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Sex Offender Treatment

Recent meta-analyses of sex offender treatment studies have concluded that modern treatment of sex offenders lowers recidivism rates (Kersting 2003). Research on sex offender treatment has reached a point where there is broad academic consensus about the value of sex offender treatment, but several issues hamper highly effective sex offender treatment programs in all states, issues such as disagreement about the best method of treatment, how to classify offenders, lack of specific programming for each level of offender and the high cost of treatment.

Major Studies

A number of meta-analyses have shown that, aggregate, sex offender treatment lowers recidivism rates by about 10%. The U.S. Department of Justice found that when all major studies were reviewed sex offender treatment reduces recidivism from 30% to about 20% (U.S. Department of Justice n/d). The prominent researcher M.A. Alexander concluded that individuals who receive treatment have consistently lower recidivism rates than untreated offenders from her analyses of 74 studies in 1994. In 1999 Alexander analyzed 79 treatment outcome studies, which included close to 11,000 sex offenders. The study concluded that offenders who participated in relapse prevention treatment programs had a re-arrest rate of 7.2%, untreated offenders had a re-arrest rate of 17.6% (U.S. Department of Justice n/d). Gordon Hall of Kent State University conducted a meta analysis of twelve studies since 1989, of males that completed sex offender treatment 19% recidivated, and 27% of untreated males recidivated (U.S. Department of Justice n/d). The *Burlington Free Press* cited two Vermont studies that indicated that offenders who complete treatment are significantly less likely to commit a new sex crime, than untreated offenders (Hallenbeck 2006). It is significant that the academic literature supports treatment as opposed to incarceration; however, there is little agreement on the types of sex offender treatment that are best.

Treatment Schedules

Treatment can occur in a variety of settings and at various stages in the criminal justice system. Some states combine a probation sentence and community based outpatient treatment which may preclude confinement of the sex offender. The offender is supervised by corrections personnel during the mandated treatment and if the offender fails to make satisfactory progress, or is not adhering to the treatment plan, the case may be returned to court, reviewed by the Judge and a

prison sentence imposed. Thus, treatment is offered to the offender and if sufficient progress is not attained, incarceration remains an option. In some states, treatment programs are offered to prison inmates. Following the prison term, a correctional officer supervises and monitors the individual in the community. This post-prison monitoring is an important part of the total treatment program (Association for the Treatment of Sexual Abusers 2006).

Levels of Treatment

Offenders are treated differently according to the ‘level’ that they are ascribed. Level is determined by: types of crimes committed, legal status and case disposition, attitude toward treatment, and the accessibility of different types of treatment programs (Barnes 1994). *The Burlington Free Press* reported that in Vermont there are four tests used to predict the risk of re-offending which indicate the level in which an offender will be placed (Hallenbeck 2006).

The different level on which sex offenders are treated is based on the types of crimes committed, legal status and case disposition, amenability to treatment, and availability of treatment programs for sex offenders (Barnes 1994)

Types of Treatment

The Pennsylvania Department of Corrections sums up the lack of agreement on sex offender treatment programs:

“Research on the most effective methods of treatment for sex offenders is still in the very early stages of development... Even cognitive behavioral approaches, which have been widely supported as effective in the general rehabilitation literature, have produced mixed evaluation findings among groups of sex offenders (Gallagher, et al., 1999). While no evidence currently exists to definitively favor one treatment approach over another for sex offenders, several emerging principles should be considered when treating sex offenders.”

The Pennsylvania department of Corrections stipulates that while there is considerable disagreement on the specific type of sex offender treatment, there are four basic tenets of sex offender treatment that are generally agreed upon. The first principle is that research clearly indicates that sex offenders are a very diverse group and must be treated individually because their individual characteristics have important implications for treatment. The second principle is that the need for careful assessment of level of offender is crucial, so that higher risk and low risk offenders are not in the same program. The third principle requires that sex offender treatment be long term, with follow up treatment for long after the offender has been released from state custody because some sex offenders can never be cured. The fourth principle is that sex offenders must complete treatment, because offenders who drop out of treatment are more likely to recidivate than those who complete treatment and those who have no treatment at all (Association for the Treatment of Sexual Abusers 2004).

The Center for Sex Offender Management (Association for the Treatment of Sexual Abusers n/d) reported that in the United States and Canada the majority of programs in place use “...a combination of cognitive-behavioral treatment and relapse prevention (designed to help sex

offenders maintain behavioral changes by anticipating and coping with the problem of relapse).” In addition, the CSOM adds that

“Offense specific treatment modalities generally involve group and/or individual therapy focused on victimization awareness and empathy training, cognitive restructuring, learning about the sexual abuse cycle, relapse prevention planning, anger management and assertiveness training, social and interpersonal skills development, and changing deviant sexual arousal patterns.”

Some research has shown that “**cognitive behavior**” treatment approaches are the most promising. Proponents of this approach view sex offending as a result of a multitude of factors, including socioeconomic, cognitive, behavioral and emotional variables. The Cognitive Behavioral approach responds to this with multidimensional treatment (Barnes, 1994).

Relapse Prevention treatment is used to combat many different addictive behaviors, and its method varies for each. It is designed to control impulses in all situations (Barnes, 1994).

Psychotherapy was the first treatment used for sex offenders. Psychotherapy involves introspection by the sex offender to control undesirable behavior. Treatment models include: individual and group counseling, family therapy, milieu therapy, victim empathy, female identification, accountability, sexual education, reality therapy, psycho-drama, victim confrontation, value clarification and cognitive therapy. Evaluating the results of psychotherapy is complicated and there are no common standards of measurement (Barnes, 1994)

Behavior modification treatment applies learning theory in an attempt to extinguish undesirable behavior and replace it with socially approved responses through classical conditioning. Examples of behavior modification include: assertiveness training, aversive conditioning, biofeedback (plethysmography -instrument for measuring penile tumescence), coverts sensitization, masturbating satiation, modeling-roleplay, orgasmic reconditioning, relapse prevention, relaxation/anger management, social skills acquisition, systemic desensitization, thinking errors and thought stopping (Barnes, 1994).

Medical and Biological: The organic treatments tend to be the most controversial. These treatments manipulate hormone levels in order to alter the offender's libido. Examples of such treatment include selective inhibition of pituitary-gonadal with a long-acting agonist analogue of gonadotropin-releasing hormone which effectively reduces testosterone levels. Not all abusers are the same and anti-androgen therapy is not appropriate for use with all sexual abusers (Executive Board..., 2006). European studies have shown that castration significantly reduces recidivism. New interest in the procedure is also arising in the United States.

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