

Evidence of the effectiveness of current treatments for sex offenders

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The degree to which any sexual behaviour is considered deviant depends on the ever-changing standards of society.² What is considered sexually deviant and worthy of treatment is typically guided by the Diagnostic and Statistical Manual of Mental Disorders.³

Incarceration, or any other penalty the criminal justice system can impose, has proven to be a largely ineffective deterrent and incapable of changing sex offenders' behaviour.⁴ What has been found to be effective, in concert with the role played by the criminal justice system, is treatment.

The cost of treatment

A cost-benefit analysis on effective sex offender treatment⁵ concluded that treatment saves taxpayer dollars. Their conclusion was based on a report that compared the cost of treatment with the straightforward cost of simple incarceration and the subsequent probabilities of recidivism.

Crime rates and prevalence

Although sex offences present a concern because they are high-profile crimes, they are infrequent when compared with other crimes. Nevertheless, the high cost of sexual victimization has made this type of crime a serious problem. Public reaction to media coverage is the dominant factor influencing policy decisions⁶ and has led to heightened concern about sexual aggression, higher rates of reporting, more aggressive prosecution and longer sentences.

Physical treatments

Psychosurgery. A review of the procedure of brain ablation⁷ points to some distressing findings. The unimpressive results, the overly invasive nature of the procedure, and the risk of intellectual and emotional side-effects are reasons why psychosurgery should not be further explored.

Castration. Difficulties have been noted with the use of this procedure. One study found that treatment was more successful for offenders who freely consented to the procedure and whose offences were limited to sexual ones.⁸

Pharmacological. The advantage of the pharmacological approach is that it achieves the same sex drive reduction as surgical castration, but with fewer ethical problems; surgery is not required and the effects are completely and quickly reversible.

Sex offenders, however, have described pharmacological treatments as one of the least desired therapies. Rice and colleagues conclude that few offenders voluntarily accept treatment designed to reduce testosterone levels. Of those willing to participate, even fewer will continue to receive their dosage for significant periods of time. For those who do remain in treatment, the evidence suggests that rates of reoffending are low; however, there appears to be little convincing evidence that it is the drugs themselves that are responsible for reducing the rate of recidivism. Marshall and colleagues explain that some practitioners may discourage the use of pharmacological treatment because of its high dropout and refusal rates.

Psychological treatments

Most articles devoted to psychological treatment – in particular, those using behavioural or cognitive-behavioural treatment – share the common treatment component of behavioural techniques aimed at normalizing deviant sexual preferences. Other common components include training in social competence, sex education, anger management and relapse prevention.

Behavioural. Early psychological treatment for sex offenders was based on the idea that deviant sexual preferences motivated sexual offending. Behavioural therapy was well suited to this ideology, given its ability to restrict the focus of therapy. The use of aversion therapy has seen a loss in popularity because of its low efficacy and ethical problems.⁹

Covert sensitization has also proven to be not very effective. Its efficacy seems to improve when it is combined with other techniques such as olfactory aversion.¹⁰

Behavioural therapy for sex offenders has also focused on increasing nondeviant sexual arousal. A summary of research on this approach¹¹ concludes that the overall results are mixed; some studies found the method effective and others found no change in participants' sexual arousal patterns.

Cognitive-behavioural. Cognitive-behavioural treatment came into use when it was noted that sex offenders viewed themselves, along with the behaviours and feelings of their victims, in a distorted fashion.¹² This multifaceted treatment permits therapists to attend to a number of areas considered criminogenic needs among sex offenders, such as: denial and minimization, inappropriate attitudes, deviant sexual preferences, victim impact and empathy, social skills, anger control, substance abuse, relationship issues, and life skills.

Most treatment programs address the majority of these areas with group therapy. In a group format, therapists model supportive but firm challenges (based on the arresting

officer's report and a transcript of the trial), all offenders are encouraged to participate fully in discussions, and participants achieve a full understanding of the relevant issues.¹³ A group format encourages participants to put forward pro-social beliefs and to discuss the benefits of such beliefs.¹⁴

Relapse prevention. Relapse prevention is a theoretical treatment model based on the concept that offence precursors can be identified and addressed.¹⁵ It also accepts the likelihood that precursors associated with sexual abuse will recur. The first element in the relapse prevention model asks offenders to identify their offence chain. In the next phase, offenders detail how they would deal with each risk factor identified in the offence chain. Relapse prevention provides a more realistic therapeutic goal of control, as opposed to cure. It relies on multiple rather than single sources of information concerning offender behaviour, integrates mental health, parole and probation professionals, and defines behavioural maintenance as a continuum rather than an abstinence-relapse dichotomy.

Cognitive-behavioural and relapse prevention. Adding relapse prevention to the cognitive treatment of sex offenders reduces their recidivism rate.¹⁶ Marshall notes that work in this area has yet to systematically compare programs with and without relapse prevention. Nevertheless, work in this area has demonstrated impressive findings.¹⁷

Meta-analyses

One meta-analysis¹⁸ concluded that there was no evidence that treatment effectively reduces the risk of sexual reoffending. Another¹⁹ disagreed with this conclusion on a number of issues; its chief criticism was that many of the treatment models in the first meta-analysis were obsolete.

An even more recent meta-analysis²⁰ found that 19% of the treated offenders recidivated during an average follow-up period of 6.85 years compared with 27% of the untreated offenders. Hormonal ($r = .31$) and cognitive-behavioural ($r = .28$) treatment approaches yielded greater effect sizes than studies that used behavioural ($r = -0.1$) treatments. The fact that one to two thirds of participants refuse hormonal therapy has influenced practitioners' choice of treatment.

Sexual arousal patterns as a factor in recidivism among sex offenders

Researchers can only speculate on the interaction between sex offender's deviant desires and normal sexual arousal patterns. The rates of recidivism among sex offenders are distressing, especially over time after treatment. The assumption must remain that rates of recidivism would increase if sexual arousal did not decrease in the late middle-aged male. The mapping out of the male sexual arousal pattern in future research may point to the true effect of treatment.

Methodological and measurement issues

Most studies of sex offenders lack random sampling and control groups. Marshall and Pithers note that withholding treatment from sex offenders will likely result in the psychological and physical injury of human beings. Most sex offender will not be paroled until they have effectively participated in a recognized program. Marshall and colleagues also emphasize their belief that the pursuit of scientific standards cannot be held in higher account than the protection of innocent children, women and men from victimization.

Difficulties result from relying on recidivism as the sole measure of outcome. Principal among them is the use of arrest and conviction records to measure reoffence, ignoring the fact that victims may not report all counts of victimization. In addition, many sex offenders are known to have committed two to five times as many sex crimes as those for which they were arrested.

Researchers have expressed concerns over the use of phallometric assessment because of offenders concealing the true nature of their response and the ease with which results can be falsified, for example, through not attending to the stimuli.²¹ Phallometric assessment may yet prove useful to clinicians who are aware of its limitations and take steps to guard against faking.²²

Offender typology

Knowledge of typology appears to reduce recidivism by ensuring the offender's treatment is the most efficacious for his or her prime sexual deviance. For example, a comprehensive review of cognitive-behavioural programs indicated that exhibitionists, male child molesters and female child molesters benefit from different approaches.

Measuring treatment effectiveness through proximal measures

Researchers have put forward a number of proximal measures. These include repeated measure of an offender's cognitions throughout treatment,²³ empathy for victims of sexual offences,²⁴ level of denial and minimization,²⁵ adult attachment styles,²⁶ time in treatment and treatment stage attained,²⁷ and other dynamic risk factors.

Future directions

Barbaree and Cortoni, as well as Pithers, believe sex offender treatments can be improved by revising current approaches. They recommend that treatment be specific to sex offender issues and conducted in a designated sex offender treatment setting. They recommend group therapy with a peer group because it facilitates confrontation when denial or minimization are inevitable, while ensuring a controlled and supportive environment. Zamble and Quinsey²⁸ recommend focusing on psychologically meaningful variables (e.g., coping ability) and dynamic updating of the offender's progress in treatment and their risk of reoffending. Nicholaichuk and colleagues note that to detect treatment effects, treated and untreated offenders must be properly matched by need and risk levels rather than the past practice of relying on samples of convenience.

Mander and colleagues note that sex offenders are a heterogeneous group. Future treatment and research should acknowledge this by reporting outcome as defined by different typologies rather than overall rates of recidivism. Specifying the treatment program offenders enter would result in greater impact on an offender's rate of recidivism.²⁹

Advancement in statistical analyses demonstrates that the Criminal Career Profile may prove efficient at predicting the occurrence of violent offences. In addition, given financial constraints and the large number of sexual offenders who would benefit from treatment, an objective criterion for determining when an offender has derived maximum treatment benefit would be useful. Such a measure may help identify offenders not likely to participate in or benefit from treatment. Money earmarked for their treatment would be better directed at implementing external monitoring.

In conclusion, Marshall claims the assessment of sex offenders is in its infancy. As such, he believes the area will only continue to improve once it begins to take into account the impact of treatment through the use of proximal measures.

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