Do Clients Retain Treatment Concepts? An Assessment of Post Treatment Adjustment of Adult Sex Offenders

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Abstract

This study utilized semi-structured interviews and official criminal records to assess the post-treatment functioning and re-offense rate of 153 men who completed long term outpatient sex offender treatment. The participants, age 18-72, had committed or been convicted in criminal court of sex or sex related crimes against children or adults. A total of 555 interviews were conducted with 134 of the 153 participants and official criminal records were reviewed at 67 months post-treatment. Interviews occurred at regular intervals for five years following treatment discharge. Interview questions assessed participants ability to name re-offense precursors and coping strategies, the status of relationships with partners and family, chemical use, work adjustment, and contact with law enforcement.
Participants showed positive post-treatment adjustment including the ability to name precursors and coping mechanisms that would occur early in a re-offense cycle. Results from official records review showed an overall criminal re-offense rate of 12.4%; 2.6% sex related and 9.8% non-sex related. Rates for a comparison group were 32.7%, 4.4% and 28.3%, respectively. Implications for treatment are discussed.

Key words: adult sex offender, treatment outcome, recidivism

The efficacy of treatment of adult sex offenders is a much-discussed topic in the professional literature. Research on treatment outcome often uses sexual and non-sexual re-offense as a measure of treatment success or failure (Marques, Day, Nelson & West, 1994, Zgoba, Sager, & Witt, 2003; Hanson, Steffy, & Gauthier, 1993). Meta- analyses of criminal recidivism studies have been conducted by Nagayama-Hall (1995), Hanson and Bussierre (1998), Alexander (1999) and Hanson, Gordon, Harris, Marques, Murphy, Quinsey and Seto (2002). Investigators have assessed factors associated with treatment success and failure (Maletzky, 1993; Simkins, Ward, Bowman & Rinck, 1990); and recidivism in outpatient programs (Dwyer & Rosser 1992). Dynamic factors (Hanson & Harris, 2001, Hanson & Morton-Bourgon, 2005) have emerged as possible variables related to risk for re-offense and are related to treatment adjustment and targets of treatment programs.
Treatment impact has also been measured during treatment (McGrath, Livingston & Cumming, 2002) and at the end of treatment using objective change measures (Beech & Hamilton-Giachritsis,

2005). Studies have yielded varied results depending on the measures of change, type of treatment approach, offense type and length of time at risk. The generalizability of results has been limited by the differences in length and type of treatment, offense histories of research participants and study design.

The present study was conducted to assess the long-term effectiveness of an adult outpatient treatment program by assessing the post-treatment adjustment and occurrence of re-offense of men who completed treatment. One hundred fifty three men who completed outpatient treatment were followed for 5 years post treatment completion using semi-structured interviews to assess retention of treatment concepts and behavior change. Official criminal records were accessed to compare official re-offense with self- report. A comparison group was identified to contrast official recidivism records with the treatment group.

Program Description

The program was based on the premise that effective treatment would reduce the risk for re-offense and the rate of recidivism when clients:

1. Learned their unique offense cycle and the sequence of thoughts, emotions, and behaviors that put them at risk;
2. Knew precursors to a re-offense and possessed strategies to manage those circumstances;
3. Were able to intervene early in the chain of events that could lead to another offense;
4. Learned to manage day-to-day life difficulties that could be precursors to a re-offense; and
5. Were able to ameliorate underlying psychosocial, biological, relational, lifestyle

and behavioral difficulties or symptoms.

In this model, clients would develop a thorough understanding of the factors that contributed to the commission of their offense. They would also resolve underlying psychological, emotional, or relational problems. Resolution could include prescribed medications for mood disorders, relationship counseling for chronic relationship conflict, measures to increase self-esteem, or activities to increase life satisfaction. Clients would then develop a plan to actively manage dynamic life circumstances and to identify and intervene on early precursors in the sequence of events that could lead to a re-offense.

Program Format

The outpatient treatment program, operated by a community based non-profit agency, was based on a multiple strategy approach utilizing cognitive-behavioral, family systems and psychodynamic theories and techniques. The treatment format was structured around weekly group therapy and twice monthly individual, conjoint or family therapy. Treatment was open ended; clients remained in therapy until all treatment goals were completed. Reviews of progress were conducted approximately four times per year. If a probation officer was involved in the case, he/she was included in progress reviews and consulted on all significant treatment events.

Prior to treatment admission, all clients were assessed utilizing clinical interviews, standardized psychological tests, review of all relevant legal documents and available prior treatment records. All treatment expectations were given to clients in writing at the beginning of treatment. The treatment consisted of 19 goals, each representing a specific issue, dynamic factor or task to be accomplished by the client. Some goals required the inclusion of a spouse, family member or significant other. The content of the treatment goals included:

- a history of all illegal behavior,

- the ability to identify the sequence of behaviors, thoughts and emotions which were associated with the current and prior offense
- willingness to resolve minimization and/or denial,
- ability to identify offense cycles or patterns and other aggressive behaviors that were part of the offense pattern,
- identification and resolution of shame or self denigrating thoughts,
- understanding the meaning of the offense,
- resolution of their own personal victimization,
- developing healthy sexuality,
- victim empathy,
- expressive and receptive communication skills,
- resolving significant and relevant family of origin conflicts,
- enhancing moral development,
- building pro-social relationships,
- repaying the victim and community, and
- developing and implementing a relapse prevention plan.

Referral to an aftercare group and other aftercare recommendations were made according to an individualized treatment plan.
Treatment group composition was heterogeneous by age and offense with the exception of two special focus groups: one of young men whose offense involved consensual sex with a known underage female and another of men who had lower social/cognitive functioning. A male and female co-therapy team facilitated the majority of groups. The treatment was not manualized but clinical staff utilized the same written treatment expectations and goal structure.

Method

The study utilized a combination of semi-structured (self-report) interviews and review of official criminal records. A verbal description of the study was given to the first 160 clients who completed the program between 1990 and 1998 and they were asked if they would be willing to participate. Of the 160 who were asked to participate, 153 consented (96%). Participants signed a consent form outlining the procedures and limits of confidentiality including a statement that known or suspected abuse of a child was subject to reporting to local authorities. This reporting requirement was not minimized nor was any advice offered to aid the participants in avoiding the risk of a mandatory report. At 6, 12, 24, 36, 48, and 60 months post-treatment, a letter was sent asking the participants to contact the interviewer. A follow-up phone call was placed if the client did not contact the interviewer. Interviews were conducted in person or by telephone by the first author. The study procedures and interview protocol, which was reviewed by an academically based institution review board, were originally developed by Dwyer and Amberson (1985) and Dwyer and Rosser (1992). Interview topics included a query about incidents of re-offense or near offense, the ability to name re-offense warning signs, strategies and techniques to manage warning signs, offense related fantasies before treatment and in the 6 months or 1 year period before the current interview, quality of relationships at work and with family, any contact with the law, and chemical use pattern. In addition, three questions were asked regarding the clients experience in the treatment program. The interview included some closed-ended questions requiring a Yes or No answer such as, Have there been any situations where you felt you were close to another sex offense? Two open-ended questions were utilized: Can you describe for me early warning signs or red flags that would be clues you may be headed toward another offense? and Can you describe for me strategies you would use to intervene if warning signs did occur? The responses to questions regarding knowledge of warning signs (precursors to an offense) and strategies to manage warning signs were categorized into thoughts, emotions, behaviors, and situations. Definitions were derived

from a standard dictionary of psychology (Reber, 1985). Thoughts were defined as cognitive processes or mental manipulation or concept formation that cannot be directly observed (e.g., desire, sexualizing, attitudes, or self-dialogue). Emotions were defined as acute or momentary conditions, subjectively experienced, affect-laden states (e.g., nervousness, depression, low self esteem, urges, or loneliness). Behaviors were defined as observable acts, activities, responses, movements, or any measurable action (e.g., being defensive, body language, going to or leaving a situation). Situations were defined as a place, locale or position or set of circumstances (e.g., stress, isolation, or being at home alone). Responses from a sample of initial interviews were coded by the first author and a research assistant using these definitions to develop a set of response examples to guide coding and all subsequent coding was conducted by the first author. A total of 555 interviews were conducted and coded by the first author.

Attendance was a factor in total time in treatment and has been correlated with therapy progress (Simkins et al.,1990). A treatment attendance rate was calculated by a simple count of all group sessions attended divided by 4 (representing 4 groups in a typical month). In addition to the interviews, official criminal records were obtained from a database maintained by the state of Minnesota that included arrests and convictions and related court dates for felony and gross misdemeanor level crimes. National data maintained by the Federal Bureau of Investigation (FBI) and misdemeanor level crimes were not included in this record search. Records were accessed on all 153 participants 7 months after the final participant had been out of treatment 5 years. Total time post-treatment ranged from 67 months to 13 years. However, to compare consistent time frames the criminal records were compared at 67 months post- treatment for all participants.

Re-offense was defined as any self-report of any criminal behavior, sex related or not sex related, and any misdemeanor, gross misdemeanor or felony arrest or conviction found in official records. Sex related or non-sex related crimes were determined by a review of the statute cited in the official record or by a description of the behavior from the self-report. Conversely, positive results were defined as 1) an absence of sex or non-sex-related criminal behavior; 2) an absence of situations close to a re-offense; 3) a demonstrated ability to name re-offense precursors early in a re-offense chain; 4) an ability to identify and name a variety of strategies to manage precursors; and 5) positive relationship functioning within family and work relationships.

Results

The participants were primarily employed, high school educated Caucasians with a mean age of 35 (Table 1).

Table 1:
Demographic Profile by Offense Type

	Child Molestation: Intra-familial (n = 38)	Child Molestation: Extra-familial (n = 69)	Rape (n = 29)	Other (n = 17)	Offender Group Differences
Age					**p<.001**
Mean	40,6	35	26,6	37,9	

Range	19 - 69	19 - 72	19 - 56	25 - 60	
Race					**ns**
Caucasian	34	59	23	17	
Non-Caucasian	4	10	6	0	
Relationship Status at Discharge:					**ns**
Married/coupled	24	42	17	9	
Not coupled	14	27	12	8	
Education (yrs.)					**ns**
7 - 11	7	11	3	2	
12 or GED	25	39	16	6	
13 - 15	5	9	7	5	
16+	1	10	3	4	
Female Victim					**p<.01***
< 12	19	31	0	2	
12 - 17	13	31	12	2	
Adult	0	0	18	11	
Male Victim					**ns**
< 12	7	3	0	1	
12 - 17	0	6	0	1	
Adult	0	0	0	0	
Totals	**39**	**71**	**30**	**17**	

Notes:
1. Rape includes attempted rape and non-rape sexual assault.
2. Other includes exhibitionism, voyeurism and obscene phone calls.
3. Total N = 157 victims as some participants had multiple victims.
4. Differences in age across offender groups were assessed by analysis of variance, $F(3,149) = 8.47$.
All other differences were assessed by the chi-square test of significance.

ns - Statistically nonsignificant
*The 'Adult' category was excluded from this analysis because victims can not be adults in cases of child molestation, $x^2(3,n=110) = 12.84$.
na - Too few cases to allow significance testing.

Nearly two thirds (60%) were in a relationship at the time of discharge from treatment. The sexual offenses committed by the participants included intra-familial and extra-familial child molestation, exhibitionism, rape, attempted rape, other non-rape sexual assaults, obscene telephone calls and voyeurism. The reported victims were primarily prepubescent, adolescent and adult females with 11.5% (n=18) being male victims. Five participants reported multiple victims. Demographic profile differences across these four groups of offenders were insignificant with the exception that rapists were younger than other offenders, one way ANOVA
$F(3,149) = 8.47$, $p < .001$, and their victims were always females, ages 12 years or older, $2(3,N=110) = 12.84$, $p < .01$. A total of 555 interviews were conducted at 6 time intervals with 34% completing all 6 interviews over five years (Table 2.)

Table 2:
Interviews Conducted by Interval Period and Number Per Client

Interviews by Interval Period	
Time Post-treatment	**Number of Interviews**
6 months	126
1 year	104
2 years	99
3 years	90
4 years	72
5 years	64
Total	555
Interviews Per Client	
Number of Interviews	**Number of Clients**
6	46
5	22
4	13
3	22
2	19
1	12
0	19
Total	153

The mean length of time in treatment for all offense categories was 32 months with some variation between offense type. Offense category by attendance rate, length of time in treatment, and number of interviews are summarized in Table 3. An attendance rate was calculated for each offense category utilizing a method described by Simkins et al. (1990) and was found to be 85% - 97%.

Table 3:
Number of Months in Treatment, Attendance Rate, and Number of Interviews

	Child Molestation: Intra-familial (n = 38)	Child Molestation: Extra-familial (n = 69)	Rape (n = 29)	Other (n = 17)
Months in Treatment				
Mean	36	31	31	25
Range	12-59	13-73	16-50	11-44
Attendance Rate				
Mean %	97	96	88	85
Total Number of Interviews	**169**	**245**	**87**	**54**

Notes:
1. Rape includes attempted rape and non-rape sexual assault.
2. Other includes exhibitionism, voyeurism and obscene phone calls.
3. Attendance Rate is the number of treatment sessions attended / total possible sessions.
4. There were no interviews with 19 participants.

At least one interview was conducted with 134 (88%) of the 153 participants who agreed to participate. One participant requested to not be interviewed prior to the first interview and one was deceased prior to the first interview. The remaining 17 who were not interviewed did not respond to interview requests. Two of the 19 who did not respond were found to have an additional criminal sanction at 67 months. At least one interview was completed with 15 of the 18 who were found to have any re-offense.

Interview results

Positive self-report results were found in a number of areas. An important finding was the ability of the participants in all offense categories to name multiple re-offense precursors at each interview interval (Table 4).

Table 4:
Strategies and Precursors Identified by Interview Period

	Child Molestation: Intra-familial (n = 38)		Child Molestation: Extra-familial (n = 69)		Rape (n = 29)		Other (n = 17)	
Precursors								
Months post-Treatment	**n**	**mean**	**n**	**mean**	**n**	**mean**	**n**	**mean**
6	35	3	58	4	22	3	11	3
12	32	3	46	4	16	3	10	3
24	29	3	40	3	19	3	11	4
36	27	3	41	3	13	3	9	4
48	24	3	33	3	9	3	6	5
60	22	2	27	3	8	3	7	5
Strategies								
Months post-Treatment	**n**	**mean**	**n**	**mean**	**n**	**mean**	**n**	**mean**
6	35	4	58	3	22	3	11	3
12	32	3	46	4	16	3	10	4
24	29	3	40	4	19	3	11	3
36	27	3	41	3	13	3	9	5
48	24	3	33	3	9	4	6	5
60	22	3	27	3	8	3	7	3

Notes:
1. Rape includes attempted rape and non-rape sexual assault.
2. Other includes exhibitionism, voyeurism and obscene phone calls.

Many participants named precursors that would occur at the beginning of a re-offense chain, as described in Pithers, Cumming, Beal, Young, and Turner (1988) and Pithers and Cumming (1995). Examples of such negative emotional states named as precursors included felt rejected , felt lonely and felt angry . Few participants named precursors that would occur immediately prior to a re-offense such as watching children at a playground, cruising or stalking victims or arranging time alone with children, suggesting they were aware of early precursors. Participants named behavioral precursors most frequently (33%); thoughts (26%), emotions (24%) and situations (17%) were named less frequently. The mean number of precursors named appeared to be stable over time.

For instance, we compared the mean number of precursors for all four offender categories combined at six months with the same clients at 60 months (n=63). The means were 3.50 and 3.09, respectively. The difference in these means was not statistically significant, paired sample t-test, t (62) = 1.50, p < .14.

Strategies to intervene on a re-offense pattern were also categorized into behaviors, thoughts, emotions and situations. Most participants were able to name multiple strategies. Participants named behavioral strategies most often (63%) followed by thoughts (33%), situations (3%) and emotions (1%). Participants named early behavioral interventions such as talk with my wife, tell someone if I am angry or thoughts such as recognize depression. Some also named more immediate behavioral strategies such as leave the situation. This response pattern suggests an action-oriented approach to managing risk. The mean differences in number of strategies named between six months and 60 months was non-significant for the 63 clients examined, M= 3.50 vs. 3.22, t (125) = .96, p < .34. Thus, there appeared to be little decay in clients abilities to name either precursors or strategies.

Relationships with family or significant others were found to be generally positive or improved with little observed change over time. Overall, participants reported having difficulty with any member of their family of origin in 129 (23%) of the 555 total interviews. Few reported difficulty with more than one family member or difficulty across multiple interviews. Across all interviews, difficulty with father or mother were reported with similar frequency whereas reports of difficulty with siblings was higher. Reports of quality of relationship with spouse or partner were positive. Across all interviews with all participants, 19.8% reported having difficulty with a partner at some time with a range 11% to 18% across all interviews. Approximately 29.7% reported having difficulty with children in at least one of the six interviews of those who reported problems with a family member in more than one interview, only a small number reported family problems in all interviews. For example, seven reported problems with mother, only one of seven reported problems with mother in all interviews. Of the 21 who reported problems with children only 6 reported problems with children in all interviews. Overall, participants reported improved relationships at work in 73.3% of the interviews with little change across the five-year time span. Over half reported increased productivity at work. They attributed their improved relationships to having better communication skills, higher self-esteem or improved self-confidence.

Participants reported decreases in the occurrence of offense-related fantasies compared to fantasies prior to treatment. When asked to estimate the percent of offense related fantasies prior to treatment they reported a mean of 39% (SD = 32, range 0 - 100). When asked to estimate percent of offense related fantasies post-treatment they reported a mean of 2.8% (SD = 7.6, range 0 - 75).

Re-offense results

At 67 months post-treatment, 19 participants were found in official records who were charged or convicted of one or more incidents of criminal re-offense, including probation violations (Table 5).

Table 5:
Recidivism Rates for the Treated Group and Comparison Group at 67 Months Post-treatment

	Treated Group[1] (n = 153)		Comparison Group (n = 113)		Difference[2]
	no.	**%**	**no.**	**%**	**%**
Sex Related Reoffenses	4	2,6%	5	4,4%	1,8%
Non-sex related Reoffenses	15	9,8%	32	28,3%	18,5%***
Total Reoffenses	**19**	**12,4%**	**37**	**32,7%**	**20,3%*** **

Notes:
1. When the official records were obtained, 153 or 100% of the treated group, but 113 or 64% of the comparison group had been at least 67 months post-discharge.
2. Percent differences were tested via chi-square with 1 degree of freedom where: *** $p < .001$ (in both cases, minimum expected cell count is > 5.0)

Eighteen re-offenses (3 sex-related and 15 non-sex related) were found by official record and one sex related incident was self-reported, but was not found in the official records. From official sources, one sex related record consisted of two instances of exposing by the same subject, both of which were also self-reported. The other two sex related offenses consisted of one instance each of invasion of privacy. Five cases of drug or alcohol related criminal re-offense were reported by official record: three for Driving While Intoxicated (DWI) and two for possession of an illegal drug or narcotic. Three cases of assault and two driving violations were also found. As shown in Table 5, a sex related re-offense rate of 2.6% (4/153), a non-sex related re-offense rate of 9.8% (15/153) and an overall criminal re-offense rate of 12.4% (19/153) was found.
We compared the treatment group re-offense rates with a comparison group (Table 5). The comparison group was a convenience sample that consisted of men referred to the same agency only for evaluation and who were not admitted to treatment after the evaluation. Clients who failed out of treatment, those admitted to treatment without receiving treatment, those transferred to another agency, or those deemed inappropriate for treatment were excluded from the comparison group. The comparison group and the treated group consisted of men who were discharged from the agency over similar time periods and both groups were referred by criminal justice agencies after arrest and conviction for a sex related crime and were not remanded directly to prison but remained in the community. The two groups were not statistically different on education, never married, number of prior convictions as an adult and juvenile, and age at first offense (Table 6).

Table 6: (con't.)

	Treated Group (n = 153)	Comparison Group (n = 113)	Chi-square	p value
No. of Previous Sex Related Convictions:				
As adult:				
0	77,8%	74,3%	0,675	,713
1	14,4%	20,0%		
2 or more	7,8%	5,7%		
As juveline:				
0	94,4%	94,3%	2,38	,230
1	0,0%	2,9%		
2 or more	5,6%	2,9%		
Index Sexual Offense:				
Contact offense	95,8%	82,3%	8,08	,004**
Non-contact offense	4,2%	17,7%		
Any Male Victims:				
Yes	15,1%	5,4%	5,31	,021*
No	84,9%	94,6%		
* p < .05; ** p < .01; *** p < .001				

At the time of the criminal record check, it was not known if the comparison group ever received any treatment at another institution after the initial evaluation. The comparison group was not interviewed after discharge and self-reports of re-offending were not possible to obtain. The sex related recidivism rates from official records were found to be lower for the participants who received treatment than for the comparison group (2.6% vs. 4.4%). However, the difference did not reach statistical significance (Table 5).

We identified 10 potential correlates of recidivism for additional examination. A summary of the differences between the two groups on these potential correlates is found in Table 6. Of the 10 variables investigated, five were found to have statistically significant differences between the treated group and the comparison group. Only two of these five variables, however, showed a statistically significant relationship with recidivism: age at discharge and employment status. A greater percent of the treated group (86.9%) was older than 25 as compared to the comparison group (76.1%). The degree of unemployment was considerably lower for the treated group (13.3%) than it was for the comparison group (37.1%). To examine whether these two differences might significantly impact our comparisons, we selected only those clients in both groups who were over 25 years in age at discharge and who were employed. We found that 9 of 99 or 9.1% of this selected treated group recidivated, whereas 11 of 52 or 21.2% of this selected comparison group recidivated (whether sex-related or not sex-related). This re-offense difference was statistically significant, ^{2} (1, N=15) = 4.32, p<.038.

Discussion

These results suggest that this comprehensive treatment approach had a positive impact on behaviors that were the focus of treatment and related to sexual offense cycles. For example, most participants reported positive social, relational and employment circumstances. Reports of relationship conflict were limited to cases where a divorce occurred during or after treatment or where chronic family conflict had been the norm. Many participants reported positive relationships and work functioning over multiple interviews, which suggests stability in these areas. Contact with law enforcement was limited to traffic violations and the criminal violations identified in official records.

Eleven percent reported having felt close to a re-offense at least one time although only 1% reported this circumstance in consecutive interviews. This appears to be a positive outcome as participants named precursors that would occur early in a re-offense cycle resulting in an earlier opportunity to intervene to prevent re-offense. However, it is likely that others had, at one time or another, felt close to a re-offense and did not report those instances.

Social and work-related functioning reflect the overall social skills and life stability of the participants. Many participants reported increased work productivity and most reported improved relations at work. In describing these changes they noted improved self-esteem, communication skills and greater self-confidence as contributing factors. The treatment model tied improved social skills to a lower level of risk. Therefore, a goal of treatment was to improve social skills and relationship competence. Therefore, a positive outcome was when a client gained greater satisfaction from their employment or benefits from improved conflict management skills in relationships.

Participants reported improved relationship functioning. Few participants reported chronic family problems that persisted over time or problems with all members of their family. This finding suggests that, in general, participants experienced their family as a potential source of support with few participants experiencing complete alienation from their family. While an indirect measure, job satisfaction and relational success are related to a high degree of self-efficacy, which contributes positively to self-esteem and social functioning (Bandura, 1997).

The sex related re-offense rate (2.6%) was lower than some studies but generally consistent with published studies (Nagayama-Hall, 1995; Hanson & Bussierre, 1998; and Hanson et al., 2002). The sex related re-offense rate for the treated group was lower than the comparison group but the difference did not reach statistical significance. Selection criteria for both groups may be a factor; both groups were part of a community sample whose current offenses were typically less severe, who on average had fewer previous offenses and were screened by the courts to remain in the community. Other characteristics of the participants may support this low re-offense rate. The current sex offense was the first for most participants and most did not have any prior criminal record. None carried a DSM IV diagnosis of Pedophilia - Exclusive Type. This population was treated in the community where they were expected to be employed, pay for at least a portion of the cost of treatment, include family members in the treatment program and report to their probation officers on a regular basis.

The treatment approach was long term and comprehensive. It was designed to assess and treat the thoughts, behaviors, affect, and relationship context of each client. The client was expected to demonstrate change over time and was held in treatment until the treating clinician judged that adequate change had occurred. The client was expected to move from an external locus of control at the beginning of treatment to an internal locus by the end of treatment. The premise was that when this shift happens, a client develops internal motivation for gaining benefit from the treatment process, and begins to parallel mainstream psychotherapy patients who benefit from long-term psychotherapy, as observed by Seligman (1996).

This was an outpatient population that was mostly employed, lived in the community and many had families and/or children. Although some were incarcerated for less than 12 months in local jails as a

judicial sanction for their offense, most received probation and few had ever been incarcerated in state penal institutions for more than a year. A probation population is generally more likely to remain stable and successful in the community. Hence, a relatively low rate of re-offense could be expected in a population with a low occurrence of risk factors and a low base rate of sexual offense. We hypothesized a number of possible explanations for why some men declined to participate (7 of 160) and why others dropped out of the study or failed to respond to the request for a follow up interview or were not located (19 of 153.) There were multiple reasons given by those who directly requested to end their participation during the interview process. Some stated they did not want to be reminded of the experience of treatment, stating for example, I want to put it behind me. Others did not want to be bothered with the time and effort to complete the interviews. Others stated that the treatment experience was essentially painful and they did not want to be reminded over and over again. Some may have not wanted the additional scrutiny inherent in the follow-up questions to avoid detection due to involvement in additional illegal behavior. Some may have simply agreed to participate with no intention of follow through. This possibility would be particularly disconcerting as it suggests the possibility of intentional manipulation. Since some participants who were interviewed commented that the interviews reminded them of being in treatment, it seems likely that some of the non-responders did not want to be reminded of treatment. Some may have continued to harbor resentment toward the criminal justice system or have transferred patterns of mistrust to this study. Non-responders were included in official criminal record checks and accounted for two re-offenses; 1 sex related and one drug/alcohol related. The non-responders represented all offense behaviors and a range of ages. At least one interview was conducted with 15 of the 18 who committed an additional offense and 1 of 3 of the sex related re-offenders. Therefore, the non-responders were not more likely to have re-offended and the re-offenders were not more likely to have avoided participation in the interviews.

Limitations

Interview data on social functioning and re-offense was based entirely on self-report. Self-report of criminal behaviors was cross-referenced with official state records. However, neither self-report nor official records fully account for all illegal behaviors leading to the possibility that re-offense data does not represent the full occurrence of illegal behaviors.

There may have been varying motivations for reliable responses to the interview questions. The principle investigator who conducted all of the interviews was the treating clinician in some cases and the program supervisor or agency administrator for all cases. This relationship could have created a positive response bias in some participants. There were instances of participants making negative comments about their therapist or aspects of the treatment program as well as instances of self-report of fantasies of offense related behavior and one self-report of a re-offense, lending at some credibility to the interview data. All participants were informed of the limits of confidentiality inherent in the design and execution of the study. Consequently, any instance of known or suspected abuse of a child was subject to reporting to local authorities. This reporting requirement was not minimized nor was any advice offered to aid the participants in avoiding the risk of a mandatory report. Compliance with this law by the interviewer created a situation that may have reduced the self-report of re-offense for fear of reporting and subsequent legal consequences.

A priority was placed on interviewing as many participants as possible. Thus, some interviews were completed over the telephone because some participants were unable or unwilling to complete the interview in person. While there is no immediate evidence of bias as a result of this methodology, there may be differences in the nature or quality of the different interview methods. Results from phone and in-person interviews were not tested for differences.

Reporting of sexual offenses is generally known to under represent the actual occurrence. The criminal records databases that were accessed did not include misdemeanor in local jurisdictions or federal crimes. These public data bases managed by state and federal agencies have inherent

gaps and inaccuracies related to reporting practices, time delays and human error suggesting that the reported official recidivism rates may likely under represent the actual occurrence of post-treatment offenses.

Conclusion

Program outcome, program evaluation and recidivism studies contribute to an understanding of treatment impact, risk for re-offense and factors that deteriorate over time and contribute to increased re-offense risk. Prior studies have demonstrated the relationship between precursors to a sexual offense and the importance of early intervention on a re-offense pattern. Numerous authors have discussed the antecedents to sexual offense and the contribution of other life stressors. Comprehensive treatment approaches target the improvement of communication skills, self-esteem, appropriate sexual and relational outlets in addition to eliminating deviant and sexual behavior. The results from this study appear to support the treatment goal that clients would retain knowledge and learning after treatment completion. Participants reported improved social and relational skills, improved self-esteem, job stability, an ability to name re-offense warning signs and strategies to manage risk situations as well as a low re-offense rate. Further study is warranted to validate these results.

References

1. Alexander, M. A. (1999). Sexual offender treatment efficacy revisited. Sexual Abuse: A Journal of Research and Treatment, 11, 101-116.
2. Bandura, A. (1997). Self Efficacy. Harvard Mental Health Letter, 13, 9, 4-6.
3. Beech, A.R., & Hamilton-Giachritsis, (2005). Relationship between therapeutic climate and treatment outcome in a group based sexual offender treatment programs. Sexual Abuse: A Journal of Research and Treatment, 17, 127-140.
4. Dwyer, S. M. & Amberson, J. I. (1985). Sex offender treatment program: A follow up study. American Journal of Social Psychiatry, 4, 56-60.
5. Dwyer, S. M. & Rosser, B. R. S. (1992). Treatment outcome research: cross referencing a six month to ten year follow-up study on sex offenders. Annals of Sex Research, 5, 87-97.
6. Hanson, R. K. & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. Journal of Consulting and Clinical Psychology, 66, 348-362.
7. Hanson, R. K., & Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. Sexual Abuse: A Journal of Research and Treatment, 14, 169-194.
8. Hanson, R.K., & Harris, A.J.R, (2001). A structured approach to evaluating change among sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 13, 105-122.
9. Hanson, R. K., Morton-Bourgon, K.E. (2005). The characteristics of persistent sexual offenders: a meta-analysis of recidivism studies. Journal of Consulting and Clinical Psychology, 73, 1154-63.
10. Hanson, R. K., Steffy, R. A., & Gauthier, R. (1993). Long term recidivism of child molesters. Journal of Consulting and Clinical Psychology, 61, 646-652.
11. Maletzky, M. B. (1993). Factors associated with success and failure in the behavioral and cognitive treatment of sexual offenders. Annals of Sex Research, 6, 241-258.
12. Marques, J. K., Day, D. M., Nelson, C., & West, M. A. (1994). Effects of cognitive behavioral treatment on sex offender recidivism. Criminal Justice and Behavior, 21, 28-54.
13. McGrath, R. J., Livingston, J., & Cumming, G. (2002). Development of a sex offender treatment needs and progress scale for adult sex offenders. A report to the U. S.

Department of Justice. (Grant #1000-Wp-VX-0001). Waterbury, VT: Vermont Department of Corrections.
14. Nagayama-Hall, G. C. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. Journal of Consulting and Clinical Psychology, 63, 802-809.
15. Pithers, W. & Cumming, G. F. (1995). Relapse Prevention: A Method for Enhancing Behavioral Self Management and External Supervision of the Sexual Aggressor. In B. K. Schwartz & H. K. Cellini (Eds.) The Sex Offender: Corrections, Treatment and Legal Practice (20, pp. 1-32). Civic Research Institute, Kingston, New Jersey.
16. Pithers, W., Cumming, G., Beal, L., Young, W., & Turner, R. (1988). Relapse prevention. In B. K. Schwartz (Ed.), A practitioners guide to treating the incarcerated male sex offender-breaking through the cycle of abuse (pp. 123-140). U.S. Department of Justice, National Institute of Corrections.
17. Reber, A. (1985). Dictionary of Psychology. Penguin Books, Middlesex, England.
18. Seligman, M.E.P. (1996). Long term psychotherapy is highly effective: The Consumer Reports Study. The Harvard Mental Health Letter, 13(1).
19. Simkins, L., Ward, W., Bowman, S., & Rinck, C. M. (1990). Characteristics predictive of child sex abusers response to treatment: an exploratory study. Journal of Psychology and Human Sexuality, 3, 19-55.
20. Zgoba, K. M., Sager, W.R., & Witt, P.H. (2003). Evaluation of New Jersey s Sex Offender Treatment Program at the Adult Diagnostic and Treatment Center: Preliminary Results. Journal of Psychiatry and the Law, 31,133-164.

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