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Sex offender treatment--Does it work? Is it worth it?

By Ron Kokish

This can be a controversial subject. What constitutes success? Do we look only at sexual re-offenses, or also at related (compulsive) behaviors like alcoholism, drugs, gambling, etc.? What about other crimes -- burglary, assaults, etc.? Do we look at the probationary period only, or is post-treatment considered? If post, how long? How do we get data? Self report? Crime reports? Family follow-up? How long do we follow up?How hard do we look for failure? Do we rely only on crime reports or do we do a confidential study where we annually polygraph people post treatment for ten years? How do we count drop outs in such a study? No one expects zero recidivism, so how much does a program have to reduce re-offenses to call itself successful?

Given all the difficulties, here are some things we do know. Barry Maletzky, MD and Kevin McGovern, Ph.D. of The Sexual Abuse Clinic of Portland Oregon followed about 5000 offenders treated in their clinic and similar clinics between 1973 and 1990 using behavior oriented methods. About 3700 of these were pedophiles, 770 were exhibitionists and the remainder were referred for a variety of other paraphilias.

Criteria for "success" included:

•No re-arrest •Self report of no maladaptive sexual behaviors •Reduced deviant arousal maintained post - treatment as verified on penile plethysmograph •"Significant other" ratings of patient behavior. Using these stringent measures to follow some men for as long as 17 years post treatment, success was achieved with 94.7% of heterosexual and 86.4% of homosexual pedophiles. Rapists showed 73.5% success, exhibitionists and public masturbaters about 92% , with men referred for various other paraphilias ranging from 100% for zoophiliacs to 80% for frotteurs. These data do not represent a controlled study, but the sample is large and with success criteria as stringent as they were, the data gives strong indication that treatment is effective for a great many offenders.

A June 1991 report to the State of Washington legislature also supports community treatment as a viable alternative for sex offenders. The report covers 613 probation eligible offenders sentences between January 1985 and July 1986. Three hundred thirteen of these actually received probation sentences while 300 were sent to prison. Both groups were followed. The probationers had significantly lower re-arrest rates and conviction rates in all crime categories. The study concluded that, generally speaking, probationary sentences did not place the community at undue risk and offered a cost - effective alternative to prison.

An Oregon study of sex offender monitoring using polygraphy indicated dramatic success having offenders complete their probationary periods without re-offenses.

In 1993 Margaret Alexander, Ph.D. (Oshkosh, Wis. Correctional Facility) examined no less than 424 studies. After eliminating 356 of them because they were poorly done she presented a "meta analysis" of the remaining 68 studies covering 7,753 offenders with some being followed as long as ten years post treatment. (ATSA National Training and Research Conference, Boston, 1993) Here are some of her findings. •Over all, treated offenders reoffended at a rate of 10.9%, untreated at 18.5%. •When subjects were followed for as long as ten years, the "treatment effect" weakened over time, but even in the tenth year, treated offenders reoffended only about 80% as often as untreated men. •Men treated before 1980 (more traditional methods) reoffended at a rate of 12.8%. while men treated after 1980 (present day methods) reoffended at 7.4% •Men receiving traditional only therapy reoffended at a rate of 13.4%, while men who received therapy and specific instruction in relapse prevention techniques reoffended at 5.9% •Treatment is more effective with child molesters and exhibitionists than with rapists, where treatment seemed to have hardly any effect at all. •Men who entered treatment voluntarily reoffended at 80% the rate of men mandated into treatment, but both groups did much better than untreated men.. •Men who dropped out of treatment reoffended almost twice as much as men who completed their programs.

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None of this represents true controlled studies. Such experiments are under way in California and Vermont using in-patient populations and preliminary data are promising, but samples are so small that really meaningful data will not be available until the year 2005 and even then we will not necessarily be able to generalize to out patient programs. Controlled out patient studies may never be done because of reluctance to have matched controls at large in the community without any treatment. Even the prison studies in CA and VT may never be complete, due to recent funding cutbacks.

Robert Prentky, Ph.D. (Bridgewater. Mass. Correctional Facility) developed a cost effectiveness model for "success." He suggested comparing the cost of prosecuting a single re-offense, incarcerating the offender, and treating one additional victim to the cost of meaningfully treating an offender during his initial incarceration. According to his figures, Bridgewater program is cost effective if it reduces re-offenses by 11%. When Janice Marques applied his model to California she arrived at a 14% cutoff.

Conclusions Given available data, it appears that out patient programs do much better than that. In fact, it does not seem unreasonable to assume we cut re-offenses in half, that we teach offenders some empathy, so that they generally treat others better, and that we make a significant contribution to their social functioning (reduce non-sexual crimes, improve employment performance, etc.).

The United States already locks up a greater percentage of its people than any western nation while California, with about 10% of the country's population accounts for about 14% of the state prison population. Under the circumstances, strict conditions of probation, close monitoring and quality treatment paid for by the offenders themselves is clearly the most promising alternative. "We are beyond the point of asking whether treatment for child molesters works. Data indicate that it works for some in the short run and for others in the long run..... At the moment there is insufficient data to identify in advance those patients who will profit least,(except of course for rapists), and this topic urgently needs rearch. However, such research should be directed at what it is current programs are missing rather than identifying who should or should not be treated..... Data are now available and should be presented to legislators to inform them that not only is it efficacious to provide treatment to men who molest children, but it is also cost effective."