed the question whether sex offenders diagnosed with pedophilia could be rehabilitated through treatment in MSOP. The answer to this question by both parties was cautious. The testimony of the pedophiles in the *Karsjens* trial tested medico-legal perceptions about treatment, possible cure, and prognosis or predictable risk. Specifically, the defense claimed that pedophiles needed long-term treatment and supervision, despite MSOP's limited success in treating such clients, whereas the plaintiffs argued that some pedophiles were confined long after they could have adjusted safely to living in the community or at least could be managed by a combination of external and internal controls. Moreover, whereas shame was a somewhat unsuccessful strategy used to impeach the juvenile-only offenders who testified, disgust seemed to stymie the pedophiles' resistance to othering.

Four sex offenders who were diagnosed specifically with pedophilia were called to testify in the *Karsjens* trial, two by the plaintiffs and two by the defendants. The first one of these offenders was called by the plaintiffs most likely to demonstrate that some pedophiles could be managed within the community, although the second of these witnesses failed to support this argument. If E. T. and C. B. served as the poster boys for juvenile-only offenders who did not belong in MSOP, D. S. represented one of those

offenders who could resist continued confinement in MSOP by accepting external control.[12]

Resistance by Accepting External Control

As called by the plaintiffs to support their argument that sex offenders civilly confined by MSOP could be safely provisionally discharged, D. S. testified that, through such drug regimens as Zoloft to control depression and "negative thinking," he could "put a real good hold on deviant sexual thoughts." Moreover, D. S. admitted in testimony, "You don't lose your attractions," but he had now "worked it all out up to my age group." During the time of the *Karsjens* trial, D. S. was interviewed by a local television station and confirmed this stance: "I know that I'll never do it again. I'll never want to do it again." MSOP just does not get it, said D. S: "You can't lock somebody up forever for what they might do in the future" (quoted in Volpe, 2015, January 29, n.p.). Both in this interview and his court testimony, D. S. claimed to find a way to recognize and manage his impulses with some reasonable help. When questioned by the defense as to whether

[12] When he took the stand in *Karsjens*, D. S. was 65 years old and had spent more than 23 years in MSOP. He admitted to molesting 31 boys between the ages of eight and 16 years of age, and he had agreed to enter MSOP after his last conviction because he believed that he would spend only three to four years in treatment there, as opposed to 12 years in prison. In terms of his offense cycle, D. S. said that he had been lonely and attracted young males to help him work on his home and boat.

B. F. was committed as a SPP and SDP in 2007. He had been sexually abused throughout his childhood. In February 1990, when B. F was 19 years old, he was convicted of assaulting a 13-year-old female stranger. A year later, B. F. was convicted of assaulting a 19-year-old female, and in March 1991 he provided an 11-year-old girl with alcohol and assaulted her. Later that month, B. F. violated his probation by giving alcohol to another minor, and he received a sentence of 36 months. Then in 1993, 22-year-old B. F. was convicted of second-degree criminal sexual conduct and sentenced to another 54 months. During this time, he participated in various sex offender programs but continued to violate the terms of his parole by having sexual conduct with minors.

At the time of the *Karsjens* trial, J. R. was 64 years old and had been committed to MSOP as a SDP and SPP in 2009. He had pled guilty to sexually assaulting ten children and was sentenced to 480 months in prison. He participated in a prison sex offender treatment program but was terminated upon discovery of a sexually explicit letter he sent an inmate in which he described how he had offended against more children. J. R. testified that because he "never had a proper sexual upbringing," and because he suffered from premature ejaculation in sexual encounters with adults, he turned to children to avoid rejection.

In 1984, P. L. pled guilty to second-degree criminal sexual conduct in connection with an incident involving the eight-year-old daughter of his sister-in-law. Then in 1992, he was similarly convicted of sexually assaulting another eight-year-old and served 268 months in prison. In anticipation of his release from prison, in 2006 P. L was civilly committed as a SPP and SDP.

he needed additional sex offender treatment, D. S. responded, "Not at Moose Lake," but "for the rest of his life." Therefore, in their closing arguments, even the defense repeated the MSOP Executive Clinical Director's testimony that D. S. was a "really good example of someone who has figured out a lot of things" and was ready to move into the next stage of treatment (Defendants' Closing Argument, p. 63; see also Janus & Brandt, 2015, n.p.).

D. S.'s testimony argued that treatment for offenders like him is best individualized—in his case continually managed by external controls such as drug therapy, as well as by newly developed internal controls. As Linda Grossman, Brian Martis, and Christopher Fichtner (1999) recognized, cognitive restricting or confronting and changing distorted beliefs can prevent such relapses; sex offenders could learn to avoid predictable relapse sequences and interrupt them (see also Kaplan, 2015). Sex offenders, including those diagnosed with pedophilia, could thus become what Tony Ward, Theresa Gannon, and Astrid Birgden (2007) called "purposive agents," or those for whom freedom was "constituted by internal and external components" (p. 211; see also Balmer & Sandland, 2012; Göbbels, Ward, & Willis, 2012). If "complete cure" was not possible, D. S. resisted continued othering by confirming his desire for intimate relationships within his own age group. Thus, D. S.'s testimony had the potential not only to support the plaintiffs' arguments but also to disrupt any medico-legal position that pedophiles were diagnosable but incurable.

Resistance by Reinterpreting Criminal History and Medical Diagnosis and Prognosis

D. S. was the exception to those MSOP clients who were challenged about their pedophilia during the *Karsjens* trial, however. Starting with the plaintiffs' next witness, B. F., the arguments designed to successfully resist othering by the legal-medico community deteriorated. In direct testimony and cross-examination, the other three clients in this subgroup of offenders denied their criminal histories, their medical diagnoses, their potential danger to society, the damage done to their victims, and the authority and professionalism of the MSOP staff.

Of course, denial is directly related to the social and personal cost of being identified, essentialized, and marginalized as a dangerous sex offender. As Jannine Hébert explained in her testimony for the defense in the *Karsjens* trial, it was "not uncommon" for such sex offenders to "minimize" because

"the cost of owning a sex offense is just too high." Medical researchers, however, disagree about the relationship between denial and successful treatment. On the one hand, William Marshall et al. (2001) found: "[T]here is no evidence available confirming the assumption that it is necessary to overcome denial in order for treatment to be engaged" (p. 206). On the other hand, Jill Levenson and Mark Macgowan (2004), after observing 61 male sex offenders in outpatient group therapy, confirmed their hypothesis that "denial is inversely related to treatment progress" (p. 50; see also Goffman, 1963; Kennedy & Grubin, 1992; Schultz, 2011). Given this uncertainty, it is worth noting the considerable burden on and challenges faced by medical practitioners working in such programs as MSOP and supporting legal civil commitment laws in hearings and trials.

Again, the theoretical perspectives of Nussbaum (2004) and Mona Lynch (2002) regarding the emotion of disgust are helpful in understanding further the propensity of pedophiles to question or attempt to revise their diagnoses and prognoses. RHM studies of the medico-legal grid of disciplinary power can call attention to the ways that emotions such as shame and disgust are operative. These offenders diagnosed with pedophilia minimize the effects on their victims, identify their victims as complicit in the sexual act, or claim victimization themselves by the medico-legal system that must identify, treat, and manage them. Again, if the child represents the most vulnerable and innocent within society, the pedophile seems to remain disgusting regardless of how he or she may resist the boundaries that separate the normal from the abnormal. Jannine Hébert may have praised D. S. for figuring out how to control his attraction to children, but when B. F. was next called to testify by the plaintiffs, the "evil" or "monstrous" image of the pedophile reemerged despite the plaintiffs' efforts to focus on the problems inherent in MSOP. B. F. resisted his initial and ongoing othering as a pedophile, the so-reviled subgroup of sex offenders, by first differently interpreting the incident that violated his supervised release from prison and brought him to MSOP, and then by linking his cure to a somewhat convoluted version of masculinity. Moreover, he was not able to control his outrage during cross-examination as the defense began to impeach his testimony.

B. F.'s testimony about his criminal history centered on his violation of his parole, which involved "inadvertent" contact with minors in 2004 at a gathering attended by some of his AA sponsors. He offered soft drinks to two minor girls sitting on the porch of his complex but did not assault them.

B.F. protested the charges issued against him and asserted that he did not meet the criteria for civil commitment. Moreover, he did not participate in treatment because, as he testified, "They can't teach me no more." During cross-examination, the defense challenged B. F. about the incident with the minor girls, by defining his actions as grooming, by reviewing his criminal history, and by reading from the treatment reports of B. F.'s therapists. These therapists noted that B.F. "lacked accountability" and "minimized very serious behavior" by continuing to "blame the victim." While crying and shouting at the state's attorney, B. F. resisted these characterizations by entreating that the defense "not talk down to him" and "take stuff out of context"; the defense, B. F. charged, was "going off of a kid" (his self-identity during earlier crimes) and should instead "look at the whole person."

In addition to resisting his othering by denial, B. F. attempted to redefine the identity of the sex offender to include a distinct definition of masculinity. As Steven Angelides (2005) observes, such redefining of masculinities is not unusual in the history of placing the pedophile outside of society: "The image of the predatory paedophile was . . . enlisted in the process of constructing subordinated or negated masculinities" (p. 295). Instead, B. F. declared that MSOP treatment demanded that he become a "girly man," "talking about his feelings more" instead of "stuffing his feelings." Treatment, according to B. F., diminished his masculinity, and therefore he was no longer dangerous to children or society. The legal-medical collaboration was incapable, claimed B. F., of understanding his actions and treating him without changing his gender identity.

Resistance by Blaming the System or the Victim

The next two sex offenders diagnosed with pedophilia attempted to resist the medico-legal diagnoses and prognoses about them by further redefining pedophilia, including the motivation for it. J. R. identified uncontrollable forces, rather than personal responsibility, as leading to his sexual offenses with children. J. R. described abusing children as "the thrill of being a burglar," "excitement of breaking into something," and then "getting away with it." In turn, when the defense challenged P. L., the next offender to testify, with evidence that this treatment team considered him "dangerous," "untreatable," and with "no remorse." P. L. claimed, "I am not a pedophile," and specifically he was "not attracted to children" but instead to "innocence, which unfortunately comes with children." Moreover, P. L.

testified that instead of engaging in pedophilia, he had lived a "criminal lifestyle" and abused such substances as heroin and methamphetamines. He claimed that sex offenders were not criminals; criminals considered their crimes as "business" and had an "impersonal attitude" toward their acts and victims. Instead, sex offenders were like murderers in that their crimes were "very personal," less frequent, and therefore presented less danger to society. P. L. claimed that he fell in the former category, a long-term criminal, and therefore had no place in MSOP.

Thus, on the one hand, in calling these offenders diagnosed with pedophilia to testify, the impeachment strategies of the defense seemed designed to confirm the need for MSOP treatment and relied on the fear and the disgust that a pedophile generally provoked. On the other hand, these offenders might blame their victims and interpret their actions as innocent and not criminal. To them, the categorization and therefore marginalization of sex offender, let alone the diagnosis of pedophilia, was flawed. Such othering, claimed these sex offenders, disregarded them as "whole" men, who perhaps were attracted to innocence or were combating loneliness, but instead were stigmatized solely on misinterpretations of their criminal histories and their medical diagnoses. P. L., however, was the only such offender who was considered successfully treated and safe to discharge with supervision from MSOP, but as yet, he remains in MSOP.

Medico-Legal Collaboration: Conclusion

We have sought with this study to contribute to understandings of medico-legal collaboration and discourse, as well as to RHM scholarship, in particular through research about othering and the sex offender. We have also sought to illuminate some of the rhetorical strategies used not only to other the offender but also to resist that othering or attempt to do so. Thus, we placed our *Karsjens* trial observations within the context of those 33 civil commitment cases within Minnesota. We found in the commitment cases that the legal definitions of SDP and SPP depended on criminal history but also medical diagnosis and prognosis. Moreover, we found in the *Karsjens* trial that the rhetorical strategies used to other the sex offender considered too dangerous to release into society included essentializing, dividing, shaming, and impeaching.

Through our examination of the *Karsjens* trial, we discovered that rhetorical strategies used by MSOP clients to resist othering seemed most

convincing when arguing for personal change, perhaps the result of treatment in the program; when distinguishing within the othered group, perhaps the result of resisting treatment uniformity rather than individualization within the program; and when recognizing strategies for internal control over unacceptable impulses, especially when accepting that some external control was necessary even after discharge. Largely because of their criminal and personal histories and their low recidivism rate, the juvenile-only offenders seemed more persuasive in the courtroom. Certainly Judge Frank and even the defense acknowledged that E. T. needed particular attention to move him to discharge.

During our trial observations, we also sensed that the least persuasive rhetorical strategies to resist othering were exemplified by some of the sex offenders diagnosed with pedophilia. Such a label, of course, would be devastating to most offenders, who might attempt to revise their criminal histories, to reject their diagnoses and the prognoses that might seem to preclude any cure and resulting discharge, and instead to blame their victims or the unfair medico-legal systems that committed them to MSOP. Two such offenders, for instance, created controversial definitions of masculinity and criminal behavior to reject the label of pedophile.

We relate these observations to Koerber's (2013) conclusion about resistance and agency: "[W]e should not understand rhetorical agency as simply a two-way struggle between the individual and the ideological force of institutions" (p. 107). Certainly the medico-legal collaboration in regard to managing and treating sex offenders complicates and limits the agency that those offenders can achieve. We did find that the resistance strategies of E. T. and C. B. and to some extent D. S. granted them what seemed an effective voice in the *Karsjens* trial—as they claimed their ability to control the impulses that once led them to offend, accepted continuing external management even after discharge, and pointed to how personal growth now distinguished them from those in the othered group. The offenders who denied their criminal histories and medical diagnoses and blamed their victims and the system were viewed as less credible. However, the institutions and disciplines that initially other still determine the parameters of resistance, parameters that require the individual to speak the language and reflect the values of those in power.

We add this new knowledge to the work of RHM scholars such as Malkowski (2014), who suggests, for instance, that to understand counterpublics that pose ideological threats or abnormalities, one must practice

rhetorical listening or a "stance of openness," broaden our views of how public health and individual action "mutually inform each other," and "instigate deeper discussion and insight" about current circumstances (pp. 222–224). Rhetorical listening, of course, must include listening to the offenders' victims and their perspectives on these civil commitment practices. As we mentioned before, debates about civil commitment tend to focus on public safety, but the accounts of the physical, psychological, and even financial losses of these individual victims of sexual assault must inform any decisions about how to manage and treat sex offenders. We hope that our study of the medico-legal collaboration to civilly confine sex offenders, with a specific look at the problematic circumstances surrounding Minnesota statutes and the application of these statutes by MSOP will add to such scholarship.

Moreover, our study also illuminates some unanticipated areas for consideration; that is, we believe our study reveals some potential inequality within the power structure of medico-legal collaboration. We think it bears noting that medical practitioners seem to face an additional challenge in predicting risk for recidivism, particularly when the forensic tools upon which they depend might not be specifically designed for the MSOP setting or offender. Moreover, the interpretation given to the criteria for discharge from the program, as clarified in *Call v. Gomez* (1995), is that a MSOP client would be discharged from civil commitment when the original reason for commitment no longer exists. The state statutory criteria and the practices of MSOP, however, continue to demand a forensic risk assessment to support discharge as well as agreement by therapeutic teams. In our observations and analysis, we found that practitioners disagreed about the results of such assessment. Again, Dr. Powers-Sawyer and Dr. Pascucci took different stances on the potential discharge of E. T. Of course, Dr. Pascucci appeared for the defense, and Dr. Powers-Sawyer for the plaintiffs, but still their stances seemed affected by the different assessment procedures they used. Moreover, researchers have not settled on whether such offenders as those diagnosed with pedophilia can be cured and whether denial of diagnosis and criminal history can affect or be addressed in treatment. Thus, again we appreciate and share with our RHM readers in particular Corey Rayburn Yung's warning (2013) that medico-legal collaboration in the case of civil commitment of sex offenders may fail from both perspectives.

Finally, we endorse Ahmed's (2000) suggestion that othering may be based on inflexibility toward others: "Encounters between embodied

subjects always hesitate between the domain of the particular—the face to face of this encounter—and the general—the framing of the encounter by broader relationships of power and antagonism" (p. 8). Elaine Scarry (2002) argues that "The human capacity to injure other people is very great precisely because our capacity to imagine other people is very small" (p. 103). Even though these MSOP clients were selected to testify because they were thought to represent or resist the othering of the sex offender, and because they were viewed as supporting or refuting the necessity of civil commitment, in some cases their individual stories may potentially challenge the reasons for their marginalization and the medico-legal collaboration that sustains that framework.

Appendix A: Materials Analyzed

Listed chronologically below are the 33 Minnesota opinions on civil commitment that we reviewed for this study (all except those marked with an asterisk are available through Google Scholar) and court documents from *Karsjens v. Jesson*. We often allude to particular Minnesota opinions that repeat or reflect the medico-legal discourse we are discussing in the body of this article.

In re Blodgett, 510 N.W.2d 910 (Minn. 1994).
In re Linehan (*Linehan I),* 518 N.W.2d 609 (Minn. 1994).
Call v. Gomez, 535 N. W.2d (Minn. 1995).
In re Linehan (*Linehan II*), 544 N.W.2d 308 (Minn. 1996).
In re Linehan (*Linehan III*), 594 N.W.2d 867 (Minn. 1999).
In re Robb, 622 N.W.2d 564 (Minn. Ct. App. 2001).
In re Kindschy, 634 N.W.2d 723 (Minn. Ct. App. 2001).
In re Civil Commitment of Ramey, 648 N.W.2d 260 (Minn. Ct. App. 2002).
In re Martinelli, 649 N.W.2d 886 (Minn. Ct. App. 2002).
In re Civil Commitment of Jackson, 658 N.W.2d 219 (Minn. Ct. App. 2003).
In re Civil Commitment of Martin, 661 N.W.2d 632 (Minn. Ct. App. 2003).
In re Civil Commitment of Stone, 711 N.W.2d 831 (Minn. Ct. App. 2006).
In re Civil Commitment of Williams, 735 N.W. 2d 727 (Minn. Ct. App 2007).

In re Civil Commitment of Giem, 742 N.W. 2d 422 (Minn. 2007).
In re Civil Commitment of Rick, No. A06-1612 (Minn. Ct. App. Feb. 6, 2007).*
In re Civil Commitment of Bolte, No. A07-1413 (Minn. Ct. App. Jan. 29, 2008).
In re Civil Commitment of Travis, 767 N.W.2d 52 (Minn. Ct. App. 2009).
In re Civil Commitment of Johnson, 800 N.W.2d 134 (Minn. 2011).
In re Civil Commitment of Lonergan, 792 N.W.2d 473 (Minn. Ct. App. 2011).
Beaulieu v. Minnesota Dep't of Human Services, 798 N.W.2d 542 (Minn. Ct. App. 2011).
In re Civil Commitment of Navratil, 799 N.W.2d 643 (Minn. Ct. App. 2011).
Braylock v. Jesson, 819 N.W.2d 585 (Minn. 2012).
In re Civil Commitment of Crosby, 824 N.W.2d 351 (Minn. Ct. App. 2013).
Coker v. Jesson, 831 N.W.2d 483 (Minn. 2013).
In re Civil Commitment of Moen, 837 N.W.2d 40 (Minn. Ct. App. 2013).
In re Civil Commitment of Ince, 847 N.W.2d 13 (Minn. 2014).
Larson v. Jesson, 847 N.W.2d 531 (Minn. Ct. App. 2014).
In re Civil Commitment of Spicer, 853 N.W.2d 803 (Minn. Ct. App. 2014).
Foster v. Jesson, 857 N.W.2d 545 (Minn. Ct. App. 2014). See also, *In the Matter of the Civil Commitment of Bradley Wayne Foster*, No. A07-1564 (Minn. Ct. App. Jan. 15, 2008).
In re Civil Commitment of Thomas, No. A15-1092 (Minn. Ct. App. July 27, 2015).
In re Civil Commitment of Hand, 878 N.W.2d 503 (Minn. Ct. App. 2016).
In re Civil Commitment of Lonergan, No. A15-1866 (Minn. Ct. App. May 16, 2016).*
In re Civil Commitment of Daywitt, No. A15-1569 (Minn. Ct. App. May 23, 2016).

Some of the materials relating to *Karsjens v. Jesson,* Civil No. 11-3659 (D. Minn.), that we analyzed:

Rule 706 Expert Report and Recommendations, *Karsjens v. Jesson,* Civil No. 11-3659 (D. Minn. Nov. 17, 2014), ECF No. 658.* Retrieved

at http://stmedia.startribune.com/documents/Expert+panel+report+on+sex+offender+program.pdf

Plaintiffs' Proposed Findings of Fact, *Karsjens v. Jesson,* Civil No. 11-3659 (D. Minn. March 27, 2015), ECF No. 914.*

Defendants' Closing Argument, *Karsjens v. Jesson,* Civil No. 11-3659 (D. Minn. April 10, 2015), ECF No. 930.*

Karsjens v. Jesson, 109 F. Supp. 3d 1139 (D. Minn. 2015). (Judge Frank's findings of fact, conclusions of law, and order).

Karsjens v. Piper (formerly *Jesson*), No. 15-3485 (8th Cir. Jan. 3, 2017).

Karsjens v. Piper (formerly *Jesson)*, "Petition for Writ of Certiorari to the Supreme Court of the United States" (2017).*

Appendix B: Categories and Subcategories Identified in Civil Commitment Court Opinions

Precedent set in *In re Blodgett*

- § 526.09 through 10 Minnesota Psychopathic Personality Commitment, 1992
- Five psychologists testify
- Definition of antisocial personality disorder

Common Diagnoses

- Psychopathic personality commitment
- Antisocial personality disorder
- Sexually dangerous person (SDP)
- Sexual psychopathic personality (SPP)
- Chemical/alcohol dependency
- Paraphilia
- Pedophilia

Treatment/cure

- Possibility of cure
- Right to treatment
- Adequacy of treatment

Prognosis

- Forensic risk assessment
- Statistics on recidivism
- Habitual course of harmful sexual behaviors
- Age of victims
- Frequency of sexual assault crimes

Commitment criteria
- Inability to control sexual impulses
- Past harmful sexual conduct
- Public safety

Standard of proof
- Commitment: Burden on state—clear and convincing evidence
- Discharge: Burden on sex offender
  - Evidence from polygraph and risk assessment
  - Clinical and therapeutic progress
  - Need for security and continued institutionalization

Discharge criteria
- Likely to reoffend
- Refined in *Call v. Gomez*—no longer had to prove "capable of making an acceptable adjustment to open society"

Appendix C: Categories and Subcategories Identified in *Karsjens* Testimony

Major legal challenges to and defenses of MSOP
- "How come nobody gets out?"—Common refrain of plaintiffs
  - Recidivism statistics on juvenile-only offenders and adults
  - Recidivism statistics on provisionally discharged sex offenders
- Fourteenth Amendment constitutional challenges raised by plaintiffs
  - Right to be free from inhuman treatment in violation of Fourteenth Amendment
  - Right to less restrictive alternative confinement
  - Right to be free from deprivation of "life, liberty, or property without due process of law"
- Fourteenth Amendment clarifications raised by defendants
  - No right to annual independent forensic risk assessments
  - No right to treatment
- Standards of proof argued as appropriate by parties
  - Strict scrutiny (must meet compelling government interest; be narrowly tailored to achieve that interest; use the least restrictive means to achieve that interest)—promoted by plaintiffs

    - Shocks the conscience ("egregious and malicious" action by governmental agents, usually with deliberate indifference or negligence)—promoted by defendants

Major medical challenges to and defenses of MSOP

- Diagnosis of sex offender by medical expert in commitment stage
- Administration of forensic risk assessment tools to support prognosis (e. g. Stable-2007 plus Static-99R)
- Review of petition for discharge from MSOP
    - Use of polygraph and penile plethysmograph
    - Assessment of progress in treatment phases
    - Use of recommendation from therapists
- MSOP treatment phases
    - Phase 1—rule compliance and treatment "readiness"
    - Phase 2—sex offender treatment though group therapy and individual counseling with a psychologist
    - Phase 3—continued therapy but with fewer living restrictions and more privileges and development of internal controls

Political climate

- Influence of Dru Sjodin murder
- Influence of Dennis Linehan's criminal history
- Influence on low discharge rate by Governor Pawlenty

Public perception and response

- Public and media scrutiny of discharged offenders
- Testimony of victims against discharge
- Fear of recidivism—"public outcry"
- Resistance to sex offender placement in community
- Need for public education
- Need to maintain public safety

Othering the sex offender

- Typifying the class
- Essentializing, dividing, shaming, and impeaching

Resisting civil commitment

- Rejecting medical diagnoses and prognoses
- Blaming unfair system
- Blaming victim
- Presenting evidence of character change
- Distinguishing between self and rest of othered group

- Claiming internal control
- Accepting continued external control

Juvenile-only sex offenders

- Low recidivism rate
- Only offenses committed while juveniles
- Few or questionable risk assessment tools

Sex offenders diagnosed with pedophilia

- Considered incurable
- Redefining criminal history
- Reject diagnosis and prognosis

Role of medical expertise

- Disagreement among practitioners
- Pressured to support legal criteria and goals

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References

Ahmed, Sara. (2000). *Strange encounters: Embodied others in post-coloniality*. London: Routledge.

American Psychiatric Association. (2000, June). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, D.C.: Author.

Angelides, Steven. (2005). The emergence of the paedophile in the late twentieth century. *Australian Historical Studies, 36*, 272–295.

Association for the Treatment of Sexual Abusers (ATSA). (2010, August 17). *Civil commitment of sexually violent predators*. Beaverton, OR: Author.

Bandes, Susan A. (1999). Introduction. In Susan A. Bandes (Ed.), *The passions of law* (pp. 1–15). New York: New York University Press.

Bierschbach, Briana, & Mannix, Andy. (2015, August 7). How one case—and geography—dramatically affected commitments to the Minnesota Sex Offender Program. *MinnPost.Com: Politics & Policy.* Retrieved from https://www.minnpost.com/politics-policy/2015/08/how-one-case-and-geography-dramatically-affected-commitments-minnesota-sex-o

Brandt, Jon, & Prescott, David S. (2015, February 1). The Minnesota Sex Offender Program: Federal intervention Part 1—The challenges. *SAJRT.blogspot*. Retrieved from https://sajrt.blogspot.com/2015/02/the-minnesota-sex-offender-program.html

Brandt, Jon, & Prescott, David S. (2015, February 7). The Minnesota sex offender program: Federal intervention part 2—The 706 expert report. *SAJRT .blogspot.* Retrieved from https://sajrt.blogspot.com/2015/02/the-minnesota-sex-offender-program_7.html

Brandt, Jon, & Prescott, David S. (2015, June 21). The Minnesota sex offender program: Federal intervention part 3—The ruling. *SAJRT.blogspot.* Retrieved from https://sajrt.blogspot.com/2015/06/the-minnesota-sex-offender-program.html

Brown, Steven, Deakin, Jo, & Spencer, Jon. (2008). What people think about the management of sex offenders in the community. *Howard Journal*, *47*, 259–274.

Butler, Judith. (1990). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge.

Chenier, Elise. (2012). The natural order of disorder: Pedophilia, stranger danger and the normalising family. *Sexuality & Culture, 16*, 172–186.

Cipolla, Cyd. (2011). "Preventative corrections": Psychiatric representation and the classification of sexually violent predators. *Journal of Medical Humanities*, *32*, 103–113.

Cohen, Stanley S. (1980). *On the concept of moral panic, crime, media, culture*. New York: St. Martin's Press.

D'Orazio, Deirdre, Arkowitz, Steven, Adams, Jay, & Maram, Wesley. (2009, January). *The California sexually violent predator statute: History, description & areas for improvement*. Santa Monica, CA: California Coalition on Sexual Offending.

Douard, John. (2008–2009). Sex offender as scapegoat: The monstrous other within. *New York Law School Law Review, 53*, 31–52.

Federal Rules of Evidence Rule 607. (2011). Who may impeach a witness. Retrieved from https://www.law.cornell.edu/rules/fre/rule_607

Federal Rules of Evidence Rule 706. (2011). Court-appointed expert witnesses. Retrieved from https://www.law.cornell.edu/rules/fre/rule_706

Fritz, Mike, Brandham, William, & Oldham, Abbey. (2016, June 28). Inside Minnesota's sex offender facility, where no one has even been released. *PBS Newshour: Nation, Broken Justice*. Retrieved from https://www.pbs.org/newshour/nation/inside-minnesotas-sex-offender-facility-where-no-one-has-ever-been-released

Goffman, Erving. (1963, 1986). *Stigma: Notes on the management of spoiled identity*. New York: Touchstone/Simon & Schuster.

Göbbels, Svenja, Ward, Tony, & Willis, Gwenda M. (2012). An integrative theory of desistance from sex offending. *Aggression and Violent Behavior, 17,* 453–462.

Gouge, Catherine C. (2018). "No single path": Desire lines and divergent pathographies in health and medicine. In Lisa Meloncon and J. Blake Scott (Eds.), *Methodologies for the rhetoric of health and medicine* (pp. 115–137). New York: Routledge.

Grossman, Linda S., Martis, Brian, & Fichtner, Christopher. (1999). Are sex offenders treatable? A research overview. *Psychiatric Services, 50*, 349–361.

Hanson, R. Karl, Gordon, Arthur, Harris, Andrew J. R., Marques, Janice K., Murphy, William, Quinsey, Vernon L., & Seto, Michael C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14,* 169–194.

Harris, Andrew J., & Socia, Kelly M. (2016). What's in a name? Evaluating the effects of the "sex offender" label in public opinions and beliefs. *Sexual Abuse: A Journal of Research and Treatment, 28,* 660–678.

Ingebretsen, Edward J. (2001). *At stake: Monsters and the rhetoric of fear in public culture*. Chicago: University of Chicago Press.

Janus, Eric. (2006). *Failure to protect: America's sexual predator laws and the rise of the preventive state*. Ithaca, NY: Cornell University Press.

Janus, Eric S., & Brandt, Jon. (2015, July 2). *Karsjens v. Jesson*: Challenging the uncivil commitment of civil rights. *American Bar Association*. Retrieved from http://apps.americanbar.org/litigation/committees/access/articles/summer2015-0715-karsjens-v-jesson-challenging-un-civil-commitment-civil-rights.html

Jenkins, Phillip. (1998). *Moral panic: Changing concepts of the child molester in modern America*. New Haven, CT: Yale University Press.

Jensen, Sune Qvotrup. (2011). Othering, identity formation and agency. *Qualitative Studies, 2*, 63–78.

Johnson, Joy L., Bottoree, Joan L., Browne, Annette J., Grewal, Sukhdea, Hilton, B. Ann, & Clarke, Heather. (2004.) Othering and being othered in the context of health care services. *Health Communication, 16*, 255–271.

Kansas v. Hendricks, 521 U.S. 346 (1997).

Kaplan, Margo. (2015). Taking pedophilia seriously. *Washington and Lee Law Review, 72*, 75–170.

Kennedy, H. G., & Grubin, D. H. (1992). Patterns of denial in sex offenders. *Psychological Medicine, 22*, 191–196.

Koerber, Amy. (2013). *Breast or bottle? Contemporary controversies in infant-feeding policy and practice.* Columbia: University of South Carolina Press.

Kristeva, Julia. (1982). *Powers of horror: An essay on abjection.* (Leon S. Roudiez, Trans.). New York: Columbia University Press.

Krumer-Nevo, Michal. (2002). The arena of Othering: A narrative study with women living in poverty and social marginality. *Qualitative Social Work, 1,* 303–318.

Lacombe, Dany. (2008). Consumed with sex: The treatment of sex offenders in risk society. *British Journal of Criminology, 48*, 55–74.

Levenson, Jill S., & Macgowan, Mark J. (2004). Engagement, denial, and treatment progress among sex offenders in group therapy. *Sex Abuse: A Journal of Research and Treatment, 16,* 49–63.

Los Angeles County District Attorney's Office. (2016). Sexually violent predators. Retrieved from http://da.co.la.ca.us/sexually-violent-predators

Lubet, Steven. (1992). Understanding impeachment. *American Journal of Trial Advocacy, 15,* 483–540.

Lynch, Mona. (2002). Pedophiles and cyber-predators as contaminating forces: The language of disgust, pollution, and boundary invasions in federal debates on sex offender legislation. *Law and Social Inquiry, 27,* 529–566.

Malkowski, Jennifer. (2014). Beyond prevention: Containment rhetoric in the case of bug chasing. *Journal of Medical Humanities*, *35*, 211–228.

Marshall, William L., Thornton, David, Marshall, Liam E., Fernandez, Yalanda M, & Mann, Ruth. (2001). Treatment of sexual offenders who are in categorical denial: A pilot project. *Sexual Abuse: A Journal of Research and Treatment, 13*, 205–215.

Mauet, Thomas A. (2000). *Trial techniques* (5th ed.). Gaithersburg, NH: Aspen Publishing.

McEnroe, Paul. (2001, April 17). Sex-offender system casts wide net. *StarTribune*. Retrieved from http://www.startribune.com/sex-offender-system-casts-wide-net/120031999/

Morris, Deborah L. (1997). Constitutional implications of the involuntary commitment of sexually violent predators—A due process analysis. *Cornell Law Review, 82*, 594–643.

Nussbaum, Martha. (2004). *Hiding from humanity: Disgust, shame, and the law*. Princeton, NJ: Princeton University Press.

Oakes, Larry. (2008, June 9). They're all close calls now. *StarTribune*. Retrieved from http://www.startribune.com/local/19645554.html?page=1&c=y&refer=y

Peternelj-Taylor, Cindy. (2004). An exploration of othering in forensic psychiatric and correctional nursing. *Canadian Journal of Nursing Research, 3,* 130–146.

Prentky, Robert, Janus, Eric S., Barbaree, Howard, & Kafka, Martin. (2006). Sexually violent predators in the courtroom: Science on trial. *Psychology, Public Policy, and Law, 12*, 357–393.

Propen, Amy D., & Schuster, Mary L. (2017). *Rhetoric and communication perspectives on domestic violence and sexual assault: Violence and sexual assault*. New York: Routledge.

Quinsey, Vernon L., Harris, Grant T., Rice, Marnie E., & Lalumière, Martin L. (1993). Assessing treatment efficacy in outcome studies of sex offenders. *Journal of Interpersonal Violence, 8*, 512–523.

Sarat, Austin, & Kearns, Thomas R. (2000). The cultural lives of law. In Austin Sarat and Thomas R. Kearns (Eds.), *Law in the domains of culture* (pp. 1–20). Ann Arbor: University of Michigan Press.

Scarry, Elaine. (2002). The difficulty in imaging other people. In Martha C. Nussbaum (Ed.), *For love of country?* (pp. 98–110). Boston: Beacon Press.

Schultz, Pamela D. (2005). *Not monsters: Analyzing the stories of child molesters*. Lanham, MD: Rowman & Littlefield.

Schultz, Pamela D. (2011). A rhetoric of retribution and redemption: Burke's terms for order in the drama of child sexual abuse. *International Journal of Law and Psychiatry, 34*, 168–176.

Schuster, Mary L., & Propen, Amy D. (2015). Expanding our understanding of *kairos*: Tracing moral panic and risk perception in the debate over the Minnesota Sex Offender Program. *Journal of Technical Writing and Communication*, *45*, 3–30.

Serres, Chris. (2016, February 22). As MSOP door opens, a sex offender ponders freedom. *StarTribune*. Retrieved from http://www.startribune.com/as-door-inches-open-from-msop-a-sex-offender-ponders-being-free/369509232/

Sex offender decision shouldn't end reform [Editorial]. (2017, October 9). *Star Tribune*, p. A10.

Smith, Michelle. (2010). Containment rhetoric and the public sphere: Imagining Amana, inscribing America. *Rhetoric Society Quarterly*, *40*, 128–145.

Sobo, Elisa J., & Loustaunau, Martha O. (2010). *The cultural context of health, illness, and medicine.* Santa Barbara, CA: Praeger.

Spencer, Dale. (2009). Sex offender as Homo Sacer. *Punishment & Society, 11*, 219–240.

Stable-2007 Assessment. (2015). *Sex offender risk assessment framework.* Retrieved from http://soraf.cyzap.net/zap_site/docs/zaps-mr-tab1-85.htm?Stable-2007%26copy%3B-Assessment

Static-99/Static-99R. Overview. Static-99 Clearing House. (2015). Static-99/Static-99R. Retrieved from http://www.static99.org/

Tewksbury, Richard. (2012). Stigmatization of sex offenders. *Deviant Behavior, 33*, 606–623.

Van Orden v. Schafter, 129 F. Supp. 3d 839 (E.D. Mo. 2015).

Volpe, Trisha. (2015, January 29). Minnesota sex offenders prepare for civil commitment court battle. KARE11 News.

Ward, Tony, Gannon, Theresa A., & Birghen, Astrid. (2007). Human rights and the treatment of sex offenders. *Sex Abuse, 19*, 195–216.

Washington State Legislature. (2001). Findings. Revised Code of Washington § 71.09.010.

World Health Organization. (2003). *Guidelines for medico-legal care for victims of sexual violence.* Geneva, CH: Author. Retrieved from http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/

Wisconsin sexually violent person commitments law. (2017). Wis. Stat. Chapter 980.

Yung, Corey Rayburn. (2013). Civil commitment of sex offenders. *AMA Journal of Ethics: Virtual Mentor, 15*, 873–877.