OFFENDERS

EVALUATING SEX OFFENDER TREATMENT PROGRAMS

—by Robert Prentky

Broadly speaking, sex offender treatment programs employ three approaches: (a) insight-oriented and/or evocative therapy, which focuses on understanding the causes and motivations leading to maladaptive behavior, increasing offender empathy for the victims of sexual assault, and increasing offenders' sense of responsibility for their sexual crimes; (b) behavioral therapy, which focuses on techniques that attempt to remedy deficits in social and interpersonal skills, alter cognitions that serve to justify and perpetuate sexually aggressive behavior, and modify deviant patterns of sexual arousal or preference, and (c) pharmacological treatment, which focuses on reducing sexual arousability and the frequency of deviant sexual fantasies through the use of anti-androgens and, recently, anti-depressants.

These approaches are not mutually exclusive. The trend in recent years has been for treatment programs to employ all three approaches to varying degrees. Due to space considerations, however, this article will focus on behavioral techniques, including the cognitive-behavioral technique generally known as relapse prevention (RP). These are the most widely-used techniques and, as a result, the most carefully studied. It should be said at the outset, however, that not enough data exist to make clearcut evaluations of treatment efforts.

Behavior Therapy

Behavioral techniques for modifying sexual arousal may be grouped into two categories: techniques aimed at decreasing deviant arousal (e.g., covert sensitization, aversion, masturbatory satiation, biofeedback, shame therapy) and techniques aimed at increasing appropriate arousal (e.g., systematic desensitization, fantasy modification and orgasmic reconditioning, "fading" techniques, exposure to explicit appropriate sexual material). Most behavioral research on methods for eliminating inappropriate sexual behavior has focused on covert sensitization and/or aversion therapy. Fay Honey Knopp and her colleagues (Knopp et al., 1986) reported that 190 of the 297 (or 64%) of the identified service providers for adult sexual offenders employed behavioral methods, and 95 of those service providers (50%) used aversion therapy as part of the behavioral program.

Both covert sensitization and aversion therapy follow a standard classical conditioning paradigm in which a noxious stimulus is paired with auditory or visual stimuli of deviant sexual content. In aversion therapy, the deviant stimuli typically are paired with noxious odors or sine wave shock. In covert sensitization, the deviant stimuli typically are paired with negative mental images (e.g., a physically unpleasant experience such as vomiting or having a cavity filled or a psychologically unpleasant experience such as being apprehended by the police and going to prison). Although over 20 different behavioral techniques have been reported in the literature, the most widely used methods have involved some variant of aversion. The relative efficacy of the different aversive techniques with different types of offenders remains an empirical quesion. Moreover, the extent to which response inhibition after repeated exposure to aversive experiences generalizes to different (albeit related) deviant stimuli and to different situations remains to be demonstrated.

Relapse Prevention

Cognitive behavioral techniques such as relapse prevention are employed in many treatment programs. In such efforts, sexually aggressive behavior is conceptualized as an addiction with most of the properties of other addictions, namely a compulsion or urge to engage in inappropriate behavior that is sparked by an antecedent (signal) event. Although the precise nature of the event is unique to each individual, the most common class of such events anteceding relapse among sex offenders is thought to be a negative emotional state. Bill Pithers and his colleagues in the Vermont Treatment Program for Sexual Offenders have reported (Pithers et al., 1988) that for rapists the most frequently described emotional experience just prior to the offense was generalized, global anger (88% of sample) and anger towards women (77% of sample). For child molesters, on the other hand, the most frequently identified experience just prior to the offense was not an emotional state but planning the offense (73% of sample) and low victim empathy (71% of sample).

The relapse prevention model targets three areas of assessment: 1) those situations that place an individual at risk for relapse, 2) the adequacy of the individual's skills for coping with high risk situations, and 3) the identification of those antecedent events that permit hypotheses about why the maladaptive coping response is to aggress sexually. Once this information is elicited, two interventions are employed: 1) strategies that help the individual avoid high risk situations, and 2) strategies that minimize the likelihood that high risk situations, once encountered, will lead to relapse. In the jargon of sex offender treatment, high risk situations are referred to as "warning signals," "red flags," or "lapses." This "internal self-management" system has been extended by Dr. Pithers to include an "external supervisory dimension." Because offenders can be unreliable informants with regard to "lapses," this new dimension is intended to provide an additional source of information from "collateral contacts" in the community.

Treatment Programs in Two States

One of the preeminent residential treatment and evaluation programs in the U.S. at this time is in California under the baton of Janice Marques (Marques, 1988). The program, initiated in 1985 by the California Department of Mental Health, was designed as a six-year project, with a recently extended sunset date of June 30, 1995. The program, which is geared toward men who are 1.5 to 2.5 years away from discharge from the residential facility, includes three groups: 1) an experimental group consisting of those men who volunteered and who were randomly selected for the project, 2) a matched control group of men who volunteered but were not randomly selected for treatment, and 3) a matched control group of men who did not volunteer for treatment. The centerpiece of the program is relapse prevention. In addition, it includes an aftercare component in which, as a condition of parole, offenders must attend two treatment sessions a week for the first year. Although it is too soon to draw any reliable conclusions, the last report to the California State Legislature (July 1, 1989) revealed a "treatment effect" of 11.4% (i.e., a reduction in recidivism of 11.4%). This is based upon a heterogeneous sample of 47 treated offenders and 49 control subjects. For both groups, the average amount of time "at risk" was only about one year. Clearly, the small size of the discharge samples and the short at-risk period preclude any verdicts at this time. The next report to the State Legislature will be available in the late summer of 1991 and should include data on 80+ treated offenders. Thus far, preliminary results are encouraging.

It may be instructive to compare Dr. Marques' program with another, equally well-known and highly regarded, program directed by Dr. Pithers in Vermont. The Vermont program is a combination of community-based outpatient and residential inpatient therapy groups. Dr. Pithers reported a 4% relapse rate from a five-year follow-up of 167 treated offenders (Pithers et al., 1988).

These two programs provide an excellent example of the problems encountered when trying to make cross-study comparisons. Both treatment programs employ relapse prevention as their model. But the similarity stops at that point. Although neither project incorporates taxonomic differentiation, we may reasonably infer that the Vermont sample is less "hard core" than the California sample, since the California sample is incarcerated. Dr. Marques randomly assigns subjects while Dr. Pithers screens subjects. Although the core of the relapse prevention model is fundamentally the same in both programs, the full treatment regimen and the manner and duration of its implementation are not the same. The assessment instruments are different, as are the procedures for follow-up and the definition of relapse (i.e., arrest in California and incarceration in Vermont). Taken independently, both programs are well-known, highly-respected, and generally considered "models." Yet no accurate outcome comparisons can be drawn between them.

Outcome Evaluation

Variations in recidivism rates associated with different treatment programs are extremely difficult, if not impossible, to interpret. Recidivism rates across studies are confounded by numerous factors, including the criterion for reoffense, duration of follow-up, the domain of criminal behavior surveyed, the sources used to document reoffense, offender characteristics, differential attrition rates, differences in program integrity and amount of treatment, amount and quality of post-treatment supervision, and a host of other variables. In addition, recidivism measures tend to be hard to assess, and result in comparisons of low statistical power. Even without attempting to attribute variations in recidivism to treatment program characteristics, the variation in recidivism rates in the published literature

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are truly remarkable.

Although there have been no comparisons of different treatment approaches within the same study using random assignment of offenders to treatment conditions, there have been some treatment/no treatment comparisons using matched designs or convenience samples. Two recent studies will be described and discussed.

Using a sample of 126 treated and untreated child molesters, Marshall and Barbaree (Marshall and Barbaree, 1988) obtained large differences in recidivism rates (as estimated by official police records and unofficial records of police and child protective agencies) between clients given cognitive-behavioral treatment in a community clinic and similar but not randomly assigned clients given no treatment. Among extrafamilial heterosexual child molesters, recidivism rates over approximately four years were 43% for untreated and 18% for treated molesters. Among extrafamilial homosexual child molesters, recidivism rates were 43% for untreated and 13% for treated molesters. For heterosexual incest offenders, recidivism rates were 22% for untreated and 8% for treated offenders.

Rice, Quinsey and Harris (Rice, Quinsey, and Harris, 1989) estimated the recidivism rates of 136 extrafamilial child molesters over an average 6.3 year follow-up period. These men were incarcerated in a maximum security psychiatric institution between 1972 and 1983. Fifty of these offenders had participated in a behavioral program designed to alter inappropriate sexual age preferences. Following release from the institution, 31% of the total sample were convicted of a new sexual offense, 43% were known to have committed a violent or sexual offense, and 58% were arrested for any offense or returned to the maximum security institution. On the basis of a number of comparisons, the authors concluded that behavioral treatment did not affect recidivism.

The differences between the outcomes of the quasi-experimental treatment evaluations reported by Drs. Marshall and Barbaree and Drs. Rice, Quinsey, and Harris illustrates the difficulties in arriving at definitive conclusions concerning treatment efficacy. Among the more important of the myriad of differences between the studies are the locus of the program (maximum security psychiatric facility versus the community), severity of the offense history of those treated in the program, and differences in the nature and amount of treatment received. Any or all of these (or other) confounded variables could be responsible for the markedly different results. Perhaps the strongest conclusion that one can draw from this literature is that treatment can reduce recidivism, but that the aspects of treatment, client population, supervision, and setting characteristics related to successful outcome remain, at present, an empirical question

Overview

Despite the weakness of the outcome literature, scientific progress, however limited, has been made, and more certain conclusions from future investigations are likely. This conclusion rests upon a number of considerations. *First*, there has been a burgeoning of interest in the issue of sexual assault. Talented therapists and researchers have been attracted to the field, and more offenders are currently receiving some form of treatment than before. Even allowing for the faddishness of clinical and scientific interest in this area, the sheer number of professionals now working in the field assures no future dearth of programs to evaluate.

Second, the apparent failure of more traditional correctional remedies, such as deterrence and incapacitation, to reduce reported frequencies of sexual assault or recidivism rates means that other interventions must be actively considered. In addition, and perhaps more importantly, even relatively small reductions in recidivism rates occasioned by treatment result in significant savings, given the great expense of legal and correctional intervention, and the incalculable human costs of recidivism.

Third, advances have been made in assessment that are directly relevant to the future development of treatment programs. Noteworthy progress has been made in the development and validation of classification systems, offering the promise of differential treatment programming and reduction in the heterogeneity of treated samples. Similarly, progress has been made in the development and validation of risk assessment instruments and self-report inventories designed for sex offenders. In addition, the discriminant validity and the limitations of the phallometric assessment of sexual age preferences have now been solidly and replicably established.

Fourth, it is now well established that pre-post treatment effects can be obtained on phallometric measures of sexual preference, sexual knowledge, and heterosocial skills training. Treatment-induced changes in beliefs and values have not received as much study. These sorts of demonstrations that treatment can achieve at least proximal goals are encouraging.

Fifth, treatment manuals now beginning to emerge are of sufficient specificity to permit standardization of procedures and thus cross-site replication and monitoring of treatment. These manuals are a prerequisite for the advancement of knowledge in the treatment of sex offenders.

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