Literature Review

CHAPTER 2

This chapter summarizes what we learned from our review of the national literature. We address the following questions:

- **What has been learned from previous research about the causes of sexually deviant behavior, sex offender reoffense rates, and the effectiveness of treatment?**
- **How do other states deal with sex offenders?**
- **What are the implications of the research for public policy regarding sex offenders?**

To answer these questions, we examined research on the causes of sexually deviant behavior and reviewed the literature on sex offender treatment and recidivism rates. We also interviewed treatment professionals and others involved in evaluating sex offender treatment programs, and we contacted other states to learn how they deal with sex offenders.

Briefly, the research suggests that sex offenders are very heterogeneous and do not all share the same personal or offense characteristics. Also, mental health professionals disagree about the causes of sexually deviant behavior and have proposed alternative theories to explain why sex offenders commit their crimes. Because sex offender treatment evaluation is a relatively new and complex field, there are no definitive answers about whether treatment is effective. Furthermore, sound evaluations of treatment effectiveness are very difficult to conduct because of inadequate follow-up data, poor measures of effectiveness, and ethical issues that make experimental designs impractical. However, some evaluations have found lower recidivism rates at the end of a three- to-five-year follow-up for treated versus untreated offenders, while other studies have found no evidence of program effectiveness. States have responded to the problem of sex offenses through varying combinations of incarceration and treatment.

BACKGROUND

The practice of singling out certain sex offenders from other criminals as appropriate for treatment dates back to the 1930s.[1] In the late 1930s and 1940s, Minnesota and most other states enacted sexual psychopath or mentally disordered sex offender statutes, which typically provided for indefinite civil commitment of sexually dangerous persons to mental health treatment in lieu of imprisonment. These laws were enacted to protect the public from potentially violent offenders and to provide treatment to those in need. They were based on a belief that sex offenders suffered from a mental disorder that may be treatable.[2] At the time, the assumptions underlying these laws were accepted uncritically and were not subjected to scientific testing. Also, significantly fewer sexual offenses were reported when these laws were in effect.

States rely on varying combinations of treatment and punishment for sex offenders.

Sex Offender Treatment in Other States

Since the 1960s, the population of convicted sex offenders has grown as the public has become more concerned about sexual assault and child sexual abuse and more crimes have been reported to law enforcement authorities. Simultaneously, most states have repealed their sexual psychopath laws and there has been less use of civil commitment and greater use of incarceration for sex offenders.[3] Currently, there is a lack of consensus among the states regarding the appropriate response to the problem of sexual assault. One study noted that as some states were establishing new treatment programs for sex offenders, others were terminating them.[4]

We contacted 19 states reported to have statutes that provided for civil commitment of sex offenders to treatment facilities and learned that most have

1 For a more complete discussion of this literature, see Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, 1994).

2 Carol Veneziano and Louis Veneziano, "An Analysis of Legal Trends in the Dispositions of Sex Crimes: Implications for Theory, Research, and Policy," *The Journal of Psychiatry and Law*, Summer 1987, 205-225.

3 Mark A. Small, "The Legal Context of Mentally Disordered Sex Offender (MDSO) Treatment Programs," *Criminal Justice and Behavior*, Vol. 19 No. 2 (June 1992), 127-142. Minnesota is one of the few states that retained its sexual psychopath statute, although it was used infrequently until the past several years when its use significantly increased. Minnesota also had a law in effect until 1978 (*Minn. Stat.* §246.43) that required sex offenders to be assessed for amenability to treatment at the Minnesota Security Hospital. This law was repealed in conjunction with the enactment of sentencing guidelines. As described in Chapter 1, more recently (since 1989), the Minnesota Legislature has re-enacted laws that mandate assessments for treatment amenability for offenders not sent to prison.

4 Janice K. Marques, et al., 1*991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project* (Sacramento: California Department of Mental Health), 5.

either repealed them or no longer actively use them.[5] However, 17 of the 19 states provided for inpatient treatment of varying numbers of sex offenders either within correctional or mental health facilities. Six of the 19 states had treatment programs for incarcerated sex offenders jointly operated by departments of corrections and mental health/human services.[6]

Washington has developed a comprehensive approach that provides for treatment in alternative settings. It has instituted a "Special Sex Offender Sentencing Alternative" under which judges can suspend prison sentences for adult sex offenders who meet certain conditions and provide outpatient treatment in the community instead. In addition, Washington provides treatment within correctional facilities and has enacted a law under which violent sexual predators may be indefinitely confined to treatment that is jointly provided by corrections and mental health departments.[7] In contrast, California has restricted inpatient treatment for sex offenders to an experimental program that treats up to 50 offenders at a time, and Florida recently terminated its sex offender treatment program.[8]

The Rationale for Treatment

Nationally, there has been a significant increase in juvenile sex offender treatment programs.

At the present time, there is a large group of mental health professionals, representing a variety of disciplines, including psychology, psychiatry, clinical social work, counseling, and medicine, that continues to believe in the potential efficacy of treating sex offenders. Over the past decade, the sex offender treatment field has grown rapidly, especially programs treating adolescent offenders. The *Safer Society Program,* a national organization that regularly surveys treatment programs, identified 20 programs nationally that treated juvenile sex offenders in 1982; by 1993, the number had increased to over 800 specialized juvenile treatment programs.[9]

The rationale for treating juvenile offenders is based on research that indicates that inappropriate sexual behavior patterns develop early and that a failure to intervene often means that the offender will continue or escalate the

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5 The states included: California, Colorado, Connecticut, District of Columbia, Florida, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, Oregon, Tennessee, Utah, Vermont, Virginia, Washington, and Wisconsin. Only Minnesota and Washington actively used their civil commitment statutes to confine sex offenders to treatment, both following prison sentences. See Office of the Legislative Auditor, *Psychopathic Personality Commitment Law*, 36-37.

6 *Ibid.*, 34-38.

7 Senator Gary Nelson, *Washington State's 1990 Community Protection Act* (Olympia: Washington State Institute for Public Policy, 1993).

8 Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project*, 12.

9 Cited in the National Council of Juvenile and Family Court Judges, "The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of the National Adolescent Perpetrator Network," *Juvenile and Family Court Journal*, Vol. 44 No. 4 (1993), 5.

inappropriate behavior, thereby representing a continuing danger to society.[10] Similarly, professionals who treat adult sex offenders have argued that even those offenders who are incarcerated for their crimes will eventually return to the community; hence, steps should be taken to reduce the likelihood that they will commit another crime, even though there is uncertainty about whether those steps will be effective. At a recent international meeting of treatment professionals, the following justification for treatment was offered:

> Although treatment is costly and unaffordable by some, not to treat can be more costly emotionally and psychologically for the offender, for the victims and future victims, and for society. Today there is more scientific evidence and consensus among professionals that paraphilias are psychosexual disorders. By contrast, the predominant view of the lay public around the world is that sex crimes can be eradicated with punishment and/or death. This predominant view is not supported by scientific evidence, and the scientific community needs to continue to promote awareness that sex crimes can also be manifestations of biomedical/psychiatric/psychological illnesses for which people must be treated, rather than simply punished.[11]

In making clinical diagnoses, mental health professionals rely on the *Diagnostic and Statistical Manual of Mental Disorders*, a regularly updated document that classifies mental illnesses and disorders and defines their symptoms.[12] Treatment professionals use the diagnostic codes from this manual to obtain reimbursement for their services from insurance companies and agencies administering medical assistance funds.

The American Psychiatric Association's diagnostic manual lists several specific sexual disorders, as well as more general categories of conduct or personality disorders, that are used in diagnosing sex offenders and assessing their amenability to treatment. The specific sexual disorders, referred to as "paraphilias," are characterized by "recurrent, intense, sexual urges and sexually arousing fantasies of at least six months' duration" that are abnormal and interfere with "reciprocal, affectionate sexual activity."[13] Many sex offenders with abnormal sexual arousal patterns (e.g., an attraction to children) may not meet the criteria to be diagnosed with a specific sexual disorder because their symptoms are not severe enough.[14]

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10 *Ibid.* Research shows that 60 to 80 percent of adult offenders reported offending as juveniles; over 50 percent of the molestation of boys and at least 20 to 25 percent of the sexual abuse of girls is perpetrated by juveniles; and many adolescents report they were victimized as children.

11 Eli Coleman, et al., "Standards of Care for the Treatment of Adult Sex Offenders," endorsed by participants of the 3rd International Congress on the Treatment of Sex Offenders, held in Minneapolis, Minnesota, September 20-22, 1993.

12 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition Rev. (Washington, DC, 1989).

13 In classifying "sexual disorders," the APA distinguishes between "paraphilias," which are not part of normal sexual arousal and activity, and "sexual dysfunctions," which are characterized by inhibitions in sexual desire and response. Paraphilias include pedophilia, exhibitionism, voyeurism, sexual sadism, and sexual masochism, among others. For definitions and a complete listing, see *Ibid.*, 279-290.

14 W. L. Marshall and A. Eccles, "Issues in Clinical Practice with Sex Offenders," *Journal of Interpersonal Violence,* Vol. 6 No. 1 (1991), 69.

RESEARCH ON SEXUAL DEVIANCY

With the increase in convicted sex offenders and the growth in treatment programs, more research has been done on the causes of sexual deviancy and how to treat it. Results from some of these studies are summarized briefly below.

Types of Sex Offenders

It is important to note that:

- **Sex offenders are not a homogeneous group.**

The term "sex offender" applies to people who have exhibited many different kinds of behavior — some violent, some non-violent, some involving strangers, and some involving acquaintenances or family members. In considering what to do about treating sex offenders, the diversity of behaviors, motivations, and victims needs to be kept in mind.

Sex offenders commit a variety of different crimes and have varying motivations and victim preferences.

One classification of sex offenders separates them by their victim preferences. The two principal categories are rapists and pedophiles.[15] The term "child molester" is often used as a synonym for "pedophile." Incest offenders, who are biological parents and stepparents or siblings, are considered a special type of child molester. Child molesters are further classified by whether they prefer victims of the same sex, opposite sex, or both. Another type of sex offender, which includes exhibitionists, voyeurs, and obscene phone callers, does not have physical contact with victims.

Early research assumed that it was possible to develop a profile of the "typical" rapist, which would identify characteristics that distinguished him from a "normal" male. Researchers have developed several typologies of rapists. One common classification identified three categories: "anger rapists" who express their hostility through sex, "power rapists" for whom sex equals conquest, and "sadistic rapists" who are sexually aroused by both power and anger.[16]

Recent classification schemes, however, are more complex and further differentiate among types of rapists and multiple categories of pedophiles or child molesters.[17] These schemes incorporate empirical research that has found considerable variation among rapists and significant differences between

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15 Based on this two-way classification, offenders who commit the offense of "rape of a child" are classified as pedophiles.

16 See Lana E. Stermac, Zindel V. Segal, and Roy Gillis, "Social and Cultural Factors in Sexual Assault," *Handbook of Sexual Assault,* 150-152.

17 For a discussion of various sex offender typologies, see Barbara K. Schwartz, Editor, *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender* (Washington, D.C.: U.S. Department of Justice, 1988), 19-27.

rapists and child molesters.[18] For example, a study of 200 sex offenders found differences in the attitudes and behaviors exhibited just prior to the victimization act: a greater proportion of rapists than pedophiles displayed anger toward women (77 percent of rapists and 26 percent of pedophiles), acted opportunistically (58 percent versus 19 percent), and used alcohol or drugs prior to offending (56 percent versus 30 percent).[19]

These and other findings suggest that sex offenders vary with respect to the amount and nature of aggression, vindictiveness, and opportunism involved, degrees of fixation and impulsiveness, attitudes toward women, and levels of social skills, personal competence, and self-esteem.[20] Hence, there appear to be no universal characteristics that distinguish sex offenders from non-offenders.

Theories of Sexually Deviant Behavior

The causes of sexual aggression are complex and not well understood.

The heterogeneity among sex offenders helps to explain why there are conflicting findings in the research and different theories that purport to explain the causes of sexual assault. Theories to explain why some people commit sex offenses may be grouped into three broad categories: biological, psychological, and environmental. Biological theories include those that emphasize a genetic basis for male aggression, propose biochemical explanations (abnormal sex steroids or endocrine malfunctions), or find neurological impairments.[21] Psychological theories usually focus on childhood experiences, such as sexual, physical, or emotional abuse, that inhibit the development of self-confidence and appropriate attachments to others or experiences that reward aggressive behavior. Environmental theories focus on the socio-cultural context of sex crimes (availability of pornography, male-dominated culture, and high level of interpersonal violence) and temporary situational factors that contribute to inappropriate responses, such as anger or stress, marital discord, and sexual dysfunction, or that remove normal inhibitions against deviant behavior, such as alcohol and drug abuse.[22]

According to a review of the literature, most existing research has focused on three topics: deviant sexual arousal patterns, heterosexual social skills, and

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18 Raymond A. Knight and Robert A. Prentky, "Classifying Sexual Offenders," *Handbook of Sexual Assault*, 23-52.

19 William D. Pithers, et al., "Identification of Risk Factors through Clinical Interviews and Analysis of Records," in D. Richard Laws, Editor, *Relapse Prevention with Sex Offenders (*New York: The Guilford Press, 1989).

20 Stermac, Segal, and Gillis, "Social and Cultural Factors in Sexual Assault," *Handbook of Sexual Assault*, 143-159.

21 Clinical research on both animals and humans suggests that in some cases, sexually deviant behavior may result from brain damage or dysfunction. For example, studies have shown that certain types of epilepsy may be associated with changes in sexual behavior. See Ron Langevin, "Sexual Anomalies and the Brain," *Handbook of Sexual Assault,* 103-113.

22 W. L. Marshall and H. E. Barbaree, "An Integrated Theory of the Etiology of Sexual Offending," *Handbook of Sexual Assault*, 257-275.

the sexual and drug history of the offender.[23] While treatment professionals recognize the importance of cognition—an individual's perceptions, mental thought processes, and reasoning—in sexual offending, little systematic research has been done on it.[24] There are indications, however, that some sex offenders may develop distorted thought patterns that help them justify their behavior. For example, survey results have found that compared with other respondent groups, child molesters thought that sexual contact was more beneficial to the child and perceived less responsibility for their behavior, greater complicity on the child's part, and less need to punish the adult.[25]

Use of alcohol and drugs has been frequently linked to sexual offending. Sexual offenders often report that excessive alcohol use was a contributing factor in their offenses, and a study of police and victim reports found that intoxication was involved in 70 percent of all rapes.[26] Clinical studies have found that some males respond differently to sexual cues when they are drunk than when they are sober, and alcohol and other drugs can temporarily remove normal inhibitions against committing criminal acts.[27] Many treatment professionals consider it to be a relevant factor since it appears to contribute to sexually assaultive behavior for some individuals.[28]

Types of Sex Offender Treatment

There are several different approaches to treating sex offenders.

The main types of sex offender treatment are described briefly in Figure 2.1 and are associated with the different causal theories discussed above. Behavioral and organic treatments are aimed at changing sexual preferences or arousal patterns through behavioral modification techniques or biomedical methods. Psycho-surgery, which involves destroying the part of the brain associated with sexual arousal, has rarely been used anywhere. Castration has been used in northern Europe with some demonstrated success, although not in the U.S. Both psycho-surgery and castration raise ethical concerns because of their invasive nature.[29]

A number of studies have reported success in reducing deviant sexual behavior using anti-androgen (hormonal) drugs. However, other researchers have noted that drug therapy has limited applicability for a number of reasons. First, these medications do not eliminate sex offending. They are primarily used in conjunction with psychological therapy as a way of reducing sexual activity to lower levels for those offenders whose sex drives seem excessively high (usually those with diagnosed paraphilias). Second, since this type of sex

23 Zindel V. Segal and Lana E. Stermac, "The Role of Cognition in Sexual Assault," *Handbook of Sexual Assault,* 161.

24 *Ibid.*

25 *Ibid.*, 169.

26 Marshall and Barbaree, "An Integrated Theory of the Etiology of Sexual Offending," *Handbook of Sexual Assault*, 268-269.

27 *Ibid.*

28 Marshall, Laws, and Barbaree, "Issues in Sexual Assault," *Handbook of Sexual Assault*, 4.

29 *Ibid.*, 12-13.

Figure 2.1: Types of Sex Offender Treatment

Behavioral

The goal is to reduce sexual arousal patterns using methods aimed at changing offenders' behavioral responses to sexual stimuli. Typical methods include aversion therapy and satiation therapy. In aversion therapy, a negative stimuli—usually the inhalation of ammonia fumes—is administered while the offender engages in deviant fantasizing. In satiation therapy, offenders masturbate to non-deviant fantasies until satiated, then switch to deviant fantasizing, thereby pairing an inability to become sexually aroused with deviant sexual behavior.

Organic/Biomedical

The goal is to reduce the sexual drive of sexually aggressive men. Organic treatments include surgical castration, neuro- or psycho-surgery, and administration of medications. Psycho-surgery involves destroying the part of the brain associated with sexual arousal. A number of different anti-androgen or hormonal drugs have been tested on sex offenders, with the most common ones being MPA (medroxy-progesterone acetate, commonly called depo-provera) and CPA (cyproterone acetate). Tranquilizers, anti-depressants, and anti-psychotic drugs also have been used.

Psychological/Cognitive

The goal is to reduce sexually deviant behavior by teaching sex offenders how to control their own sexual interest patterns. It is based on the recognition that cognition plays an important role in sexual offending, in addition to sexual arousal patterns. Typical methods include group therapy, role playing, individual counseling, and sex education. Through group interaction and structured educational sessions, sex offenders learn about the cognitive distortions that they use to justify their own deviant behaviors. They are also taught about appropriate sexual behavior. Individual problems, such as lack of self-esteem, alcohol and drug abuse, inadequate anger control, or poor social skills, are also identified and may be dealt with in therapy sessions.

Sources: W. L. Marshall, D. R. Laws, and H. E. Barbaree, Editors, *Handbook of Sexual Assault* (New York: Plenum Press, 1990); and Solicitor General of Canada, *The Management and Treatment of Sex Offenders*, 1990.

offender treatment is voluntary, many offenders have been unwilling to participate and high dropout and noncompliance (failure to take the medications) rates have been reported. Finally, some offenders who have received drug therapy have reported adverse side effects, which contributed to dropout and noncompliance.[30]

Psychological treatment techniques are based on the role that cognition and social learning plays in sexual offending. Most treatment professionals generally accept the premise that an offender's attitudes about himself and others, sexual beliefs, and thought processes are important in the psychological process that leads to sexual assault, and that attitudes and beliefs may contribute to an inability to refrain from reoffending.[31] Some treatment

30 For reviews and discussion, see: S. J. Hucker and J. Bain, "Androgenic Hormones and Sexual Assault," *Handbook of Sexual Assault*, 93-102; J. M. Bradford, "The Anti-androgen and Hormonal Treatment of Sex Offenders," *Handbook of Sexual Assault*, 297-310; Marshall, et al., "Treatment Outcome with Sex Offenders," 470-474; and Solicitor General of Canada, *The Management and Treatment of Sex Offenders*, 12-13.

31 Marshall, et al., "Issues in Sexual Assault," 4-5.

professionals believe that the deviant sexual preferences (e.g., sexual attraction to children) of some sex offenders cannot be totally eliminated. They believe that a more realistic goal of treatment is managing or controlling deviant behavior, not "curing" it.[32] At an Academy of Sciences conference on sexual aggression, Richard Laws, a noted researcher on sex offender treatment, commented:

> Most important, perhaps, is the recognition that it is what happens after the delivery of the treatment package that is critical. Consequently, long-term follow-up is now considered essential. Sexual deviation can be managed, but it is unlikely to go away. There is no `technofix' for this problem.[33]

For this reason, treatment professionals have developed a specific model within the broad category of psychological treatments referred to as "relapse prevention."[34] It was developed from studies of the relapse process in other addictive behaviors, such as alcoholism and drug abuse. Relapse prevention refers to identifying a sex offender's high-risk situations—the specific circumstances that threaten the individual's sense of self-control over illicit sexual behaviors—and developing coping mechanisms to strengthen self-control.

Many treatment professionals think that "curing" sex offenders may not be possible, but teaching them to control their behaviors is a realistic goal.

Individual treatment programs may incorporate a combination of behavioral, organic, and psychological/cognitive approaches into their overall program or treat individuals with a combination of techniques. According to a 1992 national survey of 755 adult and 745 juvenile sex offender treatment providers:

- **Most sex offender treatment programs in the U.S. used psychological techniques. Only a minority of programs also incorporated behavioral techniques or the administration of drugs.[35]**

The results from this survey suggest that over 80 percent of treatment programs (juvenile and adult) addressed the following psychological elements in their treatment: victim empathy, anger management, sex education, communication, cognitive distortions, assertiveness training, personal victimization/trauma, the relapse cycle, and relapse prevention. Over two-thirds of the programs also incorporated victim apologies, impulse control, values clarification, positive/pro-social sexuality, sex role stereotyping, journal keeping, relaxation techniques, and stress management. Most treatment programs incorporated elements that train offenders to accept responsibility for their illegal behavior and to reduce their exposure to situations where they are at risk to reoffend.

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32 Marques, et al., 1*991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project*, 5.

33 Quoted in Solicitor General of Canada, *The Management and Treatment of Sex Offenders*, 13.

34 See, for example, D. Richard Laws, Editor, *Relapse Prevention with Sex Offenders* (New York: Guilford Press, 1989).

35 Safer Society Program, "Nationwide Survey of Juvenile and Adult Sex Offender Treatment Programs" (Orwell, Vermont, 1992). Seventy-five percent of the 1,500 responding providers ran outpatient programs and 25 percent operated residential programs.

Fewer than 30 percent of the programs surveyed used plethysmography (measuring an individual's responses to different sexual stimuli with a physical device), masturbatory conditioning, or aversive techniques (associating deviant arousal patterns with negative stimuli such as ammonia fumes). Only 17 percent of adult and 11 percent of juvenile programs used hormonal (e.g., depo-provera) medications. Approximately 20 percent of the programs used tranquilizers, antidepressants, or anti-psychotic drugs in conjunction with other treatments. According to the results of this survey, no programs in the U.S. used castration or psycho-surgery as treatment methods.

MEASURING SEX OFFENDER RECIDIVISM AND TREATMENT EFFECTIVENESS

In this section, we discuss the research on sex offender recidivism and the effectiveness of treatment.

Recidivism Studies

The main goal of treatment is to reduce the rates at which sex offenders commit additional crimes. "Reoffense" or "recidivism" rates refer to estimates of the percentages of released prisoners or treated offenders who commit another offense. Recidivism rates are calculated over time and are only meaningful if the length of time since the offender's release from prison or treatment is known and recidivism is clearly defined. Typically, recidivism measures rely on official data sources, such as police arrest reports or conviction data. Since these data include only reported offenses and apprehended offenders, they underestimate the actual number of crimes committed by offenders released from prison or treatment. In the case of sex offenders, recidivism may be defined and measured in several different ways, including rearrest, reconviction, or reincarceration for sex offenses only, for all violent offenses, or for all offenses. Some studies have used self-reported data to measure recidivism, but this relies on offenders to honestly report subsequent criminal behavior.

First-time sex offenders are less likely to commit another crime than those with criminal records.

Regardless of how recidivism has been defined and measured, the cumulative reoffense rate for a given group of offenders is greater if reoffenses are measured over a longer period of time. Research findings also point to the conclusion that:

- **Sex offenders with a criminal history have higher recidivism rates than those convicted for the first time.**

Longitudinal studies of cumulative recidivism rates (irrespective of whether offenders received treatment) in the U.S., Canada, Australia, and northern

European countries have shown similar patterns: the longer an individual's criminal record, the more likely that person will commit another offense. For example, the combined results of studies that followed sex offenders in Great Britain, Denmark, and Norway for 10 to 24 years (a total of 4,347 offenders who had not received systematic therapy) found a 13 percent recidivism rate after one year, with the cumulative proportion reconvicted of another sexual or violent offense gradually increasing over time. However, the reconviction rate for first-time offenders (9 percent) was significantly lower than for those with a prior sexual and/or violent offense (28 percent).[36] Another study, which followed sex offenders released from a Canadian prison for 19 to 30 years, found that 42 percent had been reconvicted by the end of the follow-up period, but after 20 years, individuals without prior sexual convictions had been reconvicted at a significantly lower rate (less than 30 percent) than offenders with two or more prior convictions (60 percent).[37]

A U.S. Department of Justice study of more than half of all offenders released from state prisons in 1983 (108,580 persons) found that after three years, the reincarceration rate was 32 percent for rapists and 24 percent for those imprisoned for other types of sexual assault. These rates were lower than the overall reincarceration rate for all types of offenders (41 percent). Similar to the studies reported above, first-time offenders had lower recidivism rates, measured alternatively as rearrest, reconviction, and reincarceration, than offenders with prior criminal histories.[38]

The reoffense rates of most sex offenders vary from 5 to 40 percent, irrespective of whether they receive treatment.

However, because individual studies may define "recidivism" differently and follow offenders for varying periods of time, comparisons of recidivism rates across studies are difficult. Studies of treated and untreated sex offenders (excluding exhibitionists) have found recidivism rates that vary from 5 to 40 percent. Although still not conclusive, research on recidivism tentatively suggests that different types of convicted sex offenders may reoffend at different rates (regardless of whether they receive treatment or not). In 1990, Marshall and Barbaree summarized current research as follows:

- Exhibitionists tend to have the highest recidivism rates (ranging from 41 to 71 percent).
- The next highest rates have been found among child molesters who offend against boys (13 to 40 percent).
- Recidivism rates for child molesters against girls (10 to 29 percent) appear to be similar to the recidivism rates for rapists (7 to 35 percent).

36 Cited in Solicitor General of Canada, *The Management and Treatment of Sex Offender*, 15.

37 R. Karl Hanson, Richard A. Steffy, and Rene Gauthier, "Long-Term Recidivism of Child Molesters," *Journal of Consulting and Clinical Psychology*, Vol. 61, No. 4 (1993), 646-652.

38 U.S. Department of Justice, "Recidivism of Prisoners Released in 1983," *Bureau of Justice Statistics Special Report* (Washington, D. C., April 1989).

- Incest offenders tend to have the lowest recidivism rates (4 to 10 percent).[39]

Studies of Treatment Effectiveness

We reviewed the literature on treatment effectiveness and we found that:

- **Few evaluations of sufficient quality to permit definitive conclusions about treatment effectiveness have been done, mainly because sex offender treatment evaluations are very difficult to do.**

An experimental design in which subjects are randomly assigned to a treatment group or an untreated control group is the best way to evaluate treatment effectiveness. Random assignment permits researchers to control for other factors that may affect recidivism when comparisons of recidivism rates between the two groups are made. However, many treatment professionals consider it unethical to withhold treatment from dangerous men. When random assignment is not possible, a "quasi-experimental" design may be used. For instance, a group of treated offenders can be compared with a group of untreated offenders who have been matched on other characteristics that may affect recidivism, such as type of offense and prior criminal history.

Good evaluations of treatment programs are difficult to do.

Both experimental and quasi-experimental designs are difficult to use in the case of sex offender treatment for the reasons summarized in Figure 2.2. As a result, there have been few studies that have achieved the level of scientific rigor needed to arrive at definitive conclusions about treatment effectiveness. For example, most treatment evaluations have reported the recidivism rates for treated offenders and have not included a controlled comparison with untreated offenders. Others have either failed to adequately describe the treatment received or specify how recidivism was measured, treated small numbers of offenders, or followed offenders for short periods of time. Some sex offenders may reoffend many years after an initial sex offense. Based on longitudinal studies that have followed sex offenders for 20 years or more (discussed above), it has been estimated that a minimum of five years would be needed for about 75 percent of the offenders who reoffend to appear in official records.[40]

While researchers agree that more and better research is needed, they disagree about how to interpret existing findings. There have been several comprehensive reviews of the treatment evaluation literature. One review by Furby and others examined eight studies that directly compared treated and

39 W. L. Marshall and H. E. Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," *Handbook of Sexual Assault*, 371.

40 Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project*, 8.

Figure 2.2: Reasons Why Sex Offender Treatment Evaluations are Difficult and Costly

Selection Biases

Offenders are initially assessed for amenability to treatment. Selection procedures that result in the exclusion of more difficult-to-treat offenders will result in lower recidivism rates. Thus, self-selection and program administrator selection biases affect evaluation results unless an evaluation includes adequate controls or random assignment.

Heterogeniety of Sex Offenders

Sex offenses encompass a range of deviant behaviors, including incest, same- and opposite-sex child molesting, and forcible rape (which varies in degrees of seriousness and motivation). Evaluation designs must control for offender and offense characteristics that are known to be associated with differential recidivism rates or include sufficiently large samples to ensure they are representative of the larger population of sex offenders.

Individualization of Treatment

Programs are diverse and treatment is typically geared to the specific needs of the individual offender. Variation in treatment makes evaluating effects across programs, as well as isolating treatment effects from other factors associated with recidivism, more difficult. Ideally, an evaluation would be able to specify why a program was effective or ineffective.

Program Attrition

It is not unusual for large numbers of offenders to withdraw or be terminated from treatment prior to completion. The overall effectiveness of treatment must take into account those who refuse to enter treatment and those who fail to complete it.

Different Measures of "Effectiveness"

There is no consensus in the literature on the best definition of program effectiveness. Most evaluations use "recidivism," although this may be defined in several different ways. Some studies use self-reported data. Other studies rely on intermediate behavioral measures, like polygraph tests, physiological measures, or questionnaire results.

Measurement Error

If official offense data are used exclusively, they are a major source of measurement error. First, those who reoffend must be apprehended by the police. Also, arrest and conviction data are subject to different priorities, definitions, and practices among criminal justice system agencies. For example, jurisdictions vary in their charging, prosecutorial, and plea-bargaining practices.

Sample Sizes and Follow-up Periods

Since only a proportion of sex offenders are likely to reoffend (regardless of whether they receive treatment), large initial samples are required, which add to the costs of evaluation. Also, the research suggests that the probability of sexual offenders committing another offense increases if measured over a longer period. Therefore, a long follow-up period is needed in order to ensure valid results, and evaluations should take into account the differential amount of time each offender is at risk.

Sources: Janice K. Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project* (Sacramento: California Department of Mental Health); Lita Furby, Mark R. Weinrott, and Lyn Blackshaw, "Sex Offender Recidivism: A Review," *Psychological Bulletin,* Vol. 105 (1989), 3-30; and W. L. Marshall and H. E. Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," *Handbook of Sexual Assault* (New York: Plenum Press, 1990), 363-385.

The results of treatment evaluations are inconclusive.

untreated offenders, but only one found a clear positive result. Based on their review, Furby and her colleagues concluded:

> Despite the relatively large number of studies on sex offender recidivism, we know very little about it. Because of the many practical difficulties of designing and conducting studies in this area, methodological shortcomings are present in virtually all studies ... There is as yet no evidence that clinical treatment reduces rates of sex offenses in general and no appropriate data for assessing whether it may be differentially effective for different types of offenders.[41]

Since the Furby article was published in 1989, the results of additional experimental studies have become available. Other researchers have found reason for encouragement, if the expectations for treatment are realistic and do not require that it be effective across all types of offenders and programs.[42] In their review of the literature, Marshall and others cited four out of five evaluations that found lower recidivism rates for some types of treated sex offenders compared to untreated offenders. They concluded that:

> Evaluations of outpatient cognitive-behavioral programs, then, are definitely encouraging. While there is not an extensive body of outcome literature, what there is suggests that at least child molesters and exhibitionists can be effectively treated by these comprehensive programs ... equally clearly, not all programs are successful and not all sex offenders profit from treatment. Comprehensive cognitive-behavioral programs and those programs that utilize anti-androgens in conjunction with psychological treatments seem to offer the greatest hope for effectiveness and future development. However, even here not all versions of these programs are equally effective and those that are do far better with child molesters and exhibitionists than with rapists.[43]

The results of several treatment outcome studies that included a comparison to an untreated control group are summarized in Table 2.1. This table illustrates the wide variation in recidivism rates found in studies, with some of the variation due to differing treatments, types of offenders, and follow-up periods. It also shows the conflicting findings in the literature, with some studies showing lower recidivism rates for treated offenders compared to an untreated group and others showing the opposite. However, only two studies, by Romero and Williams, and Marques and others, included random assignment to a control group. The Marques study presents the most recent results from the California Department of Mental Health's Sex Offender Treatment and Evaluation Project, initiated in 1985, which is considered the most sophisticated test of sex offender treatment undertaken to date.

The Minnesota Department of Corrections has also released preliminary results from its study of sex offenders released in 1988. The department has been monitoring recidivism rates for this group of offenders for the past five

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41 Lita Furby, Mark R. Weinrott, and Lyn Blackshaw, "Sex Offender Recidivism: A Review," *Psychological Bulletin,* Vol. 105 (1989), 3-30.

42 W. L. Marshall, et al., "Treatment Outcome with Sex Offenders," *Clinical Psychology Review*, Vol. 11 (1991), 465-485. See also Solicitor General of Canada, *The Management and Treatment of Sex Offenders* (1990).

43 Marshall, et al., "Treatment Outcome with Sex Offenders," 480-481.

years. The reconviction rates (sex offenses and other violent crimes) are 9.8 percent for offenders who completed treatment while in prison compared to 14.9 percent for those who did not enter treatment. This study also tracked sex offenders who entered treatment but failed to complete it, and found that this group had the highest reconviction rate at 25.6 percent. The Marques study tracked treatment dropouts and also reported that these offenders appear to have higher recidivism rates than both treated and untreated offenders.[44] These are the only two studies to report on recidivism for offenders who failed

Table 2.1: Summary of Sex Offender Treatment Outcome Studies

Study/Treatment Program	Offender Population	Follow-Up (Years)	Reported Recidivism Rates: Treated	Reported Recidivism Rates: Untreated	Selection of Untreated Comparison Group
Marshall and Barbaree (1988); outpatient, cognitive-behavioral	Child molesters (girls) Child molesters (boys) Incest offenders	4.0 4.1 4.0	17.9% 13.3% 8.0%	42.9% 42.9% 21.7%	Patients who expressed an interest in participating but were unable to do so.
Davidson (1979); inpatient (prison), cognitive-behavioral	Mixed	1-5	11.0%	35.0%	Comparison group selected from untreated offenders in same prison, but from an earlier time period.
Romero and Williams (1983); outpatient, group therapy	Mixed	10	13.5%	7.2%	Random assignment to treatment; comparison group placed on straight probation.
Rice, et al. (1991); inpatient (Psychiatric hospital), behavioral	Child molesters	6.3	37.9%	31.0%	Unknown.
Hanson, et al. (1992); inpatient (prison), individual and group therapy, some aversive conditioning	Child molesters	10-31	44.0%	48.0% 33.0%	Two comparison groups: one group from the same prison but released before treatment was offered; second group in prison at same time as those receiving treatment.
Sturgeon and Taylor (1980); inpatient (state hospital), group therapy	All offenders Girl molesters Boy molesters Rapists	1-5	15.4% 19.8% 14.6% 19.3%	25.0% 17.9% 37.5% 27.9%	Comparison group included those not accepted into treatment and those who received some treatment but failed to complete it to program's satisfaction.
Marques, et al. (1993); inpatient (state hospital), cognitive-behavioral	Child molesters	3.2	7.9% (sex offenses) 4.0% (other violent offense)	10.0% (sex offenses) 13.9% (other violent offense)	Random assignment of matched pairs of offenders (volunteers) to experimental or control (untreated) groups.
Kaul, et al. (1994); inpatient (Minnesota prison), group therapy	Mixed	5	9.8%	14.9%	Retrospective study of sex offenders released in 1988. Comparison group includes those who did not receive treatment while in prison.

Sources: Solicitor General of Canada, *The Management and Treatment of Sex Offenders* (1990); Lita Furby, et al., "Sex Offender Recidivism: A Review," *Psychological Bulletin*, Vol. 105 (1989), 3-30; W. L. Marshall and H. E. Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," *Handbook of Sexual Assault* (New York: Plenum Press, 1990), 363-385; R. Karl Hanson, et al., "Long-Term Recidivism of Child Molesters," *Journal of Consulting and Clinical Psychology*, Vol. 61 (1993), 646-652; Janice K. Marques, et al., "The Relationship Between Treatment Goals and Recidivism Among Child Molesters," forthcoming, 1994; and James Kaul, et al., "Sex Offenders Released in 1988" (St. Paul: Minnesota Department of Corrections, 1994).

44 Janice Marques, California Department of Mental Health Sex Offender Treatment and Evaluation Project, data presented at ATSA Conference, October 1992, which showed that non-completers had a recidivism rate of 33 percent, compared to 5 percent for treatment completers and between 7 and 8 percent for the control groups. However, these results were based on very small numbers of offenders. For a discussion of the drop-out issue, see Marshall and Barbaree, "Outcome of Congnitive-Behavioral Treatment," 374-375.

to complete treatment, although in many programs large numbers of offenders are terminated or withdraw from treatment (up to 30 to 50 percent).[45] The overall effectiveness of treatment cannot be measured only by those who complete treatment; rather, evaluation of treatment effectiveness must also consider the number who refuse to enter treatment or drop out before completing it.[46]

Few studies have tracked treatment dropouts, which may be as high as 50 percent.

SUMMARY AND CONCLUSIONS

Based on our review, we conclude that the literature on treatment effectiveness cannot provide policymakers with a clear answer of whether to provide treatment for sex offenders. There is no consistent, solid evidence that clearly proves that treatment reduces sex offender recidivism nor is there solid evidence that it does not. Furthermore, given the length of time needed to conduct treatment outcome studies, it is unlikely that definitive answers will be available in the near future. Hence, policymakers have to make decisions about treatment on other grounds, such as public opinion, values and beliefs, potential risks and benefits, or cost.

More and better research and evaluations of treatment are needed.

Our literature review also suggests that a consensus may be emerging among treatment professionals. Many professionals now believe that it may be unrealistic to expect that treatment can "cure" sex offenders, in the sense that it can totally eliminate the deviant sexual desires of all sex offenders. Rather, a more realistic goal of treatment is training or educating offenders on how to control their deviant behaviors, and it is unlikely to be effective with all offenders. This approach to treatment involves lower expectations and viewing the treatment and supervision of sex offenders as a long-term process.

The literature also offers some general observations. First, recidivism studies suggest that many sex offenders will not be reconvicted of a new offense, regardless of the type of treatment they receive or whether they receive treatment at all. Second, different types of sex offenders are likely to reoffend at different base rates (irrespective of whether they receive treatment). For example, incest offenders are less likely to reoffend compared with rapists. Third, in view of the wide variation in sex offenders, treatment programs, and research methods and measurements, evaluations of individual programs may not be comparable and must be examined carefully before conclusions are drawn about their relative effectiveness. Some types of programs may be effective with particular types of offenders, but not with others. One implication is that treatment effectiveness studies must be carefully designed or they can result in misleading conclusions.

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45 Cited in Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project*, 9-10.

46 Marshall and Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," 371-376.