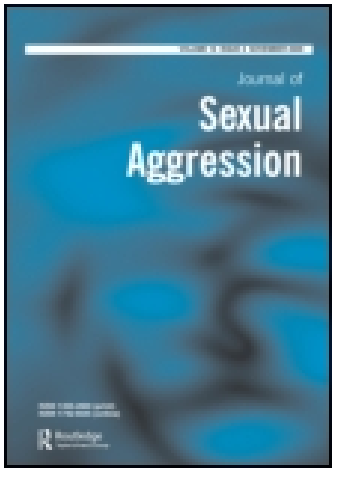

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Treating sexual offenders: how did we get here and where are we headed?

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Treating sexual offenders: how did we get here and where are we headed?

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Abstract *The field of sexual offender treatment has drawn inspiration from two major social movements: The women's movement, which defined sexual victimisation as a serious social problem, and correctional rehabilitation, which provided the vision and methods to reintegrate offenders as law-abiding citizens. In this retrospective, I argue that we should also be guided by a third social force: The movement for evidence-based practice. In order to realise the potential of evidence-based practice, we need to support more and better research on sexual offender treatment.*

Keywords *Sexual offenders; rehabilitation; evidence-based practice*

The *Journal of Sexual Aggression* is a visible product of an organisation committed to providing human service interventions to sexual offenders (National Organisation for the Treatment of Sexual Abusers). The journal is now more than 20 years old and publishes articles from credible researchers and committed practitioners around the world.

How did we get here?

When sexual offenders are mentioned, not everybody's first thought is "let's help them". More commonly, we hear fear, anger, disgust or morbid curiosity. So how did we end up with a well-established professional field of sexual offender treatment? The development of the field cannot be attributed to strong empirical evidence that such treatment is effective. The overall evidence for treatment effectiveness is weak at best (Dennis et al., 2012; Långström et al., 2013). Furthermore, the changes in our treatment practices during my professional career have had only the loosest inspiration from research findings. It is hard to argue that we switched from aversive conditioning to relapse prevention (RP) and from RP to Good Lives because of any deep commitment to evidence-based practice.

First, it is important to recognise the contribution of the women's movement. Given that it is women and children who all too frequently experience the negative consequences of sexual victimisation, the women's movement is a core stakeholder in sex offender policies and laws. We needed to hear and respect their voices before significant public resources were devoted to the problem. Some of us are old enough to remember when therapists considered patients' disclosures of sexual abuse as the fantasies of hysterics (Masson, 1984). The

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women's movement has been instrumental in shaping our belief that offenders, and not the victims, are the agents responsible for sexual abuse.

Second, we need to thank the vision and values of correctional rehabilitation, which can be traced from John Howard (1726–1790) to the latest meta-analysis by Andrews and Bonta (2010a). It is not enough to detain and monitor offenders; in order to reintegrate offenders as law-abiding citizens; we need to address their psychological and social needs through human service intervention. Andrews, Bonta, and Hoge's (1990) risk-need-responsivity (RNR) model provided a compelling vision for correctional rehabilitation, and the substantial empirical support for the RNR model gave hope to those interested in developing interventions for special offender populations, such as sexual offenders (Hanson, Bourgon, Helmus, & Hodgson, 2009).

It is important to distinguish the correctional rehabilitation model from other forms of psychological or medical treatment. In the correctional rehabilitation model, sexual offending is viewed as a serious social transgression as well as personal problem. Criminal justice sanctions can and should be used to encourage sexual offenders to engage in treatment. Offenders have the right to refuse to cooperate with any particular intervention; however, such refusal would have significant impact on sanctions received (e.g., extensions of time served, increases in conditions of supervision). The explicit goal of treatment is preventing reoffending by addressing criminogenic needs. The therapists' dual role (as authority and helper) is explicit and, I would add, largely unproblematic (Prescott & Levenson, 2010). We are all very familiar with such dual functions in our roles as boss–employee, teacher–student, and, most basically, parent–child.

In contrast, the traditional treatment models for psychological or medical service consider the doctor as a service provider for the autonomous patient. Except for the rare condition of mental incompetence, patients have full authority over the treatments that they receive or do not receive. As well, the primary responsibility of traditional mental health service providers is to patient welfare; they do not have a fundamental responsibility to prevent reoffending. Consequently, medical model interventions may help patients achieve personal goals even though it could increase their risk of criminal recidivism.

For example, in 2007 a prison physician prescribed Viagra to Francis Evrard, a high risk pedophile, just prior to Evrard leaving prison in Caen, France (Evrard, 2009). During the trial following Evrard's rapid recidivism one month following release, the prescribing physician explained that prison doctors do not have access to offenders' criminal records, and that he would not want to see them even if he was allowed to do so[1]. This point of view is not an anomaly within the medical community in France (Haute authorité de santé, 2009) and highlights the important distinction between the medical model of treatment and the correctional rehabilitation model.

In addition to women's rights and correctional rehabilitation, there is an implicit third social movement motivating the *Journal of Sexual Aggression*, and this is the rise of evidence-based practice (see Figure 1). As someone who has committed his professional career to policy-relevant research, it should be no surprise that I view the growing interest in evidence-based practice in psychology and medicine as a sign of progress. And, for all of us who want science to influence sexual offender practice, the *Journal of Sexual Aggression* is a genuine force for the good.

Since I began working in this field in the 1980s, there have been real, substantive advances in our knowledge of the risk-relevant propensities that motivate individuals to commit sexual offences (see reviews in *Journal of Sexual Aggression* by Craig, Browne, Stringer, & Beech, 2005; Craissati & Beech, 2003). Empirically validated risk factors have been identified and organised into clinically useful scales (e.g., Static-99R, Risk Matrix-2000, STABLE-2007 and SVR-20), which are now widely used and routinely accepted in court. We

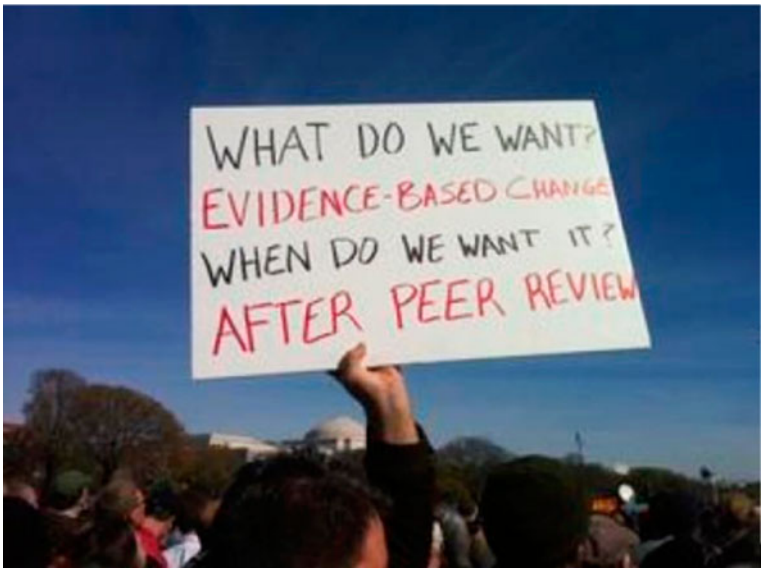

FIGURE 1. *A sign from Jon Stewart and Stephen Colbert's Rally to Restore Sanity, October 30, 2010, Washington, DC. Photo credit: Bernardo Guzman for Inside Higher Ed. Reproduced with permission© 2010.*

have remarkably precise knowledge of certain risk factors. We now know, for example, that being sexually abused as a child is a risk factor for the onset of sexual abuse (Jespersen, Lalumière, & Seto, 2009; Whitaker et al., 2008), but that it is not a risk factor for persistence among known sexual offenders (Hanson & Morton-Bourgon, 2005). We also know that emotional congruence with children is a risk factor for child molesters, but only for those who have extrafamilial victims (McPhail, Hermann, & Nunes, 2013). Furthermore, we know that risk changes and sexual offenders risk for recidivism decline the longer time they remain offence-free in the community (Harris & Hanson, 2004; Howard, 2011).

In comparison, we know very little about the effectiveness of methods used to rehabilitate sexual offenders. Although there is some evidence that treatments following the RNR model are more likely to be effective than other treatments (Hanson et al., 2009), it is hard to make any strong conclusions about whether treatment works at all (Dennis et al., 2012; Långström et al., 2013). This is a depressingly similar conclusion to that of Furby, Weinrott, and Blackshaw (1989) more than 20 years earlier. Knowing which treatment works for which type of sexual offender remains a distant dream.

The evidence based for risk prediction has advanced because it is relatively easy to conduct a good risk prediction study. The paradigm is simple: links prior assessment variables with subsequent recidivism. Such designs have few a-priori threats to validity because the offenders are typically drawn from the same setting, and the same research procedures are used for the complete sample (e.g., length of follow-up; source of criminal history records; Furby, Weinrott, & Blackshaw, 1989). The increasing availability of reliable computerised records has facilitated an explosion of sexual offender recidivism studies during the past 20 years. Furthermore, recidivism studies do not need to be fully prospective, as old data can be linked to new records. Consequently, students can start and finish a good recidivism study within the constraints of a graduate degree. For jurisdictions with centralised assessment and criminal history records, it is possible to revise and update recidivism estimates with very low cost.

In contrast, good treatment outcome studies require considerably larger investments of time and effort. Comparisons between treated and untreated offenders from the same setting are usually biased because those who get treatment are systematically different from those that do not (e.g., lack of cooperation, major mental illness). Strong experimental designs require that experimenters' control who gets treatment (Collaborative Outcome Data Committee, 2007a, 2007b). Not only is this unpopular with treatment providers, it forces researchers to use prospective designs. Given that the outcome of interest (sexual recidivism) has a low base rate (typically less than 2% per year), long follow-up periods (≥5 years) are required to detect even large effects. The combination of high costs and long follow-up periods eliminates treatment outcome studies from the options available to graduate students and most applied researchers.

So what can we do?

First, we should advocate that sexual offender treatment programmes be evaluated using high-quality research designs. Given the serious consequences of sexual victimisation, it is important to know whether our interventions make a difference. Although we, as service providers, must believe in what we do in order to do it, we also need the humility to admit that we could be fundamentally mistaken. Consequently, sexual offender treatment needs rigorous scientific scrutiny (Association for the Treatment of Sexual Abusers, 2010).

Most European countries have, through the *Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse* (Council of Europe, 2007), committed themselves to providing *effective* treatment to perpetrators of sexual offences against children, individuals at higher risk of committing such offences, and to children with sexual behaviour problems. This collective responsibility should motivate EU nations to collaborate on the implementation and evaluation of new treatment programmes for sexual offenders. Furthermore, the introduction of new programmes in settings without established services provides an important opportunity for implementing random-assignment studies. When supply is less than demand, then random assignment of equally qualified cases is an equitable intake selection procedure.

Second, we need to evaluate natural experiments as opportunities arise. Although randomised controlled trials are desirable, this is not the only acceptable research strategy (Collaborative Outcome Data Committee, 2007b). Both Hanson, Bourgon, Helmus, and Hodgson's (2009) meta-analysis and Långström et al.'s (2013) systematic review used strict inclusion criteria; nevertheless, they both included several well-executed cohort studies, including one published in this journal (Procter, 1996).

The third approach to advancing sexual offender research is to use risk assessments as outcome variables (Belfrage & Douglas, 2002; Dohrmann, 2009). Given the considerable advances in risk assessment, it is not unreasonable to consider that risk assessment scores may be equally valid measures of the propensity for criminal recidivism as the officially recorded reoffending that they are designed to predict (Vrieze & Grove, 2010). Risk assessment scores, however, only have utility as treatment outcome scores when they are capable of changing. Although there has been relatively little research on the dynamic validity of risk scores, there is accumulating evidence that sexual offenders' response to treatment (Olver, Beggs Christofferson, Grace, & Wong, 2013; Olver, Nicholaichuk, & Wong, 2013) as well as their behaviour during community supervision (Hanson, Harris, Scott, & Helmus, 2007) provide information incremental to risk assessment scores at intake. Using recent behaviours as treatment outcome variables would substantially shorten the necessary follow-up periods from years to mere months.

Currently we have hundreds of studies of sexual offender risk prediction, and hundreds of studies of treatment for general offenders (see Andrews & Bonta, 2010b). What we need now are hundreds of new studies of sexual offender treatment outcome. I am looking forward to seeing the better ones published in the next 20 volumes of the *Journal of Sexual Aggression*.

Note

1. Le médecin de prison n'a pas accès au dossier pénal du détenu et je ne veux pas le connaître … ça n'est pas pour ça que je me suis engagé dans la médecine pénitentiaire [Prison doctors do not have access to the criminal history records of prisoners and I do not want to know … that is not the reason I became involved in prison medicine.] (Evrard, 2009).

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