

# Center for Sex Offender Management

A Project of the U.S. Department of Justice, Office of Justice Programs

## Understanding Treatment for Adults and Juveniles Who Have Committed Sex Offenses

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### Introduction

Specialized treatment has been a mainstay of sex offender management approaches for several decades. In recent years, however, the heightened attention to sex crimes and its impact on victims and communities has resulted in a push for more punitive responses to the individuals who commit these crimes, including lengthier periods of confinement, tighter residency restrictions, expanded registration and community notification laws, and enhanced surveillance and monitoring strategies. The widespread focus on these types of “get tough” strategies consequently has begun to overshadow the important role of treatment in sex offender management efforts.

As has already been demonstrated by leading researchers in the general correctional field, however, an exclusive reliance on punishment-oriented and surveillance-driven approaches has limited impact on enhancing community safety (see, e.g., Andrews & Bonta, 2003; Aos, Miller, & Drake, 2006; Cullen & Gendreau, 2000). When offender management strategies include a rehabilitative focus, the outcomes are much more promising (Aos et al., 2006; Cullen & Gendreau, 2000).

Therefore, as stakeholders across the country are challenged to identify effective strategies for managing individuals who commit sex offenses and thereby ensure the safety of communities, the need to understand the role of treatment will undoubtedly arise. Yet when the topic is broached, it often raises more questions than answers. Most notable are questions about what treatment “is” for adults and juveniles who commit sex offenses, how it differs from other forms of treatment for different

populations, and, of course, whether it has a significant impact on recidivism.

The purpose of this brief is to provide a broad overview of current research, professional literature, and practice trends relative to treatment for sexually abusive individuals, in an attempt to better illuminate this rather complex topic for those who have a stake in sex offender management. Although specialized clinicians may find this brief to be of interest, the primary intended audience is the range of other management professionals seeking to understand key issues about treatment for adults and juveniles who have committed sex offenses.

### Unique Features of Treatment for Sex Offenders

It may come as no surprise that providing treatment to individuals who commit sex offenses is a distinctive undertaking. What may be less recognized are the ways in which sex offender treatment is similar to other types of treatment. Regardless of whether treatment is designed to address sex offending behaviors or other types of psychosocial, mental health, or psychiatric needs, a number of shared principles and practices across treatment settings exist, including the following:

- All clients should understand the interventions and procedures that will be utilized and any associated risks and benefits (i.e., informed consent should be provided);
- Treatment interventions should be driven by formal assessments and appropriately individualized to the needs of the client;

- Rapport must be established and maintained;
- Treatment goals should be specific and measurable; and
- Progress—or lack thereof—must be accurately and thoroughly documented.

Despite these and other commonalities across therapeutic contexts, some aspects of treatment for adults and juveniles who commit sex offenses are qualitatively different than approaches to intervention for other populations.

### How Treatment is Defined

In other settings, the term “treatment” is used to describe the provision of scientifically proven procedures to effect a cure, but within the sex offender management field, such a definition would be somewhat misleading. For the purposes of this brief, treatment is defined as the delivery of prescribed interventions as a means of managing crime-producing factors and promoting positive and meaningful goal attainment for participants, all in the interest of enhancing public safety.

#### Providing Specialized Treatment Requires Specialized Training and Experience

In a field where the stakes are high, the dynamics are complex, the interventions are specialized, and the literature is evolving, it is essential that treatment providers are equipped with the necessary skills and knowledge to provide ethically sound and quality treatment. Specialized education, training, experience, and supervision cannot be overemphasized. In some states (e.g., Colorado, Illinois, Texas, and Utah), those wishing to provide treatment for adults or juveniles who have committed sex offenses must meet established criteria or undergo a formal certification process. Many of the criteria used for these purposes are based on published practice standards from the Association for the Treatment of Sexual Abusers (ATSA), a leading authority on the types of educational and practical experiences that are considered essential before engaging in this work.

### Involuntary Nature of Treatment

Perhaps the most apparent difference is the often involuntary nature of sex offender treatment. Individuals who have committed sex offenses tend to enter specialized treatment as a result of external pressures or legal mandates, rather than being driven solely by internal motivation. In contrast, persons who experience depressive or anxiety-related symptoms, are challenged by problematic family dynamics, struggle with peer relations, or have problems with self-concept – to name a few – tend to come forward voluntarily for assistance from

a treatment professional and are often motivated by their own needs for assistance to change.

### Treatment Goals are not Solely Driven by the Client’s Desires

Because many participants in sex offender treatment programs may not be internally motivated or seeking treatment of their own volition, and because of the nature of the behaviors to be addressed, the manner by which treatment goals are determined often differs from other contexts. Specifically, in most traditional treatment settings, goals of therapy are identified largely by the client’s desires, in collaboration with the provider.

Many of the broad goals of sex offender treatment, however, are largely pre-determined. Although individuals who commit sex offenses are a fairly heterogeneous population, they also have in common several types of needs and risk factors. As such, treatment programs tend to include a number of relatively “standard” goals for participants, such as addressing denial, identifying and managing risk factors, enhancing empathy for victims, and developing prosocial skills. This is not intended to suggest that adults and juveniles who have committed sex offenses should not have a say in their treatment goals. Indeed, to promote an individualized treatment approach that meets the needs of each client, and one in which they are more personally invested in the change process, participants should certainly have involvement and influence in the identification of treatment goals for themselves.

### Confidentiality Limits

The forensic context of sex offender treatment – in other words, because the criminal and juvenile justice systems are usually involved – also creates a different dynamic with respect to confidentiality issues. With the primary exception of threats of self-harm or harm to identifiable others, information discussed in most treatment settings is held in strict confidence. However, for individuals who commit sex offenses, the routine involvement of the courts and multiple agencies (e.g., corrections, probation or parole, social services, juvenile justice, child welfare, victim advocacy, and law enforcement) often necessitates collaboration and critical information sharing in order to support accountability, enhance management strategies, and ultimately promote public safety. Therefore, those who enter sex offender treatment programs are often expected to waive some or all of the typical confidentiality protections that exist for most other clients who are involved in mental health or medical treatments (see, e.g., ATSA, 2005;

National Adolescent Perpetration Network [NAPN], 1993).

### **Impact of Unsuccessful Interventions**

In most psychosocial treatment contexts, the negative impact of unsuccessful interventions is relatively limited in scope – either to the individual alone or to a small number of involved others.

With treatment for individuals who commit sex offenses, however, the potential impact of failed interventions is more far reaching. Beyond the potential adverse effects on the client and his family, when adults or juveniles are unsuccessful in treatment, public safety may be compromised. In some circumstances, the net result is additional sexual victimization and the associated impact on the victim, victim's family, and the community.

### **Increased Potential for Vicarious Trauma and Burnout for Treatment Providers**

Similar to the experiences of therapists who work with victims of trauma, but considerably different from most other mental health professionals, individuals who provide treatment to sex offenders are exposed routinely to very detailed descriptions of abusive sexual behaviors, the attitudes and statements that support or minimize these behaviors, and the readily apparent harm to victims. Over time, this cumulative exposure – combined with other influences, such as professional isolation, a high volume of cases, intense public scrutiny, and limited healthy coping responses – can lead treatment providers to experience what has been termed vicarious or secondary trauma, as well as professional burnout (Pullen, 1999; Thorpe, Righthand, & Kubik, 2001; Way, VanDeusen, Martin, Applegate, & Jandle, 2004). This phenomenon is among the most salient differences that make sex offender treatment distinctively challenging.

#### **Sex Offender Treatment Can Take a Toll on Therapists**

In a recent study on vicarious trauma, individuals who provide treatment to sex offenders were compared to those who treat victims of sexual abuse (Way et al., 2004.) Both groups of clinicians reported similar levels of vicarious trauma, suggesting that the nature of the work may be associated with clinical levels of distressing symptoms. The researchers also found that the use of negative personal coping strategies exacerbated the impact of vicarious trauma. It is of interest to note that, compared to those providing treatment to victims, sex offender treatment providers were less likely to use positive personal coping strategies.

## **What Treatment “Looks Like”**

It is worth noting that the way in which treatment for sexually abusive individuals has been historically conceptualized and implemented has not always been consistent (see, e.g., Becker & Murphy, 1998; Laws & Marshall, 2003; Marshall & Laws, 2003 for reviews of its evolution). However, over the past two decades, treatment has become more standardized, both in terms of the underlying theories that drive the interventions and the specific programmatic elements.

### **Primary Frameworks**

At present, most programs for adult and juvenile male sex offenders<sup>1</sup> report using cognitive-behavioral and relapse prevention models as the foundation of treatment (McGrath, Cumming, & Burchard, 2003). Cognitive-behavioral treatment has a long history in the mental health field and has been found to be an effective framework to address a range of psychological disorders. Relapse prevention was originally designed for addictive disorders, such as substance abuse and gambling. Although sexual offending is not considered to be an addiction, the use of relapse prevention as a long-term behavior management strategy – rather than a cure – has made it appealing to those in the sex offender management field (e.g., Laws, 1989; Laws, Hudson, & Ward, 2000).

### **Broad Goals and Objectives**

In the broadest sense, the primary goals of sex offender treatment are for individuals to take responsibility for their behaviors, develop the necessary skills and techniques that will prevent them from engaging in sexually abusive and other harmful behaviors in the future, and lead productive and prosocial lives. An associated objective through the cognitive-behavioral lens centers around understanding the inter-relationship between thoughts, feelings, and behaviors, their impact on one's conduct, and then developing more healthy thinking patterns and appropriate ways of managing emotions. And within the relapse prevention framework, a closely related objective is to identify the risk factors or triggers that are associated with an individual's sexually abusive

<sup>1</sup> Although it is recognized that adult women and adolescent girls engage in sexually abusive behaviors, statistics indicate that the overwhelming majority of sex offenses are committed by males (Federal Bureau of Investigation, 2005, Snyder & Sickmund, 2006). Therefore, for the purposes of this brief, discussions of relevant research and treatment reflect the literature on adult men and adolescent boys.

behaviors and subsequently develop healthy coping skills to address those risk factors.

## Common Treatment Targets

To address these broad goals and objectives, treatment is often comprised of various offense-specific and offense-related treatment targets, primarily derived from various theories about both the onset and continuation of sex offending behaviors.<sup>2</sup> By and large, these factors have been supported by research, either as needs that are prevalent within samples of sex offenders or as factors that are associated with sexual recidivism.

With sexually abusive adults, for example, researchers have identified a number of relatively enduring but changeable risk factors that are associated with recidivism, including – but not limited to – the following (see, e.g., Hanson & Bussiere, 1998; Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2004):

- Deviant sexual arousal, interests, or preferences;
- Sexual preoccupation;
- Pervasive anger or hostility;
- Emotional management difficulties;
- Self-regulation difficulties, or impulsivity;
- An antisocial orientation;
- Pro-offending attitudes, or cognitive distortions; and
- Intimacy deficits and conflicts in intimate relationships.

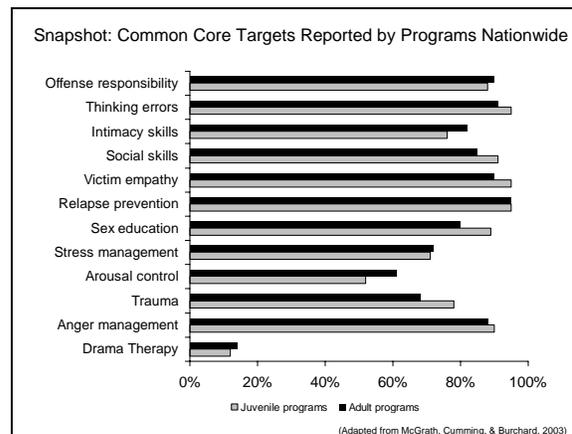
Similarly, for juveniles, dynamic factors that are believed to be associated with sexual recidivism include, among others, the following factors (see Hunter, Figueredo, Malamuth & Becker, 2003; Longo & Prescott, 2006; Worling & Langstrom, 2006):

- Deviant sexual interests;
- Problematic parent-child relationships;
- Social isolation, poor social skills, and low social self-esteem;

- Antisocial values and behaviors, including emotional callousness and an absence of empathy for others;
- Social isolation;
- Pro-offending attitudes or cognitive distortions;
- Impulsivity; and
- Treatment non-completion.

Again, because of the research support for these elements, they are considered to be among the most common targets of treatment in many programs for adults and juveniles, respectively.

At the same time, some of these traditional treatment targets – namely denial, self-esteem, and victim empathy – have not been found to predict sexual recidivism for adult sex offenders. The lack of predictive value of these targets may be the result of difficulties with consistently defining and measuring these constructs, or because they are related to the initiation of sex offending but perhaps are not predictive of future reoffending (see, e.g., Hanson & Bussiere, 1998). Despite these unanswered empirical questions, many programs continue to view denial, self-esteem, and empathy as important targets of intervention, likely because of understandable speculation that these factors are related to sex offending behaviors or because of their suspected value in the treatment process.



## Treatment Should be Individualized

As noted previously, although several components are common to all individuals entering sex offender treatment, interventions nonetheless should be designed to meet the specific needs of clients. This requires that specialized assessments are conducted to inform treatment for each participant. It is beyond the scope of this brief to detail

<sup>2</sup> Most contemporary theories involve a complex interplay of developmental, biological, environmental, psychological, sociocultural, and inter- and intrapersonal influences (see, e.g., Barbaree & Marshall, 2006; Ward, Polaschek, & Beech, 2006).

assessment processes with adults and juveniles who have committed sex offenses, although a few key points are worthy of review.

For example, it is important to use specialized, research-based tools that explore not only general mental health needs and personality functioning, but also assess offense-specific variables, such as deviant sexual interests and pro-offending attitudes, because of their association with recidivism risk. When focusing specifically on the assessment of risk of sexual recidivism for adults or juveniles, practitioners should use instruments that have been designed for those populations and, whenever possible, measures that have demonstrated predictive validity. Additionally, the use of multiple sources of data can increase the accuracy and completeness of assessments.

Ideally, then, assessments are the means by which levels of risk and needs are identified, such that individualized, meaningful, and more effective treatment plans can be developed. Indeed, researchers who have studied general criminal offenders have long known that treatment outcomes are maximized when assessments of risk and needs are conducted and clients are matched to services accordingly. For example, higher risk offenders tend to benefit from more intensive services than do lower risk offenders, and lower risk offenders are better served by low intensity programming (e.g., Andrews & Bonta, 2003). A recent meta-analysis conducted by Hanson (2006) found that these same principles are associated with maximized treatment outcome among sex offender populations as well. Finally, repeated assessments throughout the course of treatment are a critical way to objectively and consistently evaluate progress in treatment.

#### A Checklist for Policymakers and Administrators

- Is the program based on an evidence-based model?
- Is treatment individualized and assessment-driven?
- Are treatment targets supported by research?
- Are providers specially trained?
- Are approaches tailored for special populations?
- Are community-based and institutional programs parallel and linked?
- Are within-treatment changes and long-term outcomes measured?

## Modernizing Treatment

In the preceding sections, sex offender treatment for adults and juveniles was outlined in a manner that reflects the traditional model that has been in place for many years. More recently, experts have begun to modify and build upon this model because of concerns that it resembles a “one size fits all” approach to treatment and one which presumes that the same interventions are equally important and effective for every offender (e.g., Hunter, 2006; Laws & Ward, 2006).

Additionally, the ever-growing body of contemporary literature – which includes additional theories of sex offending that take into account the diversity of these populations, greater appreciation of the differences between adults and juveniles who have committed sex offenses, and attention to variables that enhance treatment engagement and response – has provided a catalyst for further refining and updating treatment approaches (see Barbaree & Marshall, 2006; Longo & Prescott, 2006; Marshall, Fernandez, Marshall, & Serran, 2006; Ward, Polaschek, & Beech, 2006). Taken together, these elements are beginning to change the face of traditional programs, revealing a more modernized approach to treatment for adults and juveniles.

### Different Pathways to Offending Means Treatment Should Vary

Although it has been long recognized that individuals who commit sex offenses are not all alike, until recently the field has lacked comprehensive theoretical and research-based models that addressed their different vulnerability factors, motivations, and contextual circumstances and that could guide treatment accordingly.

#### *Promising models for adults*

In response to this limitation in the treatment field to date, Ward and his colleagues (see Ward & Hudson, 1998, 2000; Ward, Hudson, & Keenan, 1998; Ward & Siegert, 2002; Ward et al., 2006) proposed the Self-Regulation and Pathways models as a means of outlining the varied pathways that can lead to sex offending. The Pathways model takes into account various biological, cultural, environmental, and other underlying factors that are believed to result in sexually abusive behavior toward children. Specifically, the extent to which individuals have difficulties in one or more of the following core and interacting clusters of symptoms reflects their pathway to offending, including (see, e.g., Ward & Siegert, 2002; Ward et al., 2006):

- Emotional management difficulties, or emotional dysregulation;
- Interpersonal problems, including intimacy deficits, loneliness, and social isolation;
- Attitudes and beliefs that support antisocial or sexually abusive behaviors, commonly referred to as cognitive distortions; and
- Deviant sexual fantasies, arousal, and internal interpretations about how to approach sexual encounters.

Also recognizing that individuals commit sex offenses for different reasons and possess different coping skills and deficits, a key focus of the Self-Regulation model is to classify individuals based on specific motivations and goals, self-management strategies, cognitive and behavioral elements, and contextual factors that lead to offending (Ward & Hudson, 1998, 2000; Ward et al., 1998, 2006). Four distinct categories of offense pathways are proposed:

- *Avoidant-Passive.* The intent of these individuals is to avoid sex offending, but an overall lack of effective coping strategies and self-management skills results in a failure to take definitive steps to manage their behaviors;
- *Avoidant-Active.* For offenders in this category, the desire to refrain from sexually abusive behavior is hampered by a use of ineffective strategies, and those which actually increase their likelihood of offending;
- *Approach-Automatic.* Although these individuals desire deviant sexual activity, their offenses are more driven by situational factors and circumstances rather than active planning and are often the result of poor self-management skills and impulsivity; and
- *Approach-Explicit.* Persons in this category are motivated to offend and engage in explicit planning, including specific steps to groom victims and avoid detection, which highlights an ability to regulate their behaviors for self-serving purposes.

#### *A promising model for youth*

Similarly, with juveniles who have committed sex offenses, emerging typology research by Hunter and his colleagues suggests that a range of personality characteristics, developmental

experiences, and risk factors may be associated with different pathways to sexually abusive behavior among youth, with preliminary research suggesting the following three subtypes and trajectories (see, e.g., Hunter, 2006):

- *Lifestyle delinquent youth.* These youth exhibit conduct problems early in life and continue to engage in delinquent and criminal behaviors throughout adolescence and perhaps adulthood, including sexually aggressive behavior toward peer and adult females;
- *Adolescent onset, non-paraphilic youth.* The sex offending behaviors of these individuals tend to be directed toward pre-pubescent females and appear to be either experimental in nature or as compensation for deficits in social skills and self confidence; and
- *Early adolescent onset, paraphilic juveniles.* This group is believed to have emerging deviant sexual interests and arousal and may subsequently target both pre-pubescent males and females.

By providing more comprehensive explanations of the multiple characteristics and varied means by which adults and juveniles commit sex offenses, these models offer a classification system that can assist treatment providers with the development of more refined and appropriately tailored interventions (Hunter, 2006; Ward & Seigert, 2002, Ward et al., 2006).

#### **Sex Offenders Aren't Just "Sex Offenders"**

When individuals are labeled as "sex offenders," there is a tendency for professionals and others to define them solely in terms of their sexually abusive behaviors. Within the context of sex offense-specific treatment, this narrow view can result in incomplete intervention strategies as providers may be tempted to focus exclusively on the sexually deviant nature of their actions.

#### *Holistic programming is vital*

However, adults and juveniles who have committed sex offenses may also have a range of intervention needs in the psychiatric, healthcare, family, peer, substance abuse, vocational, or educational domains, and if these additional issues are left unaddressed, their ability to lead a stable and productive life may be understandably hampered. Contemporary programs address this limitation by designing treatment in a more holistic manner, thus

offering a more complete approach to intervention that better maximizes the potential for longstanding positive impact.

#### *Shifting toward a more positive approach*

A related limitation of a more traditional approach to programming involves its primary focus on deficits, whereby treatment centers around the negative attributes of individuals and the use of escape and avoidance strategies as a means of preventing further sexual behavior problems. As one can imagine, a treatment program that outlines only what is problematic about an individual and offers restrictions and prohibitions as the road to wellness may not lead to engagement and investment in the change process (see, e.g., Mann, Webster, Schofield, & Marshall, 2004; Thakker, Ward, & Tidmarsh, 2006; Ward & Stewart, 2003). This, too, exemplifies a failure to consider individuals holistically and may neglect important clinical needs, thus limiting the impact of interventions.

Consequently, experts have recently begun to argue that an emphasis of modern rehabilitative efforts should be to equip participants with the necessary skills, competencies, values, and beliefs that will ultimately allow them to lead “good lives” (Thakker et al., 2006; Ward & Stewart, 2003). Put simply, leading a “good life” – in which needs are met in positive and self-fulfilling ways but not at the expense of others – is incompatible with sex offending, and therefore is an important treatment goal. Through this approach, adults and juveniles develop positive goals, including intimacy, health, knowledge, autonomy, and emotional balance. At the same time, they learn how to counteract obstacles, whether internal or external, that may prevent them from attaining these goals.

Because this “good lives” model of rehabilitation is strengths-based and designed to facilitate overall wellness and meaningful change for individuals, it has the potential to enhance engagement and internal motivation in treatment (Mann et al., 2004; Thakker et al., 2006; Ward & Stewart, 2003). This important shift from an exclusive risk management approach, therefore, represents a key advancement in the sex offender treatment field – and one that can enhance the likelihood of success of participants, thus translating into community safety.

### **Treatment for Juveniles Should Not Mirror Treatment for Adults**

Early in the history of the juvenile sex offender field, experts acknowledged that treatment for these youth should take into account developmental considerations (Barbaree, Marshall, & Hudson,

1993; Ryan & Lane, 1991). As the field evolved, however, significant concerns arose because interventions for these juveniles were nonetheless based primarily on the approaches used for adults (Chaffin & Bonner, 1998; Weinrott, 1996). Even today, the specific differences between adults and juveniles who have committed sex offenses are not always appreciated fully within the context of treatment<sup>3</sup>, and current reviews note that the design and delivery of programming for youth still resembles adult treatment in many ways (Bumby & Talbot, in press; Letourneau & Miner, 2005; Longo & Prescott, 2006).

Fortunately, practitioners do have guidance from the professional literature about the ways in which treatment can be modernized to meet the developmental needs of these youth, both in terms of the models that drive treatment and the modalities through which interventions are delivered (e.g., Fanniff & Becker, 2006; Hunter, Gilbertson, Vedros, & Morton, 2004; Longo & Prescott, 2006).

#### *Contemporary treatment models for juveniles*

Recognizing the inherent value of the tenets and approaches used as part of cognitive-behavioral and relapse prevention interventions, some have proposed that the manner in which these programs are implemented can be modified to ensure that it is more appropriate and relevant for youth (e.g., Murphy & Page, 2000; Hunter & Longo, 2004; Worling & Curwen, 2000). For example, the language, style, and approach to activities and treatment tasks within the relapse prevention framework can be tailored for youthful participants overall, as well as individualized to the variations within the juvenile sex offender population (Hunter & Longo, 2004; Murphy & Page, 2000.) In addition, experts suggest reframing the “incurability” emphasis within relapse prevention with juveniles, because of the potential negative impact it may have on self-esteem, motivation, and confidence to make positive life changes in treatment (Hunter & Longo, 2004).

The use of different underlying frameworks altogether has also been suggested as a means of intervening with sexually abusive juveniles, with a

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<sup>3</sup> Included among the primary suggested differences between adults and juveniles who commit sex offenses are deviant sexual arousal or preferences (which may be less common), family, peer, and environmental factors (which may be more critical for juveniles), and the potential role of maltreatment (which may be more influential for juveniles). In addition, the period of adolescence is characterized by cognitive, emotional, social, moral, and biological processes that are qualitatively different from those in adulthood (see, e.g., ATSA, 2000; Chaffin, Letourneau, & Silovsky, 2002; Fanniff & Becker, 2006; Letourneau & Miner, 2005).

primary recommendation for the use of community-based social-ecological models that address the multiple interactive factors that are associated with problem behaviors (Hunter et al., 2004; Hunter, 2006; Letourneau & Miner, 2005; Saldana et al., 2006). One very promising example is Multisystemic Therapy (MST), a community- and family-based treatment approach that is designed to address individual, family, peer, school, and community influences (Henggeler et al., 1998). Some of the common goals for MST include:

- Improving family functioning;
- Enhancing parenting skills;
- Increasing the youth's associations with prosocial peers;
- Improving school performance; and
- Building upon community supports.

Research indicates that these and other positive goals are often attained in a cost-effective manner; with significant reductions in recidivism (Henggeler et al., 1998). Although the application of MST to the treatment of juvenile sex offenders is relatively new, it has particular appeal because of the very promising outcomes that have been revealed (see, e.g., Borduin & Schaeffer, 2002).

#### *An emphasis on multiple modalities*

Although group therapy has been the favored, if not exclusive, mode of treatment with sex offenders, its use with juveniles has been challenged recently by experts in the field (Chaffin, 2006; Hunter, 2006; Hunter et al., 2004), particularly in light of the research which demonstrates the potential for negative outcomes when delinquent peers are aggregated for the purposes of intervention (e.g., Chamberlain & Reid, 1998; Dishion, McCord, & Poulin, 1999).

Although group treatment with juvenile sex offenders has its advantages – such as resource and time efficiency, opportunities to practice positive skills with peers, and sharing common experiences – it can be very limiting if used as the sole mode of treatment with youth<sup>4</sup> (see, e.g., Rich, 2003; Worling, 2004). For example, the relatively small amount of time spent in group treatment may be insufficient for addressing the range of needs of any given youth. Additionally, youth who are less mature, suffer from mental health difficulties, or who

have lower levels of cognitive functioning may be less able to understand and apply the concepts being addressed in the group setting. Furthermore, the group context is not conducive to raising particularly sensitive issues, nor does it provide the opportunity to address critical family issues and other environmental influences.

Individual therapy can be an appropriate solution to address some of these and other issues, and it also provides a forum in which the concepts and skills covered in group can be reinforced and individually tailored to each youth's circumstances. Family therapy, too, is an essential modality, particularly when used as part of a more integrated approach to intervention with juveniles who have committed sex offenses (e.g., Rich, 2003; Thomas, 2004; Worling, 2004). Perhaps for these and other reasons, most juvenile sex offender treatment programs nationwide report using multiple modes of treatment, including individual, family, and group treatment as part of their programming (McGrath et al., 2003).

#### **How Treatment is Delivered is as Important as What is Delivered**

The underlying frameworks and substantive content are certainly among the critical factors to consider for ensuring quality sex offender treatment programs. Indeed, much of the professional treatment literature to date has focused on treatment models and content of programs for adults and juveniles who have committed sex offenses. Notwithstanding these elements, experts in the field are now drawing attention to the importance of process-related variables in treatment, recognizing the influence of treatment providers' characteristics and engagement strategies (e.g., Fernandez, 2006; Marshall, Ward, Mann, Moulden, Fernandez, Serran, & Marshall, 2005).

#### *Therapist characteristics*

To illustrate, for many years, providers in sex offender programs seemed to favor somewhat aggressive, confrontational, and punitive approaches to treatment, a style which was later questioned because of concerns that it may actually lead to undesirable outcomes such as increased resistance and hostility, less engagement, and fewer within-treatment changes (Bumby, Marshall, & Langton, 1999; Kear-Colwell & Pollack, 1997; Marshall, 1996).

Researchers have since supported these concerns, finding poorer outcomes when sex offender treatment providers were cold and confrontational,

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<sup>4</sup> Many of the limitations regarding an exclusive reliance on group treatment for juveniles may also be applicable when considering treatment modalities for adults.

and when they failed to create a cohesive and therapeutic climate for participants (see, e.g., Beech & Hamilton-Giachritsis, 2005; Marshall, 2005). Conversely, treatment progress – such as reductions in denial, minimization, and victim blaming – is enhanced when sex offender therapists are empathic, warm, rewarding, encouraging, firm but flexible, and relatively directive (Beech & Hamilton-Giachritsis, 2005; Marshall, 2005).

### *Engagement strategies*

Practitioners are also becoming more familiar with specific techniques and strategies that have been found to be helpful for engaging clients, both adult and juvenile. Perhaps one of the most common is Motivational Interviewing (Miller & Rollnick, 2002). Generally speaking, this approach suggests that the way in which professionals interact with a client should vary depending upon the client's level of motivation and readiness for change, which may ultimately reduce client resistance and promote engagement in the assessment and intervention process. Motivational Interviewing has become an increasingly popular strategy for working with sex offenders (Ginsburg, Mann, Rotgers, & Weekes, 2002).

Similarly, and specifically for professionals working with juvenile sex offenders, the Invitations to Responsibility model has been suggested as a means of promoting internal motivation to invest in the treatment process, rather than using confrontation as an attempt to externally motivate youth (Jenkins, 1998). The accompanying techniques and strategies are based on the importance of personal choice and identifying one's own reasons to change, and emphasize the need to develop partnerships – rather than coercive relationships – with clients (Jenkins, 1998, 2006).

Overall, the emphasis on process-related variables, positive treatment goals, and strategies that can enhance internal motivation is reflective of a more positive psychological approach to sex offender treatment (e.g., Fernandez, 2006; Thakker et al., 2003; Ward & Stewart, 2003). This shift – which promotes engagement, investment, and success in the treatment process – is critical because of the research demonstrating that adults and juveniles who complete treatment are less likely to recidivate than treatment non-completers (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002; Hunter & Figueredo, 1999; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005; Worling & Langtstrom, 2006).

“Early studies of sexual offender treatment focused primarily on techniques and virtually ignored the influence of the therapist...it may now be time to turn our attention *to those who provide the treatment* in an effort to further refine and improve our ability to provide effective treatment” p. 195, emphasis added.

(Fernandez, 2006)

## **Does Treatment Work?**

For professionals in the sex offender management field, it is virtually impossible to avoid the inevitable question about whether sex offenders can be treated or rehabilitated. A definitive response – either in the negative or affirmative – would imply that a simple answer exists, when in reality, the answer is not a clear-cut one. Yet as is often the case in the social and behavioral sciences, there tends to be evidence on either side of the issue of interest. The same holds true with research on sex offender treatment, whereby both skeptics and advocates can produce some level of empirical evidence to support their respective positions.

### **The Skeptical Perspective**

Roughly two decades ago, a review of multiple treatment outcome studies led to the bleak conclusion that treatment for sex offenders does not reduce recidivism significantly (Furby, Weinrott, & Blackshaw, 1989). The authors acknowledged, however, that the designs of many of these treatment outcome studies were significantly flawed, recognized that many of the evaluated programs were somewhat outdated when compared to the then-current approaches to treatment, and left open the possibility that treatment actually may be effective for some types of sex offenders. Nonetheless, their review became very influential in putting forth the notion that treatment does not work for sex offenders. In some areas, this research was used to support the elimination of specialized sex offender treatment programs.

Years later, additional groups of investigators synthesized the findings of multiple studies and reached the same general conclusion, noting that the poor methodology of the range of available studies made it impossible to determine with any certainty whether treatment for sex offenders “worked” (Quinsey, Harris, Rice, & Lalumiere, 1993; United States General Accounting Office, 1996). Even today, some experts contend that no conclusions can be drawn about treatment effectiveness because of the lack of scientific rigor in the available research (Rice & Harris, 2003).

Most recently, critics point to the final analysis of a single long-term study in California with perhaps the best research design to date for exploring the impact of treatment interventions on recidivism rates for sex offenders (Marques et al., 2005). No significant differences in recidivism rates were found between the treated sex offenders and the untreated comparison groups overall, seemingly supporting previous assertions that scientific evidence does not support the effectiveness of treatment. However, it should be noted that the authors acknowledged a variety of limitations to their study and warned consumers against prematurely drawing broad conclusions that treatment for sex offenders is not effective.

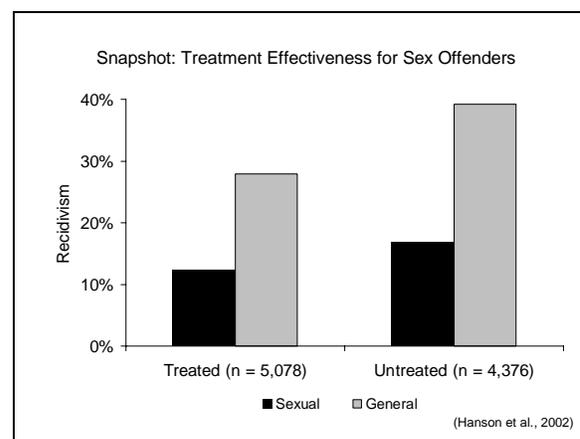
### A More Optimistic Perspective

After the initial unfavorable reviews of treatment outcome research were published, several experts responded with a series of investigations that offered evidence to the contrary (see, e.g., Alexander, 1999; Hall, 1995; Marshall & Pithers, 1994). These analyses indicated that a treatment effect does in fact exist for specialized treatment programs for sex offenders, particularly when programs utilize more contemporary approaches to treatment, such as cognitive-behavioral and relapse prevention models.

In the years that followed, there was no shortage of additional scientific inquiries into the issue of treatment effectiveness, with multiple reviews synthesizing and integrating the ever-growing body of research to examine whether an overall treatment effect existed. And these most recent analyses converge around optimistic findings, namely that recidivism rates are lower for those who complete sex offender treatment than for those who do not receive or complete treatment (e.g., Aos et al., 2006; Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Hanson et al., 2002; Lösel & Schmucker, 2005).

Among the most commonly cited examinations, because of its relatively strong research methodology, breadth of credible studies included, and attempt to discern treatment effects for more current versus older programs, is the Hanson et al. (2002) meta-analysis. After combining 43 published and unpublished studies that included more than 9,000 sex offenders, the authors found a significant difference between the “treated” and “untreated” groups, with better outcomes for those who received treatment – particularly current approaches to treatment. The researchers noted, nevertheless, that more conclusive evidence was needed because of the variations in the quality of the various studies that were included in the meta-

analysis. In addition, it was reiterated that, given the diversity of the sex offender population, additional research is critical in order to better determine which types of offenders benefit from which types of treatment.



It is worth noting that the California study used by some to argue that treatment is *not* effective actually provides some evidence of the differential impact of treatment on different types of offenders (Marques et al., 2005). Namely, individuals with child victims who met the goals of treatment recidivated at lower rates than those who did not. Similarly, higher risk sex offenders who evidenced more progress in treatment had lower rates of recidivism than high risk sex offenders who made less progress in treatment. These findings are consistent with other research that reveals better outcomes when offenders are matched differentially to services based on identified levels of risk and needs (e.g., Andrews & Bonta, 2003).

Finally, as noted previously, the researchers in the California study cited a number of factors that may have impacted the overall null findings, including a program design that may not be considered state-of-the-art when evaluated against current standards, a less than optimal individualization of treatment based on risk and needs, and the lack of a more developed and collaborative aftercare component (Marques et al., 2005).

Taken together, the best available evidence suggests that these interventions hold promise for adults who have committed sex offenses. Nonetheless, additional high quality research is needed in the field.

### Treatment Outcomes for Juveniles

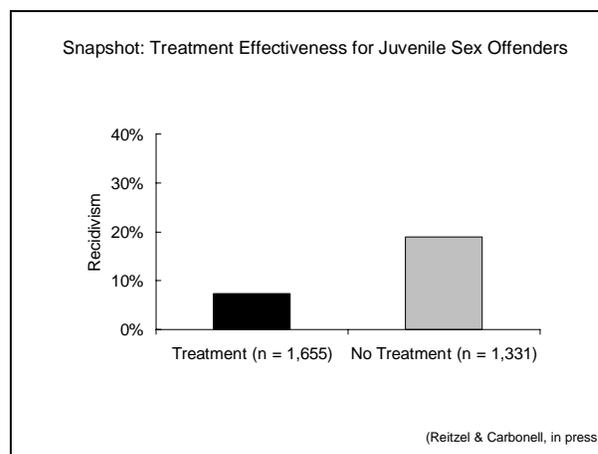
Given that the juvenile sex offender management field is much less developed than the adult field, it is not surprising that there is a paucity of well-controlled research on treatment effectiveness with

these youth. Similar to the mix of skepticism and support of the treatment outcome evidence with adults, the jury remains out within the juvenile field. While some experts question the ability to draw any conclusions about treatment efficacy with these youth because of the wide variability in the quality of research designs, others suggest the data is promising for some types of interventions with some types of youth (Chaffin, 2006; Fanniff & Becker, 2006; Letourneau & Miner, 2005; Marshall & Fernandez, 2004; Reitzel & Carbonell, in press; Walker, McGovern, Poey, & Otis, 2004).

From a cognitive-behavioral perspective, one published study is particularly noteworthy because of its relatively sound research design and follow-up across different types of recidivism (Worling & Curwen, 2000). Compared to untreated juveniles, youth who received cognitive-behavioral treatment with an emphasis on family interventions had significantly lower recidivism rates not only for sexual offenses, but also for non-sexual violent offenses, and non-sexual, non-violent offenses.

As described previously, researchers have also highlighted the promise of Multisystemic Therapy (MST) with sexually abusive youth, most notably because of the exceptional research designs and positive outcomes from treatment efficacy studies (see, e.g., Borduin, Henggeler, Blaske, & Stein, 1990; Borduin & Shaeffer, 2002; Saldana et al., 2006). The first randomized trial, comparing outcomes between juvenile sex offenders who received MST and those who received individual therapy, revealed superior results for the MST group (Borduin et al., 1990). The most currently published study yielded similar findings (Borduin & Schaeffer, 2002). More specifically, in contrast to youth in the comparison group, those who received MST evidenced fewer behavior problems, improved family and peer relationships, better academic performance, and reduced rates of recidivism for both sexual and non-sexual crimes.

Perhaps most compelling are the recent meta-analyses examining the effectiveness of treatment for juvenile sex offenders, both of which have yielded very positive results that favor treatment (Reitzel & Carbonell, in press; Walker et al., 2004). In the most current examination, the researchers considered treatment outcomes across multiple studies that included nearly 3,000 sexually abusive youth, and found that youth who received treatment recidivated at significantly lower rates than those who did not (Reitzel & Carbonell, in press).



## Conclusion

A comprehensive approach to managing individuals who have committed sex offenses requires the consideration and integration of a number of key components, including the critical and very promising role of treatment. In recent years, the face of treatment has begun to change in important ways, primarily in response to the ever-growing body of research on those who perpetrate these crimes. The future of treatment may indeed reflect more tailored and ultimately more effective interventions for adults and juveniles, taking into consideration the diversity both within and across these populations. It will also be dependent upon the steadfast attempts of researchers to highlight which types of individuals benefit most from which interventions.

For now, although the current research on treatment effectiveness remains somewhat equivocal, the available evidence suggests that these interventions hold promise for reducing recidivism both among adults and juveniles who have committed sex offenses. Moreover, there is no compelling reason to conclude that specialized treatment and other rehabilitative interventions should be abandoned in favor of a sole reliance on more punitive approaches that have already been demonstrated as having very limited impact on enhancing community safety.

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