# Does Sex Offender Treatment Work?

By Brett Trowbridge, Ph.D., J.D.

It is very difficult to conduct good research on the effectiveness of sex offender treatment. As a result, authorities seem to agree that at present there is little credible available evidence proving that a particular treatment is effective in reducing recidivism among sex offenders, although there is also no credible evidence that sex offender treatment does not work.[1] Determining conclusively that sex offender treatment is or is not effective is problematic, because it is difficult and expensive to do a definitive study for several reasons.

An ideal study would follow-up large numbers of sex offenders after they had been released for a significant period of time, comparing the re-offense (recidivism) rates of those who had received a significant course of "state-of-the-art" sex offender treatment with those who had not received any treatment. An overridingly important consideration would be that the two groups (treated and "control" un-treated) would be as similar as possible in every other respect other than whether or not they had received treatment. Otherwise it would not be possible to tell whether differences in recidivism between the two groups would be attributed to treatment, or to some other factor.

The most logical and straight-forward way to do that would be to assign offenders randomly to either the treated or untreated condition. However, ethical and legal issues arise when a researcher considers randomly assigning sex offenders to either treatment or

[1] Conroy, M.A. (2000). Assessment of Sexual Offenders, in Van Dorsten, B. (Ed.) Forensic Psychology from Classroom to Courtroom, Plenum, N.Y., p. 232; Prentky, R.A. & Burgess, A.W. (2002), Forensic Management of Sexual Offenders, Plenum, N.Y.; Harris, G.T., Rice, M.E., & Quinsey, V.L. (1998). Appraisal and Management of Risk in Sexual Aggressors: Implications for Public Policy, 4 Psychology, Public Policy, and Law, 73-115.

a no-treatment control group. Is it morally defensible to leave one group untreated? New victims of the un-treated group could file lawsuits, claiming it had been negligent not to treat those untreated offenders. Therefore, few organizations funding treatment for sex offenders are prepared to deliberately withhold treatment from any offenders for fear of the public outcry that likely will follow a re-offense among the un-treated.[2] Furthermore, treatment programs that have been around long enough to do significant follow-up of released offenders were not thinking about methodological issues for outcome research much when they established their programs. Therefore, currently available studies may have no control group at all, instead simply stating what percentages of re-offending various types of sex offenders who had been treated in their program had over what periods of time.[3] Such researchers then compare their outcomes with published recidivism rates. The problem is that the variation in published recidivism rates is truly remarkable.[4]

Those that do employ control groups usually use offenders who decline to participate in treatment, those who drop out of treatment before completing it, or those who were not selected for treatment by the treators. However, these are really not appropriate groups for comparison. It is very likely true that treators (especially those providing out-patient programs) tend to select the less dangerous offenders for treatment, those whom they predict will be less likely to embarrass them by re-offending during or shortly after treatment. Treators tend to select those offenders who admit they have a

---

[2] Barbaree, H.E. (1997). Evaluating treatment efficacy with sexual offenders: The insensitivity of recidivism studies to treatment effects. 9 Sexual Abuse: A Journal of Research and Treatment, 111-128.
[3] E.g. Maletsky, B.M. and Steinhauser, C. (2002). A 25-year follow-up of cognitive/behavioral therapy with 7,275 sexual offenders. 26 Behavior Modification 2, pp 123-147.
[4] Prentky, R.A. (1999). Child sexual molestation. In Van Hasselt, V. & Hersen, M. (Eds.). Handbook of psychological approaches with violent offenders. Plenum, N.Y. P. 289.

problem, who admit they were wrong, and who seem to be motivated for treatment. These offenders are probably less likely to re-offend even if the treatment they would receive were totally ineffective. Similarly, it is well known that offenders who complete treatment are at a lower risk for re-offense than those who decline treatment or fail to complete it.[5] However, a "selection factor" is operative here, and just because those who complete treatment have lower recidivism rates than those who decline treatment or fail to complete it does not constitute proof that treatment is effective. As one authority puts it, "These studies may simply separate the motivated, pro-social offenders from their more anti-social counterparts, thus measuring attitudinal variables rather than treatment effects."[6]

There are also other issues making research into whether sex-offender treatment is effective difficult. It seems obvious that if treatment actually works, it probably only works with some types of offenders, and not with others, and that some types of offenders need different types of treatment than others. For example, one well-respected researcher involved with the sex offender treatment program at Atascadero State Hospital in California believes their treatment may be effective with child-molesters but may not be effective with rapists.[7] However, many (if not most) studies give all types of offenders the exact same treatment. Some evidence suggests that treatment may actually increase the risk of re-offense for highly psychopathic offenders.[8] If so, in studies that attempt to demonstrate treatment effectiveness, the fact that more psychopathic (or anti-social)

---

[5] Hanson, R.K. & Bussiere, M.T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. 60 Journal of Consulting and Clinical Psychology, pp 348-62.
[6] Conroy, M.A. (2000). Assessment of sexual offenders, in Van Dorsten, B. (Ed.) Forensic psychology, from classroom to courtroom, Plenum, N.Y., p. 232.
[7] Marques, J.K. (1999). How to answer the question: "Does sex offender treatment work?" 14 Journal of Interpersonal Violence, 437-451.
[8] Rice, M.E. (1997). Violent offender research and implications for the criminal justice system. 52 American Psychologist 414-423.

offenders became worse with treatment would likely cancel out any positive treatment effects that might have occurred with less psychopathic offenders.

Research that has shown positive effects for sex offender treatment has tended to confirm that treatment is more likely to be effective in reducing re-offense rates in higher-risk offenders.[9] However, as mentioned above, treators in out-patient programs tend to select the more motivated, more insightful, less violent offenders, who may be at lower risk for recidivism. Some studies suggest that using intensive treatment services on those at low-risk may actually increase the potential for recidivism.[10] Because of these problems (as well as others) little is known about what treatments, if any, are effective, because treatment approaches have demonstrated little effectiveness.[11] [12]

Another problem in doing follow-up research on released sex offenders is that, although the public seems to believe otherwise, recidivism rates for sexual offenders (although, as mentioned above, highly variable) are fairly low; most estimates are under 20 percent. The best data on sexual offender re-offense rates, Hanson and Bussiere's 1998 meta-analysis, show that sexual offenders' five-year re-offense rate is on average only 13.4 percent, much lower than most lay people would predict, and less than the re-offense rate for criminals generally.[13] Barbaree followed up 477 adult sex offenders for an average of 5.9 years and came up with an overall sex-offender recidivism rate of 11.3

---

[9] Bonta, J., Wallace-Capretta, S., & Rooney, J. (2000). A quasi-experimental evaluation of an intensive rehabilitation supervision program. 27 Criminal Justice and Behavior 312-329.
[10] Andrews, D.A., Bonta, J. & Hoge, R.D. (1990). Classification for effective rehabilitation: Rediscovering pathology. 17 Criminal Justice and Behavior 19-32.
[11] Grossman, L.S., Martis, B. & Fichtner, C.G. (March 1999). Are sex offenders treatable? A research overview. 50 Psychiatric Services 349-361.
[12] Fonza, M. (March/April 2001). A review of sex offender treatment programs. The ABNF Journal pp 42-48.
[13] Hanson, R.K. & Bussiere, J.T. (1998). Predicting relapse: A meta-analysis of sex offender recidivism studies. Journal of Consulting and Clinical Psychology 66, 802-809.

percent.[14] Janus and Meehl reviewed the literature, and concluded that a 20 percent base-rate for sexual recidivism is roughly correct.[15] (Many sex offenses may be unreported or undetected, and therefore the true recidivism rate is probably higher, but most researchers limit themselves to using arrests and/or convictions when calculating recidivism data.) If over 80 percent of the offenders treated were not going to re-offend anyway even if they have not received treatment, a very powerful treatment effect and/or a very large number of treated offenders would be needed to demonstrate effectiveness conclusively. Barbaree has calculated the statistical power necessary to discern benefits from treatment of sex offenders. According to his calculations, with the usual low rates of re-offending and with a reasonably powerful treatment effect, almost 1,000 subjects would be needed who would be followed-up for 10 years before treatment could be demonstrated to be effective.[16]

There have been some studies, including meta-analyses, which have reported apparently significant (albeit small) treatment effects.[17] However, critiques have raised some serious methodological problems with those studies.[18] Even researchers who initially thought the data showed that sexual offender treatment was effective have now concluded that there is nothing in the literature that demonstrates sex offender treatment

---

[14] Barbaree, H.E., Blanchard, R. & Langton, C.M. (2002). Sexual aggression through the lifespan. Law and Mental Health Program, Centre for Addiction and Mental Health, University of Toronto, Toronto, Ontario.
[15] Janus, E.S. & Meehl, P.E. (1997). Assessing the legal standard for predictions of dangerousness in sex offender commitment proceedings. 3 Psychology, Public Policy and Law p 33.
[16] Barbaree, H.E. (1997). Evaluating treatment efficacy with sexual offenders: The insensitivity of recidivism studies to treatment effects. 9 Sexual Abuse: A Journal of Research and Treatment 111-128
[17] Hall, G. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. 63 Journal of Consulting and Clinical Psychology, 802-809.
[18] Rice, M.E. & Harris, G.T. (1997). Cross-validation and extension of the violence risk appraisal guide for child molesters and rapists. 21 Law and Human Behavior, 231-241; McConaghy, N. (1999). Methodological issues concerning evaluation for treatment for sexual offenders, randomization, treatment drop-outs, untreated controls, and within-treatment studies. 11 Sexual Abuse: A Journal of Research and Treatment 183-194.

reduces recidivism, as studies using the better methodologies have failed to show positive treatment effects.[19]

One very recent study takes advantage of the fact that in the 1980s Correctional Service of Canada began to require weekly community treatment sessions for all sex offenders released in the Pacific region. This policy change provided an opportunity for comparing an unselected cohort of treated sex offenders to an untreated cohort released in previous years, perhaps the best attempt to date at creating a control group that was truly similar to the treated group. After an average 12-year follow-up period, no differences were observed in the rates of sexual, violent, or general recidivism.[20]

Even those few researchers who believe that sex offender treatment can be shown to be effective (most of them believe cognitive-behavioral approaches are the only approaches which have been shown to be effective) admit that treatment has only been shown to be marginally effective with sex offenders. One researcher concludes: "If treatment is at best only marginally effective with sexual offenders, nevertheless the benefits to society, in terms of fewer victims and reduced financial burden to taxpayers, are quite dramatic."[21]

Another authority concludes that evidence is "sparse" but states "it is fair to conclude that cognitive-behavioral approaches have been found to be effective."[22]

---

[19] Barbaree, H.E. (1999). The effect of treatment on risk for recidivism in sex offenders. In American Psychological Association, Psychological Expertise and Criminal Justice: a conference for psychologists and lawyers, pp. 217-220, Wash. D.C. American Psychological Association.

[20] Hanson, R.K., Broom, I. & Stephenson, M. (2004). Evaluating community sex offender treatment programs: A 12-year follow-up of 724 offenders. 36 Canadian Journal of Behavioral Science 2, 87-96.

[21] Marshal, W.L. (1999). Diagnosing and treating sexual offenders. In Hess, A.K. & Weiner, I.B. (Eds.). The handbook of forensic psychology, 2nd Ed, JohnWiley & Sons, N.Y. pp. 640-670 (quote from page 661).

[22] Wood, R.M., Grossman, L.S. & Fichtner, C.G. (2000). Psychological assessment, treatment, and outcome with sex offenders. 18 Behavioral Sciences and the Law 23-41.

Most researchers now believe that pure relapse prevention[23] approaches have not been shown to be effective.[24] [25]

"Milieu" programs, such as the now defunct sex offender program at Western State Hospital and similar "mentally disordered sex offender" programs in many other states, came under heavy attack as early as 1977, when the Group for the Advancement of Psychiatry, originally a proponent of those programs, came to believe that "sex psychopath and sex offender statutes can best be described as approaches that have failed," and in the mid-1980s the American Bar Association recommended repeal of all such statutes partially because research data showed their treatment ineffective.[26]

---

[23] Relapse prevention approaches are discussed in Pitlers, W.D., Marques, J.K., Gibat, C.C. & Marlatt, G.A. (1983). Relapse prevention with sexual aggressiveness: A self-control model of treatment and maintenance of change. In Greer, J.G. and Stuart, I.R. (Eds.). The sexual aggressor: current perspectives in treatment. VanNostrand, Reinhold, N.Y. pp 214-239.

[24] See Marshall, W.L. & Anderson, D. (1996). An evaluation of the benefits of relapse prevention programs with sex offenders. 3 Sexual abuse: A Journal of Research and Treatment 499-511.

[25] Marques, J.K.; Wiederanders, M.; Day, D.M.; Nelson, C.; and Van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation project (SOTEP). Sexual Abuse: A Journal of Research and Treatment, Vol. 17, No. 1, pp. 79-107.

[26] Cited in Melton, G.B., Petrila, J., Pothress, N.G. & Slobogin, C. (1997). Psychological evaluations for the Courts (2nd Ed.), p. 272.