

## **Cognitive/behavioral approaches to the treatment of adult sex offenders**

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*This article presents an overview of psychotherapeutic treatment modalities of adult sex offenders. It considers recent developments in treatment methods; discusses methods of measuring therapeutic change; presents a discussion of evaluation and outcome studies of these modalities.*

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“It was the best of times, it was the worst of times, . . .”  
—CHARLES DICKENS (1812-1870)  
*A Tale of Two Cities*

For sex offenders, the current legal and sociocultural climate in the West (Noble, 2002) is both the “best of times” and the “worst of times.” For the former—the “best of times”—clinical understandings and treatment approaches to deviant, or aberrant, or unacceptable sexual behaviors

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have advanced considerably over the past 20 years, and show promise for both reduced recidivism and clinical improvement. To the extent that treatment outcome studies can offer evidence-based (Geddes, 2004) data concerning the efficacy of such treatment, such studies suggest that sex offender specific treatment is effective both in terms of reduced recidivism and reincarceration rates (Zgoba, Sager & Witt, 2003) and in terms of improved clinical outcomes—such as increased life satisfaction—for those in treatment (Bradford, 2000).

However, for the latter—the “worst of times”—such public attitudes as “All sex offenders repeat their crimes. They are hopeless. Treatment cannot help them” seem increasingly prevalent and are expressed virtually every day in the news media (Witt & Zgoba, 2005). From the criminal/legal perspective, examples of the “worst of times” for paraphilics and sex offenders include the fact that all states and the Federal Jurisdiction in the U.S. have community notification and registration laws (Megan’s Laws) for convicted and released sex offenders, and as of 2006, 16 states had laws permitting the virtually indeterminate civil commitment of Sexually Violent Predators (SVP’s), or Sexually Dangerous Persons (SDP’s) following completion of their criminal sentences for sex crimes in the past (Douard, Friedman, Greenfield & Santina, 2006).

In this article—a companion piece to “Organic Approaches to the Treatment of Paraphilics and Sex Offenders” published in a recent issue of this journal (Greenfield, 2006)—we will focus on the former—the “best of times”—by discussing current psychotherapeutic and cognitive/behavioral approaches to the treatment of sex offenders and by emphasizing that such treatment—often in conjunction with organic approaches, especially pharmacotherapy (Greenfield, 2006)—can be effective for sex offenders in a variety of ways.

Sex offender  
treatment  
methods

The treatment approach generally accepted (and best researched) for sex offenders throughout North America is a cognitive-behavioral/relapse prevention approach (Freeman-Longo, Bird, Stevenson & Fiske, 1995; Witt, Rambus & Bosley, 1996). Recent research, in fact, has focused almost entirely on such programs and methods. Witt and Zgoba (2005, p. 45) characterize these methods as follows:

Cognitive-behavioral treatment aims to change both an offender's maladaptive thinking and actions. Although such a statement might be made about a range of treatment approaches, cognitive-behavioral treatment frequently has a distinctly educational tone, with structured teaching modules and out-of-session tasks (homework assignments). Moreover, relapse prevention, an approach originally developed on substance abusers, aims to help offenders recognize and effectively manage their precursors to sex offending.

The relapse prevention approach has had an enormous impact on sex offender treatment. Over the past few decades, a cognitive-behavioral treatment approach to adult sex offenders has become synonymous with what is characterized as a relapse prevention approach. As Serran and Marshall note (2006, p. 118):

The relapse prevention model has had a major impact on the design and implementation of treatment for sexual offenders. From this perspective, treatment programs have focused on self-management strategies designed to help sexual offenders manage specific high-risk situations. Skills acquisition is a major focus for most programs and emphasizes different, more effective coping responses.

Originally developed by Allan Marlatt for the treatment of substance abusers (e.g., Marlatt & Gordon, 1985), relapse prevention was first applied to sex offenders by William Pithers and Janice Marques (Pithers, Marques, Gibat & Marlatt, 1983). The approach proposes that there are identifiable risk factors that lead to negative emotional states in sex offenders. Sex offenders use ineffective means to cope with these negative emotional states, and thereby become more likely to commit sex offenses. Relapse prevention treatment, then, assists sex offenders to identify high risk

situations and learn more effective means of coping with stress.

In institutional programs, in particular, treatment is frequently broken into psychoeducational modules of a fixed duration. In some instances, there will be one or more specific relapse prevention modules, and in other cases, relapse prevention is more of an overarching philosophy, under which the various treatment components are implemented. A typical menu of institutional psychoeducational modules would consist of (paraphrased from Witt & Zgoba, 2005, p. 45; see also Green, 1988):

- *Orientation:* This module introduces the offender to the concepts and vocabulary of treatment. It includes identification of types and motivations of sex offenders. This module allows patients to understand what treatment will involve and on what issues they will be working. However, it is primarily educational, providing an orientation. It also provides hopes and reduces isolation for patients who may see themselves as isolated and hopeless.
- *Victim empathy/awareness:* The victim empathy module assists the offender in identifying the short- and long-term consequences of sexual abuse on victims in general, and if possible on the offender's victim in particular. It acts as a motivational tool, ideally increasing the offender's commitment to avoiding relapse.
- *Cognitive restructuring:* Both research and clinical experience indicate that sex offenders typically rationalize and justify their behavior, convincing themselves that their sex offending is, if not acceptable, at least not so reprehensible. This module examines the justifications that the offenders used and assists the offender to accept more responsibility for his behavior. The goal is not self-blame, but rather a middle ground of acceptance of wrongdoing and an objective appraisal of the harm the offender's behavior has caused.
- *Deviant sexual acting-out:* Many offenders have an identifiable sequence of internal and external events associated with their sex offending. In this module, the offender is helped to identify the precursors to sexual assaulting in terms of motives, emotions, thoughts and behaviors, as well as the

internal and external events that follow the sexual assault. Considerable work in this module involves having the offender diagram his thoughts and feelings at varying points in the sexual assault process.

- *Anger management:* Some, although not all, offenders have difficulties appropriately modulating and expressing anger. This module helps the offender identify the situational precipitants of anger and the internal thoughts and physical sensations associated with anger. The offender is then helped to develop a self-management plan to prevent anger from overwhelming him, and, once reasonably calm, for appropriately expressing anger.
- *Assertiveness training:* Many sex offenders find it difficult to be appropriately assertive. They frequently confuse aggression (that is, expressing oneself at the expense of others) with assertion (that is, expressing oneself while considering others' rights and feelings). This module helps the offender identify assertive, passive, and aggressive behavior styles and assists the offender to adopt a more assertive and adaptive style.
- *Social skills training:* Because sex offenders so frequently have impaired capacity for emotional intimacy, social skills training involves helping them increase their ability to relate to others. The module covers both simple conversational skills, such as initiating and maintaining conversations, and more subtle skills, such as expressing emotions respectfully in an intimate relationship.
- *Autobiographical awareness:* The offender is given autobiographical assignments to develop a timeline of significant events and decisions points in his life. This provides a means for the offender to explore his life and examine the determinants and decisions that have shaped his life. Review and group presentation of the time line can be an emotionally evocative experience for the offender.
- *Sex education:* Because many sex offenders are poorly informed regarding human sexuality, sex education regarding not only basic biology and physiology, but also concerning sexual myths and cultural expectations about sexual performance is a critical component of treatment. Frequently included is information regarding healthy sexuality, sexual expressiveness in intimate relationships, and sexual self-acceptance.

- *Stress reduction:* Many sex offenders have difficulty managing anxiety and stress. Consequently, relaxation training or meditation is a common component of sex offender treatment.
- *Chemical abuse:* Substance abuse disorder is commonly comorbid with the sex offender's sex offending behaviors. Therefore, a chemical abuse module includes education regarding the effects of intoxicants. In addition, this module frequently assists the offender to identify what role intoxicants played both in his life generally and in his sex offending behavior specifically.

Given the heterogeneity of sex offenders, treatment programs must be flexible to allow these modules to be tailored to the offender's specific pattern of needs, providing different treatment emphases with different offenders. In institutional treatment programs, whether in prisons or in psychiatric facilities, the above treatment components and elements are typically implemented in a broader context of phases or levels (of privileges). That is, as offenders behave well in the institution and progress in therapy, they are allowed a greater range of privileges and responsibilities. In many institutional programs, a therapeutic community, in which the institutional residents self-govern to a limited extent, is the highest level in the institution, one that the offender typically passes through before leaving the institution.

#### Recent developments in treatment methods

In recent years, the cognitive-behavioral/relapse prevention approach has been broadened to what is called a self-regulation approach, identifying particular pathways or goals that sex offenders used in committing their offenses, the major proponents being Tony Ward and Stephen Hudson (e.g., Ward & Hudson, 2000). The components of this self-regulation model are nicely summarized by Beauregard and Leclerc (2007, p. 116): "Thus, the different offense pathways provided evidence that sex offenders vary in their primary goals (e.g., sexual gratification versus redressing harm to self), their capacity of planning (e.g., explicit versus implicit), and the kinds of emotions (e.g., negative versus positive) they experienced throughout the offense

process....” One novel change to the relapse prevention model was the recognition in the self-regulation model that in some sex offenders, those characterized by what is called an approach pathway to offending (Ward & Hudson, 2000), it is actually positive emotional states that lead to sex offending, not simply difficulty managing negative emotional states. In these offenders, training in general self-control strategies is essential, not solely training in managing negative emotions. There has also been a detailed analysis of the types of coping skills involved, generally divided into task-focused coping, emotion-focused coping, and avoidance-focused coping (Endler & Parker, 1994). Task-focused coping is the most direct, effective, problem-oriented approach and has generally related to positive adaptation. Emotion-focused coping (including fantasizing or self-blame) or avoidance-focused coping (including the use of distraction) may be effective in the short-term for reducing negative affect but ineffective in the long-term for solving the precipitating problem. Serran and Marshall (2006) suggest that a relapse prevention approach would be improved if there were additional attention on the specifics of sex offenders’ coping mechanisms, which in general have been found to be more emotion-focused and avoidance-focused than task-focused.

Another significant recent modification of the relapse prevention model has been an increased focus on helping the offender develop and move towards positive life goals, rather than merely managing negative emotions or negative risk factors, as has been the therapeutic focus in the past. This positive emphasis, consistent with the general trend in psychotherapy towards focusing on more positive aspects of human experience, has been formulated as the Good Lives model (Ward & Stewart, 2003). Ward and associates (Ward & Stewart, 2003; Ward & Fisher, 2006) propose that treatment goals for sex offenders should include the following ten “primary human goods”:

- Life (healthy living and functioning)
- Knowledge
- Excellence in play and work (mastery experiences)
- Excellence in agency (autonomy and self-directedness)
- Inner peace (freedom from emotional turmoil and stress)
- Friendship/Relatedness (intimate, romantic, family relationships)
- Community (connection to others)
- Spirituality (meaning and purpose to life)
- Happiness/Pleasure
- Creativity

The above Good Lives model suggests that treatment planning for sexual offenders explicitly include a conceptualization “that takes into account [the sexual offenders’] preferences, strengths, primary goods and relevant environments, and specifies exactly what competencies and resources are required to achieve these goods” (Ward & Fisher, 2006, pp. 153-154).

Consistent with the Good Lives model is a gradual movement away from the harsh, critical, confrontational therapeutic relationship that characterized earlier treatment approaches (Ward & Fisher, 2006), with an emphasis instead on warmth, support, and motivational techniques in the therapeutic relationship. As Fernandez notes:

If there was only one thing we could recommend to sexual offender therapists it would be to avoid an aggressive confrontational approach with clients. Therapists inevitably serve as models to their clients, thus their actions should exemplify prosocial behaviors and attitudes. If the therapist is aggressive and confrontational they can expect this to elicit either the same response from assertive clients or withdrawal from the therapeutic process by the unassertive clients (2006, p. 188).

Fernandez is clear, however, that the above recommendation does not mean that the therapy should collude with a sex offender client. She states:



Our experience of training therapists has suggested that encouraging therapists to avoid a confrontational approach has sometimes been misinterpreted as an endorsement of the opposite approach; that is, of an approach that is too soft, and essentially collusive with clients. An unconditionally supportive stance toward offenders is definitely not recommended. Therapists who are overly compassionate, do not challenge and do not set firm boundaries are at risk of becoming collusive and are doing a disservice to their clients. (2006, p. 190).

### Measuring change in treatment

One critical issue is how to measure change in treatment. Although many therapists rely on unstructured clinical impressions, the literature indicates that such unstructured impressions tend to be relatively unreliable. Consequently, especially in comprehensive treatment programs, there has been a movement towards use of structured treatment progress rating forms.

There are many measures of how well treatment is working. A number of structured tools assess generally agreed upon benchmarks in treatment, such as motivation, cooperation, and mastery of specific therapeutic skills (for example, identifying personal risk factors). A number of scales include general treatment indicators (that is, those common to any treatment approach or population, such as motivation and cooperation) and sex offender specific indicators (such as learning relapse prevention skills). Seto refers to these as the nonspecific and specific aspects of therapy, respectively (Seto, 2003).

One commonly used scale is the Sex Offender Treatment Rating Scale (SOTRS) (Anderson, Gibeau & D'Amora, 1995). Scoring categories for the SOTRS include:

1. Insight
2. Deviant thoughts
3. Awareness of situational risks
4. Motivation
5. Victim empathy
6. Offense disclosure

Although a reliability study based upon a sample of 122 sex offenders referred to outpatient treatment through probation or parole suggested the scale had high internal consistency, no predictive validity study has yet been conducted.

A second scale is the Goal Attainment Scale (GAS) (Stirpe, Wilson & Long, 2000), which assesses three areas: non-relapse prevention clinical dimensions, relapse prevention clinical dimensions, and motivational dimensions. Non-relapse clinical dimensions include:

1. Acceptance of guilt for the offense
2. Showing insight into victim issues
3. Showing empathy for their victims
4. Acceptance of personal responsibility
5. Recognizing cognitive distortions
6. Minimization of consequences

Relapse prevention clinical dimensions include:

7. Understanding of lifestyle dynamics
8. Understanding the offense cycle
9. Identification of relapse prevention concepts

Motivational dimensions included:

10. Disclosure of personal information
11. Participation in treatment
12. Motivation to change

In a concurrent validity study, individuals with positive attitudes were more likely to complete the treatment program, whereas offenders with negative attitudes were less likely to complete the program. Given that other research has found that those sex offenders who complete treatment have lower rates of recidivism, the ability of the GAS to predict treatment completion is useful (Stirpe, Wilson & Long, 2000).

Also available are some hybrid scales, which include variables related to progress in therapy and broader risk factors related to community adjustment. The prime example of a hybrid scale is the Treatment Progress Scale (TPS) (McGrath, Livingston & Cumming, 2002). The TPS considers:

1. Admission of offense behavior
2. Acceptance of responsibility
3. Sexual interests
4. Sexual attitudes
5. Sexual behavior
6. Sexual risk management
7. Criminal attitudes
8. Criminal behavior
9. Substance abuse
10. Emotion management
11. Mental health stability
12. Problem solving
13. Impulsivity
14. Stage of change
15. Cooperation with treatment
16. Cooperation with supervision
17. Employment
18. Residence
19. Finances
20. Adult love relationship
21. Social influences
22. Social involvement

TPS scores demonstrated a moderate correlation with existing actuarial static risk assessment scales known to have predictive validity, including the Rapid Risk Assessment for

Sex Offender Recidivism (RRASOR) (Hanson, 1997) and the Static-99 (Hanson & Thornton, 1999).

Measuring  
treatment  
effectiveness

As useful as the above rating scales are, in the end, they measure proxy variables for the one variable that is of key concern—recidivism. The most fundamental measure of treatment effectiveness for sex offenders is recidivism—that is, does sex offender specific treatment decrease the frequency with which sex offenders commit new offenses? This would be analogous to a decrease in mortality in traditional medical outcome studies. This issue is one of considerable debate in the profession.

One difficulty has been precisely defining and measuring recidivism. There are many methodological difficulties in assessing recidivism including (see further discussions in Zgoba, Sager & Witt, 2003; Witt & Zgoba, 2005):

1. *Lack of a standard definition of recidivism:* Recidivism is variously defined as new sex offense arrest, a new sex offense conviction, a new arrest of any kind, a new conviction of any kind, or even a new technical violation of parole. Any change in the definition of recidivism changes the frequency with which it is found. More inclusive definitions result in higher levels of measured recidivism.
2. *Underreporting of sex offenses:* Because sex offenses are underreported, probably more than other offenses, it is difficult to ascertain true reoffense rates. Although this problem occurs in attempting to measure offense rates for any crime, many believe that sex offenses are particularly underreported.
3. *Lack of a homogeneous sample:* Recidivism studies frequently aggregate diverse groups of offenders, failing to separate offenders into meaningful subgroups. Because different subgroups of offenders reoffend at different rates, aggregating them results in imprecise measures of recidivism.
4. *Variation in follow-up period:* The longer the follow-up period, the more opportunity offenders have to reoffend and the higher the rate of recidivism is likely to be. Because many studies of recidivism have had short follow-up periods, recidivism rates in those studies may be unrealistically low.

5. *Attrition:* Some participants drop out of the studies during treatment. Some are unable to be located during the lengthy follow-up period. Consequently, it is not possible to track all members of a treatment outcome study.

In assessing treatment outcome, traditionally, a hierarchy of studies is used. In increasing order of methodological rigor, these are:

1. Qualitative (anecdotal) studies
2. Non-randomized clinical trials without a comparison group
3. Non-randomized clinical trials with a comparison group
4. Non-blinded randomized clinical trials
5. Blinded randomized clinical trials (RCTs) (Witt & Greenfield, 2002)

As one progresses up the hierarchy, it becomes possible to rule out alternative hypotheses more easily. For example, in studies without a comparison group, it is not possible to conclude that factors other than the one of interest affected the outcome. In a blinded RCT, one can also rule out the possibility that experimenter bias affected the outcome.

Unlike medical and pharmacologic research, in which blinded RCTs are the required methodology by regulatory agencies (such as the Food and Drug Administration [FDA]) for approval of proposed agents, social science outcome research can rarely employ that methodology, especially in the evaluation of treatment programs in correctional settings. In such studies, the issue has been raised of whether or not correctional inmates can truly give informed and voluntary consent as subjects in treatment protocols and studies. Incarcerated persons are considered vulnerable subjects. In that vein, the ethical conundrum of depriving a control group of the purported beneficial effects of the treatment program or protocol under investigation may also present a thorny dilemma to the investigators.

There is a traditional distinction between efficacy studies and effectiveness studies. Marshall (2006) best summarizes the distinction between these two:

Efficacy is said to be determined by studies in which methodological rigor takes precedence over considerations of clinical relevance; effectiveness, on the other hand, is shown by studies evaluating the clinical application of treatment (p. 256).

There are problems in relying too heavily on RCTs more generally in evaluating sex offender treatment. These difficulties are summarized by Marshall (2006):

1. Requirement of adherence to a detailed treatment manual in RCT
2. Lack of similarity to how treatment is actually conducted
3. Inability to tailor treatment to individual patient's needs and style
4. Ethical problems in random assignment, particularly with prison inmates, generally considered a vulnerable population
5. Impossibility of long term follow up, particularly on untreated sex offenders
6. Typical short follow up periods, thus not allowing sufficient time for differences to emerge between treated and untreated sex offenders
7. Lack of ability (to date, including the Sex Offender Treatment Evaluation Project [SOTEP] study) of random assignment to result in matched treated and untreated groups

Other authorities have suggested that randomized clinical trials may not, in fact, be the best method for evaluating psychotherapy. For instance, Seligman (1995) states that randomized clinical trials may be, "the wrong method for empirically validating psychotherapy as it is actually done, because it omits too many crucial elements of what is done in the field" (p. 966). In other words, RCTs lack ecological validity. Even if one were able to overcome some of the difficulties noted above in constructing a true RCT, there

would always be the question of how well the treatment procedures used in the RCT match those used in actual clinical practice, and the most frequent answer would be, “Not very well.”

Given the many difficulties with obtaining a true randomized control group, and the possibility that randomized clinical trials may not be the best method for evaluating psychotherapy, most sex offender outcome studies have relied on samples of convenience (or “incidental” samples), which are matched to the treatment group as much as possible. Such samples involve selecting untreated sex offenders from the same institution or a similar institution from which the treatment staff was drawn, matching both samples on as many variables as possible, such as demographic characteristics and underlying criminal offenses. Marshall (2006) notes that when studies with incidental designs are considered, treatment effects are quite commonly found. Because many treatment groups actually receive treatment due to some unique characteristic or characteristics—such as a particular diagnosed mental disorder or a high rate of prior sex offending—finding an appropriate comparison group can be difficult. For these and other methodological reasons, the results of sex offender specific treatment outcome studies can be difficult to interpret.

Much of the above debate is actually disagreement in the professional field as to whether effectiveness studies or efficacy studies are the better measure of whether sex offender specific treatment works. Those favoring RTCs such as propose that without true efficacy studies, it is not possible to rule out alternative hypotheses for any supposed treatment effect. Those favoring less methodologically rigorous studies (i.e., effectiveness studies) propose that RCTs, even if conducted, lack generalizability because they are not conducted in the manner in which treatment is actually performed in the field. The issue is as yet unresolved.

Some  
representa-  
tive studies

Recognizing the methodological difficulties in sex offender treatment outcome studies described above, we nevertheless note that efforts to conduct evaluation studies date back two decades, to the 1980's. In 1989, in a widely cited meta-analysis, Furby, Weinrott and Blackshaw (Furby, Weinrott & Blackshaw, 1989) suggested that sex offender treatment was ineffective, which had the same dampening effect for sex offender treatment as did Martinson's work in previous decades had for general criminal rehabilitation (Martinson, 1974). However, several years later, in another meta-analysis of all sex offender treatment studies since the Furby study, Nagayama-Hall (1995) found that many of the studies previously reviewed by Furby had not used current treatment methods and therefore did not reflect current treatment effectiveness. As a practical matter, Nagayama-Hall's findings also offered a slightly more optimistic view than the Furby study, with the conclusion that cognitive-behavioral treatment did result in a small improvement relative to comparison conditions (specifically, an approximately one-third reduction in recidivism, from 12% to 9%, and an average effect size of 0.35).

More recently, a study by Nicholaichuk and colleagues at the Correctional Service of Canada (Nicholaichuk, Gordon, Gu & Wong, 2000) offered an optimistic result that sex offender treatment, specifically cognitive behavioral approaches, can significantly reduce recidivism of sex offenders. The authors compared 296 treated and 283 untreated offenders for an average follow-up period of six years. During the follow-up period, approximately 15% of treated sex offenders were convicted for a new sexual offense, whereas 33.2% of untreated matched sex offenders were re-convicted of new sex offenses, giving a 50% reduction in recidivism attributable to treatment. The following year, the Ohio Department of Rehabilitation and Correction reported on a large sample of release sex offenders over a ten-year follow-up period. In the Ohio study, offenders involved in treatment programs had lower levels of recidivism than those not



involved in treatment, 33.9% and 55.3%, respectively (Ohio Department of Rehabilitation and Correction, 2001). In 2003, Zgoba, Sager, and Witt (2003) reviewed and analyzed ten year recidivism data for individuals placed at the New Jersey Department of Corrections' state facility for the treatment of repetitive-compulsive sex offenders, the Adult Diagnostic and Treatment Center (ADTC). The authors, in summary, found that intense treatment can reduce the recidivism level of a high risk population to at least the level of a population not found to be and sentenced as "repetitive and compulsive" (the historical clinical criteria for placement at the ADTC). The ten-year rate of sexual offense recidivism for ADTC sex offenders (treated) and general prison sex offenders (untreated) were 9% and 13% respectively. In addition, 65% of the sample of sex offenders from the ADTC did not show any recidivism, whereas only 43% of the general population had no recidivism.

In perhaps the largest meta-analysis, Hanson and his associate (Hanson and Bussiere, 1998) pooled 61 studies with an overall sample size of 23,393 sex offenders. In this meta-analysis, on the average, the sexual offense recidivism rate was found to be low at 13.4% of individuals in the sample re-committing sexual offenses, with 36.3% of the sample committing non-sexual re-offenses. More recently, another meta-analysis by Hanson and associates (Hanson, Gordon, Harris, Marques, Murphy, Quinsey & Seto, 2002) examined the effectiveness of psychological treatment for sex offenders by summarizing 43 studies, resulting in a sample size of 9,454. Similar to the previous studies, the sexual re-offense rate was lower for the treatment group (12.3%) versus the comparison group (16.8%). The nonsexual re-offense rates for the treatment and non-treatment groups were 27.9% and 39.2% respectively.

Perhaps the best known attempt to implement an efficacy study is the Sex Offender Treatment Evaluation Project (SOTEP) (Marques, 1999) in California, using a randomized

clinical trial RCT. The Marques SOTEP study, in fact, is the most commonly cited study by those who suggest that sex offender treatment is ineffective, given that the SOTEP study showed no effect of treatment. The SOTEP study, for all its admirable qualities, had a number of problems, which make generalization from its results difficult. These problems are nicely reviewed by Marshall and Marshall (2007), from which we summarize:

- All treatment participants received the same program for the same number of sessions, preventing individualization of treatment.
- The SOTEP study deliberately excluded many sex offenders who would typically be enrolled in treatment programs, such as those with more than two prior felonies, and those with major mental disorders, brain injury, or having an IQ of less than 80.
- The program also excluded individuals who during the initial intake interview denied committing the offense, whereas most programs would at least make some motivationally-based effort prior to terminating treatment.
- The sex offender volunteers who were randomly assigned to the no-treatment condition remained in prison, whereas the treatment group was transferred out of a prison to a state hospital for the duration of their treatment. Consequently, living conditions for the two groups were not strictly comparable.
- Members of the untreated group in prison may have also received some counseling (such as anger management and substance abuse treatment) even if not a full scale sex offender treatment program.

**Effect size** In the end, when one determines whether sex offender psychotherapy is effective, one always has to ask the question, “Effective compared to what?” The best way to answer this question is to look at the effect size (typically calculated by examining the statistic called “Cohen’s *d*” (Cohen, 1962), which is calculated by comparing the reduction in problem behavior in the treatment group with that of an untreated group and adjusting for the variability of each group. Cohen considers effect sizes of 0.20 to be small

but meaningful, effect sizes of 0.50 to be of medium strength, and effect sizes at or above 0.80 to be large. Comparisons of effect size for either meta-analyses or large clinical studies of various accepted medical treatments, mental health disorder treatments, general criminal offender treatments, and sex offender treatments are nicely summarized by Marshall (2006, pp. 264-268). Surprisingly perhaps, some medical treatments that we accept as effective have remarkably small effect sizes, for example (Marshall, 2006, p. 264):

- Aspirin for myocardial infarction: effect size = 0.03
- Coronary artery bypass surgery: effect size = 0.15
- Chemotherapy for breast cancer: effect size = 0.08

By contrast, the results of meta-analyses and large clinical studies for the treatment of mental health disorders typically have larger effect sizes (Marshall, 2006, p. 265):

- Depression: effect size = 0.65-0.84
- Agoraphobia: effect size = 1.62-2.10
- Bulimia: effect size = 1.14

Effect sizes for the treatment of sex offenders tend to be more modest than those for general mental health treatment, but still significant. For example, two meta-analyses of cognitive behavioral therapy and relapse prevention reviewed by Marshall (2006, p. 265) found effect sizes of 0.47 and 0.28. One well accepted meta-analysis by Hanson has found a relative reduction of 40% in recidivism attributed to participation in treatment (Hanson, et al., 2002). Moreover, even these effect sizes are well above those for many accepted medical treatments. Consequently, it appears reasonable to conclude that although the issue is far from settled, sex offender treatment is effective in reducing recidivism, particularly a relapse prevention/cognitive behavioral approach.

**Conclusion** Cognitive/behavioral treatment of sex offenders—which is a directive, educational approach that focuses on changing both an offenders’ problematic way of thinking and their actions—has advanced over time as it has shifted toward a more flexible, individually tailored approach, become less confrontational, and emphasized current and recent functioning. Although cognitive/behavioral approaches continue to emphasize a relapse prevention approach, which was first applied to sex offenders in the early ’80’s, over time it has evolved into including the acquisition of self-regulation skills (such as managing both positive and negative emotions) and including positive aspects of the human experience, usually referred to as the “good lives model” (Ward & Stewart, 2003). Most, if not all treatments in various settings (i.e., outpatient, correctional) include psychoeducational models to organize treatment, such as identifying the sequence of internal and external events associated with sex offending (often referred to as relapse prevention), management of deviant sexual arousal, victim empathy, cognitive restructuring, and anger management, to name a few. In addition, as this area has evolved, so has the availability of tools to measure change in treatment, such as the Sex Offender Treatment Rating Scale (SOTRS) (Anderson, Gibeau & D’Amora, 1995), Goal Attainment Scales (GAS) (Stirpe, Wilson & Long, 2000), and Treatment Progress Scale (TPS) (McGrath, Livingston & Cumming, 2002), which has been a welcome development for therapists and researchers.

Early studies of sex offender treatment outcome were disappointing. Over time, however, as the field’s sophistication has increased, both in terms of treatment and statistical methods, studies have found a positive effect for treatment. Although not without methodological issues and controversy (see Marques, 1999), recent studies suggest that cognitive/behavioral treatment with sex offenders is effective, both in terms of reducing re-offense and clinically. For example, a recent meta-analysis by Hanson et al. (2002) using a sample size of 9,454 and 43 studies, found that sexual

reoffense rates were lower for those receiving treatment than those who received no treatment. Also encouraging is the effect sizes for various treatments (Marshall, 2006). For example, some accepted medical treatments have small effect sizes, such as coronary bypass surgery (.15), whereas treatment for depression and agrophobia are much larger (.65 – .84, 1.62 – 2.10, respectively). Effect sizes for the treatment of sex offenders range from .28 to .47.

Despite the field's advances over the years, referred to at the beginning of this article as the "best of times," it is also a time when the public, and as a result legislators, have strong negative attitudes toward this population despite much evidence to the contrary; hence, it is also the "worst of times." All states now have community notification laws for sex offenders but for no other type of offender; many towns have passed residency restriction laws, which virtually prohibit someone with a sex offense conviction from living in their town; and many states have now passed laws permitting the indeterminate civil commitment of sex offenders after having completed their criminal sentences. A recent federal law known as the Adam Walsh Child Protection Act (*H.R. 4472*) has continued this trend, requiring lifetime registration for many sex offenders and of some juveniles convicted of a sex offense. How we as evaluators, therapists, and researchers manage these "best and worst of times" will continue to be challenging, and continued research in these areas will allow us to provide accurate, empirically based information.

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