Treatment of Adult Sex Offenders

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With contributions from Gail Burns-Smith

The purpose of this article is to provide an overview of the current state of sex offender treatment, with a focus on the question of the effectiveness of treatment. We begin by discussing some problems that arise in answering this question, followed by a brief discussion of the history of sex offender treatment, and a more in-depth discussion of studies that have looked at the effectiveness of treatment programs, most of which took place under markedly poor conditions (in highly restrictive prison environments). The larger question – and the "bottom line" concern – is the overall effectiveness of management strategies for reducing sexual victimization rates. Management of sex offenders in the community (i.e., on probation or parole) makes use of, in varying degrees, numerous strategies, including supervision by trained probation and parole officers, medication, substance abuse screening, polygraphy, tracking with global positioning systems (GPS), community notification, and treatment. In this article we only address treatment of adult males. All of these other strategies can, and should, be evaluated for their effectiveness alone and in combination, but doing so is beyond the scope of this paper.

The effectiveness of treatment, or any other management strategy for that matter, boils down to one question: Does it reduce victimization and, if so, by how much? We try to answer this question by examining the re-offense rates of known sex offenders. Available data admittedly provides an imperfect answer. The number of sex offenders known to the criminal justice system represents only a small proportion of the total estimated number of sex offenders. Moreover, among those who are known to the criminal justice system, our estimates of re-offense rates are based only on those prosecuted and convicted of sex crimes. As such, our analysis does not include persons who commit at least three types of "re-offense" – those who are caught but not prosecuted for a sex re-offense, those who are prosecuted for a sex re-offense but are not convicted or pled to non-sexual charges, and those who were caught, prosecuted, or convicted for an offense that was not a sex offense (ie, a property crime). To reiterate, the term "re-offense," as used throughout this paper, signifies a sex offender who as been caught, prosecuted, and convicted for a subsequent sex offense.

Of all of the groups of individuals who are treated for behavioral problems, sex offenders may be the only group generally considered by many clinicians, and certainly by the general public, to be "untreatable." Since the problematic behaviors evidenced by sex offenders are often quite similar, if not the same, as behaviors observed among many non-offenders (e.g., anger management problems, social skills deficits, depression, low self-esteem, impulse control problems, sexual entitlement, and distorted attitudes justifying antisocial behavior), it is not clear why sex offenders, as a group, are commonly viewed as untreatable. One plausible explanation has to do with misconceptions about sex offenders held by the public.

One clear misconception concerns sexual re-offense rates. As Hanson, a noted researcher, pointed out, when interviewed for an article in the American Psychological Association's magazine, Monitor on Psychology, even law enforcement officials typically think that the sexual re-offense rates of sex offenders are very high, generally 70% to 80%, whereas the actual documented rates are 10% to 20% (Kersting, 2003). Indeed, a Bureau of Justice Statistics (U.S. Department of Justice) report

*The production and dissemination of this publication was supported by Cooperative Agreement Number U1V/CCU324010-02 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC, VAWnet, or the Pennsylvania Coalition Against Domestic Violence.

indicated that the re-arrest rate for new sexual offenses for 9,691 sex offenders from 15 states was 5.3% over 3 years (Langan, Schmitt, & Durose, 2003).

This particular misconception is important from the standpoint of understanding the effectiveness of treatment for sex offenders. As we will see, we examine the effectiveness of treatment by comparing groups of similar sex offenders ("matched" for characteristics that are considered important, such as age, race/ethnicity, and sexual offense history), some of whom have been treated and some not. The groups of treated and non-treated offenders are followed in the community for a number of years and the re-offense rates recorded. The differences in re-offense rates between groups must be large enough to be statistically significant. If the differences are statistically significant, we report that treatment was "effective" in reducing re-offense.

The issue of statistical significance is critical, since it determines whether we conclude that treatment is effective. When the proportion of non-treated sex offenders who re-offend is relatively small (for example, around 15%) the proportion of treated sex offenders who re-offend must be very small (around 8-10%) for there to be a statistically significant difference. At the present time, given current methods of treatment and conditions of treatment (typically in prison), reducing re-offense rates among treated sex offenders to 8-10% is rarely accomplished. The result is a mixed, and often confusing, message. Treatment often reduces re-offense rates but not enough to be statistically significant. This same "mixed message" has been trumpeted both by treatment advocates and treatment opponents to support their "causes."

Unfortunately, there is no simple way of trying to make sense of this mixed message. There are two realities that we must accept: (1) Management and treatment decisions regarding sex offenders are frequently uninformed by research and driven by high voltage feelings, passionate convictions, and social and political agendas, and (2) Personal, legal, and methodological considerations limit, often profoundly, accurate estimates of the number of sexual assaults in a given year, the total number of offenders committing sexual assaults, and the actual effectiveness of treatment. The net result is that we simply do not have sound, reliable information on the incidence of sexual assault, or, for that matter, the real effectiveness of treatment if provided under optimal conditions to a much larger proportion of the offending population.

History of Sex Offender Treatment

Until the mid-1980s the treatment of sex offenders was conducted primarily in civil commitment programs in a few state hospitals, prisons, and outpatient clinics scattered around the country. Sex offenders were often treated using a variety of psychodynamic and client-centered techniques. A major shift in the field came in 1983 with the publication of an article that presented for the first time a relapse prevention model designed for sexual offenders (Pithers, Marques, Gibat, & Marlatt, 1983). Pithers and Marques adapted the work pioneered by Marlatt for alcoholics. Relapse prevention is essentially a self-control model that teaches the individual to identify and recognize a unique pattern of thoughts, feelings, and situations that precede and lead to relapses. Relapse in the case of sex offenders is a re-offense. This pattern has a "signature" quality to it. It is tailored to the cognitive, affective, and situation markers that are unique for each individual. Once the pattern is fully understood, the individual learns strategies for interrupting the pattern, or offense "cycle" as it is referred to.

By 1984, the relapse prevention model was adopted by the National Academy of Corrections (NAC). NAC trained teams from most of the fifty states and established a uniform model of treatment in correctional institutions. The treatment model developed in the early 1980's has not changed substantially over the past twenty years or more. The same relapse prevention model, with some revisions and adaptations (Laws, Hudson, & Ward, 2000), continues to be used today.

Perhaps the most significant change has been the increasing acceptance of the importance of medication as an adjunct to therapy. The pharmacological

options includes three categories of drugs: (1) a class of anti-androgens that lower testosterone, such as Depo Provera, (2) a different, more powerful, class of anti-androgens that can lower testosterone to castrate levels, such as Lupron and Zoladex, and (3) a class of anti-depressants called selective serotonin reuptake inhibitors (SSRI's), such as Prozac, Paxil and numerous others, used primarily, as noted, for the treatment of depression and obsessive-compulsive symptoms (Kafka, 1997, 2001, 2003). It should be emphasized in the strongest of terms that medication is: (1) not a "quick fix" for all sex offenders, (2) not needed, and indeed not appropriate, for all sex offenders, and (3) not an isolated treatment (i.e., it is administered in conjunction with psychotherapy). Having said that, it must be equally emphasized that, when appropriate, medication can be a very potent addition to treatment.

Those sex offenders that can benefit the most from medication fall into roughly two broad categories: (1) sex offenders with very strong, sometimes irresistible sexual urges; for these individuals, gratifying sexual urges can be highly compulsive; anti-androgens, which lower testosterone, reduce considerably the frequency and intensity of sexual thoughts, sexual fantasies, and sexual urges, (2) sex offenders with a history of depression and/or anxiety may have learned to cope with those negative emotional states by temporarily soothing themselves with a sexual experience; these individuals may be helped with the class of anti-depressants known as SSRIs. An additional benefit of the SSRIs is a common side effect of this class of drugs - a decrease in sexual interest or drive and occasional sexual dysfunction (reduced ability to reach orgasm, erectile dysfunction, or ejaculatory failure).

What can we conclude about the Effectiveness of Treatment?

In times of limited resources, demonstrating that sex offender treatment actually reduced repeat offending became increasingly important. Evaluating the effectiveness of therapy for sex offenders, however, proves to be complicated. All treatment outcome studies, including those targeting sex offenders, must control for individual differences among therapists, regardless of the technique used, establish adequate control groups, and address ethical issues, such as denying treatment to patients and measuring outcomes. Although the last problem is easily addressed with sex offenders, since the outcome is typically whether the individual re-offends sexually, there are problems with accomplishing this task accurately. How studies define "recidivism" (e.g., new charge or arrest, new conviction, technical violations of probation and parole), the sources of data that are relied upon, and length of time that offenders are followed all produce variability among studies (Prentky, Lee, Knight, & Cerce, 1997). In addition, of course, all treatment outcome studies with sex offenders are plagued with the problem of unknown, unreported, or otherwise undetected recidivism, due in large part to low reporting rates, as well as the problem of "selective attrition" (treatment and control drop-outs).

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. Matched designs are particularly effective, since they match treated and non-treated offenders on potentially important factors, such as age, intelligence, "type" of offender (e.g., rapist, incest offender, or child molester), total number of known sex offenses or total number of known victims, and other variables. By insuring that the two groups (treated and untreated) are as similar as possible, we can properly attribute any differences in recidivism to the treatment.

Research

A powerful statistical technique for looking at the question of how effectively treatment reduces recidivism is meta-analysis. Meta-analysis is a statistical procedure for evaluating the results of a group of studies by combining them. The result is a potentially very large total sample. In the first of several meta-analyses of treatment studies with

sexual offenders, Hall (1995) found a small but significant overall effect size for treatment. The effect size is a statistic that reflects the strength of the effect of an intervention, such as treatment. In Hall's meta-analysis, 12 studies were combined for a total sample of 1,313 sex offenders. The recidivism rate for all treated sex offenders was 19%, compared with the recidivism rate of 27% for all untreated sex offenders. The effect size for treatment was stronger in those studies that used cognitive-behavior therapy or anti-androgen medication. Cognitive-behavior therapy and anti-androgen medication were significantly more effective than behavioral techniques, such as covert sensitization or aversion. Covert sensitization and aversion are techniques used to decrease deviant arousal, mentioned previously. In Hall's meta-analysis, cognitive-behavioral therapy and anti-androgen medication appeared to be equally effective in reducing recidivism. Not surprisingly, the treatment effect sizes for the 12 studies were quite different. Hall (1995) suggested that the likely causes of the different effect sizes were: (a) highly variable base rates of recidivism, (b) variable length of follow-up after treatment, (c) the degree of "pathology" of the offenders in the different studies, and (d) the types of treatment provided in the different studies.

A General Accounting Office study summarized 22 reviews of research on sex offender treatment (GAO, 1996). Although not a meta-analysis, the reviews, which were published between 1977 and 1996, covered 550 studies. The gist of the GAO (1996) report was that the results were promising but inconclusive: "The most optimistic reviews concluded that some treatment programs showed promise for reducing deviant sexual behavior. However, nearly all [of the reviews] reported that definitive conclusions could not be drawn because methodological weaknesses in the research made inferences about what works uncertain. There was consensus that to demonstrate the effectiveness of sex offender treatment more and better research would be required," (GAO, 1996).

From a scientific standpoint, the very best treatment outcome study, which included random assignment to treatment and no treatment groups, was California's Sex Offender Treatment and Evaluation Project (SOTEP). Stationed at Atascadero State Hospital, SOTEP operated from 1985 to June, 1995, with the final wave of data collected in 2000. The most recent recidivism data, reported by Dr. Marques and her colleagues in 2005, indicated that, with an average of 8 years at risk, the 167 subjects who completed treatment did not have a lower sexual re-offense rate (22%) than the 225 volunteer control subjects (20%) or the 220 non-volunteer controls (19%). Indeed, it would appear that the treated group actually had a slightly higher reoffense rate than the other groups. Included in the treated group, however, were 1) those who withdrew prior to receiving any treatment and 2) those who either quit or were removed from the program. A weakness of the SOTEP study was the relatively small number of treated offenders (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005).

The weakness in the SOTEP study was addressed by the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002) Hanson and his colleagues reported on a meta-analysis of 43 studies with a total of 9,454 subjects (5,078 treated and 4,376 untreated). Although the average period at risk was 46 months, follow-up periods ranged from 12 months to 16 years. Averaged across all studies, the sexual recidivism rates were 12.3% for treated and 16.8% for untreated subjects, a difference of 4½ % in favor of treatment. A further analysis that selected only more recent treatment studies, presumably using state of the art treatment (i.e., cognitive behavioral) yielded a sexual recidivism rate of 9.9% for treated offenders and a sexual recidivism rate of 17.4% for untreated offenders, a difference of 7½ % in favor of treatment

The most recent meta-analysis collapsed across 69 studies with a total sample size of 22,181 sex offenders (Losel and Schmucker, 2005). This study, conducted by investigators in Germany, included documents published in five languages, and thus reflected a more European flavor than the predominantly "Anglo" studies examined in the

Collaborative Outcome Data Project. Overall, Losel and Schmucker found a 6% reduction in sexual recidivism with treatment.

Zgoba and Simon (2005) compared sex offenders drawn from New Jersey's sex offender prison where treatment is provided (total sample of 495) with sex offenders drawn from the general prison population. Of the total sample, 14% committed a new sexual offense over seven years. Importantly, the sexual recidivism rates were not significantly different between the treated and non-treated sex offenders: 15% vs. 19.4% of the rapists and 11.3% vs. 16.1% of the child molesters, respectively.

The large sample sizes and the diversity of the studies examined in the Collaborative Outcome Data Project and the study by Losel and Schmucker (2005) provide reasonably convincing evidence that treatment can reduce sexual recidivism. How much, however, remains uncertain. The most reasonable estimate at this point is that treatment can reduce sexual recidivism over a 5 year period by 5 - 8%. We must hasten to point out, however, that there are numerous factors that can influence the assessed effectiveness of treatment in lowering sexual recidivism rates, including the quality of the treatment program, treatment completion vs. drop-outs, provision of outpatient treatment, provision of a variety of other management strategies, and the age of the offenders. Thus, this estimate of 5% - 8% must still be regarded as crude, most importantly because it collapses across a highly mixed population of offenders with widely varying risks of recidivism. Not only do rapists, child molesters, and incest offenders pose different risks for sexual recidivism, re-offense risks vary widely within each subgroup and among criminals who offend in more than one subgroup.

In a paper on the critical role of recidivism rates in treatment outcome studies, Barbaree (1997) concluded that, "Recidivism studies were found to be quite insensitive to the effects of treatment," (p. 111). The problem is a relatively simple one. As Barbaree noted, the rates for sexual recidivism across studies may range from 10% to 40%. Sample sizes in most studies are generally small, rarely more than 200 offenders. When the rates are quite low, close to 10%, the treatment effect has to be very large (greater than 50%) to observe a significant difference between treated and untreated offenders. It is unrealistic to expect treatment effects of that size. Consequently, as Barbaree demonstrated, it is unlikely that conventional treatment outcome studies will be able to demonstrate significant treatment effects.

According to the 2004 National Crime Victimization Survey, there were 209,880 rapes and sexual assaults in 2004 (Catalano, 2005), and these estimates do not include child victims of sexual assault (age 11 or younger). The NCVS figure reflects a broad estimate of the number of incidents of sexual assault in 2004. This estimate does not mean that there were 209,880 offenders, since many offenders commit multiple assaults. Moreover, this estimate does not mean that there were 209,880 victims, since some victims may have been assaulted on multiple occasions. Although we do not know from this estimate how many individual offenders were responsible for almost 210,000 reported sexual assaults in 2004, it is reasonable to surmise that the number is considerable. Of these offenders, a substantial proportion were undoubtedly already known to the criminal justice system and could have been required to participate in treatment. If we accept, as a general rule, that out of every 100,000 identified sex offenders, treatment can reduce sexual recidivism by 5% to 8%, the end result may be 5,000 to 8,000 fewer recidivists (individuals who commit further sexual assaults). Thus, relatively small reductions in sexual recidivism rates can have a notable impact on the number of victims, even if the reduction in sexual recidivism is not "statistically significant."

Concluding Thoughts about the Role of Treatment

Given the failure of more traditional correctional remedies, such as deterrence and incapacitation, for reducing the level of sexual violence in society, other interventions must be actively sought. One potentially effective intervention for known offenders is treatment. A dispassionate conclusion would be that treatment is not likely to be effective for all offenders

and that treatment is likely to be effective for some offenders. Essentially, such a conclusion is accurate and, for most of us, obvious. Given the extraordinary variation of sex offenders, it would be only logical that some, but not all, offenders would benefit from treatment. Stated otherwise, treatment undoubtedly will help to restore some offenders to a nonoffending lifestyle and will fail to touch other offenders. The answer to the question of "how many" fall into each category is unclear, since, as we have seen, it often depends on the particular sample. Based on the research discussed here, it is reasonable to conclude that current treatment interventions can reduce rates of sexual recidivism by 5% – 10% in mixed samples of adult male sex offenders. Perhaps the more pressing question, certainly from a public policy standpoint, is "who" is most likely to be impacted by treatment and how best should they be treated. When resources are limited, optimal resource allocation becomes critically important.

In sum, the verdict as to the effectiveness of treatment for sexual offenders will inevitably be a complex one that addresses: (a) optimal treatment modalities for specific subtypes of offenders, (b) optimal conditions under which treatment and follow-up should occur, and (c) selection (or exclusion) criteria for those assigned to treatment. Although these more complex issues can be answered by research, the emotionally-charged climate that drives policy and ultimately law as a strategy for managing sexual offenders is all too often uninformed by research. Treatment too often becomes a tool for justifying social and legal remedies rather than a tool for advancing those remedies. As a justification for instituting statutory management schemes, such as civil commitment, prison-based treatment programs often provide more solace to the courts than to the offenders.

Treatment should be regarded as one potentially effective intervention for managing the risk of sexual offenders that have been returned to the community. Treatment should not be regarded as a cure for sexual offenders, or as a stand-alone intervention. Treatment is one element of a comprehensive release plan that may include medication, probation, GPS monitoring, polygraphy, random urine screens, and other interventions.

The most important point, however, is that the overarching goal of reducing sexual violence in society must rest squarely with the forces within society that promote and foster sexual violence. Sexual violence is a serious public health problem. The branches of this pervasive problem insinuate themselves into, and directly affect, all aspects of society. The problem is not confined to the handful of offenders who spend time in prison and are offered some form of treatment. By merely reducing the risk of those who have already turned to sexual violence, we will never achieve the ultimate aim of making society a safer place by restoring the rights to sexual autonomy for women and children.

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Suggested Citation: Prentky, R. & Schwartz, B. (December, 2006). *Treatment of Adult Sex Offenders*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Retrieved month/day/year, from: http://www.vawnet.org

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The Center for Sex Offender Management
www.csom.org

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The National Adolescent Perpetrator Network
www.kempe.org

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In Brief: Treatment of Adult Sex Offenders

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This article provides an overview of the current state of treatment of adult male sex offenders, with a focus on the effectiveness of treatment, which boils down to one question: Does it reduce victimization and, if so, by how much? Available data admittedly provides an imperfect answer. The term "re-offense" signifies a sex offender who as been caught, prosecuted, and convicted for a subsequent sex offense. Re-offenders represent only a small proportion of the total number of sex offenders.

Relapse prevention, a treatment model developed in the early 1980s that continues to be used today, is a self-control model that teaches the individual to identify and recognize a unique pattern of thoughts, feelings, and situations that precede and lead to relapses. It is sometimes used in conjunction with medications. Evaluating the effectiveness of therapy for sex offenders, however, proves to be complicated. All treatment outcome studies, including those targeting sex offenders, must control for individual differences among therapists, regardless of the technique used, establish adequate control groups, and address ethical issues, such as denying treatment to patients and measuring outcomes. Treatment often reduces re-offense rates but not enough to be statistically significant. This result is a mixed and often confusing message that has been trumpeted both by treatment advocates and treatment opponents to support their "causes."

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Given the failure of more traditional correctional remedies for reducing the level of sexual violence in society, other interventions must be actively sought. One potentially effective intervention for <u>some</u> known offenders is treatment. Perhaps the more pressing question, certainly from a public policy standpoint, is "who" is most likely to be impacted by treatment and how best should they be treated. When resources are limited, optimal resource allocation becomes critically important. Treatment should be regarded as one potentially effective *intervention* for managing the risk of sexual offenders that have been returned to the community. Treatment should not be regarded as a *cure* for sexual offenders, or as a *stand-alone* intervention. Treatment is one element of a comprehensive release plan that may include medication, probation, GPS monitoring, polygraphy, random urine screens, and other interventions.

The most important point, however, is that the overarching goal of reducing sexual violence in society <u>must</u> rest squarely with the forces within society that promote and foster sexual violence. By merely reducing the risk of those who have already turned to sexual violence, we will never achieve the ultimate aim of making society a safer place by restoring the rights to sexual autonomy for women and children.

*The production and dissemination of this publication was supported by Cooperative Agreement Number U1V/CCU324010-02 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC, VAWnet, or the Pennsylvania Coalition Against Domestic Violence.