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The Reduction of Sexual Offense Recidivism following Commitment and Psychodynamic Treatment:

A Challenge to the Dominant Cognitive-Behavioral Model

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ABSTRACT

This brief report presents the reanalysis of data from two studies that examined the recidivism rates of sex offenders who were subjected to a one-day-to-life civil commitment evaluation in which they were deemed to be "sexually dangerous" by two "qualified examiners." One study then presented the recidivism rates of the "more dangerous offenders" (N = 251) who were civilly committed by the courts (the judges agreed with the clinicians) to the Massachusetts Treatment Center for Sexually Dangerous Persons (Prentky, Knight, Lee, & Cerce, 1997). The other study examined recidivism among the "less dangerous dangerous offenders" (N = 31) who were found to be "not sexually dangerous" (the judges disagreed with the clinicians) and were released without treatment, after serving whatever criminal sanctions the court imposed (Cohen, Groth, & Siegel, 1978). After five years in the community, the "more dangerous," treated offenders had recidivated at half the rate of the "less dangerous," untreated offenders (19% vs 38%, $p<.007$). The data appear to pose a challenge to the dominance of the cognitive-behavioral model.

Introduction

Studies that examine the effects of psychotherapy have produced a body of evidence that treatment works. A variety of symptoms are reduced, patients function better, and patients feel better. However, much to the chagrin of clinicians, these studies have not produced evidence of markedly different results based on either expertise or theoretical model (Bornstein & Masling, 1994; Kriegman, 1998; Masling & Cohen, 1987; Seligman, 1995), or even the quite different

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[ii] I would like to thank Karl Hanson for his encouragement and suggestions on how to organize the manuscript. I would also like to thank Robert Prentky and Murray Cohen whose work this is based on; with personal integrity, they brought the empirical method to the difficult work we did at the Massachusetts Treatment Center for Sexually Dangerous Offenders.

treatment modalities of psychotherapy and medication (Kriegman, 1996; Whitaker, 2002). There are some studies that seem to indicate that the cognitive-behavioral model that is currently in vogue for a variety of disorders—and specifically for the treatment of sex offenders—has demonstrable efficacy and superiority over other treatment modalities (e.g., Hanson, Gordon, Harris, Marques, Murphy, Quinsey, and Seto, 2002; Laws, Hudson, & Ward, 2000; see Witkiewitz & Marlatt, 2004).

This brief report presents the reanalysis of data from two studies that examined the recidivism rates of sex offenders who were subjected to a one-day-to-life civil commitment evaluation under the "sexually dangerous persons" statute in Massachusetts. After a 60-day commitment for an evaluation, all of the offenders in the two studies were deemed to be "sexually dangerous" (SD) by two "qualified examiners." One study then presented the recidivism rates of those (N = 251) who—in addition to whatever criminal sanctions the courts imposed—were civilly committed by the courts (the judges agreed with the clinicians), received psychoanalytically oriented, psychodynamic treatment, served their criminal sentences, and were then released (Prentky, Knight, Lee, & Cerce, 1997). The other study examined recidivism among those (N = 31) who were found to be "not sexually dangerous" (the judges disagreed with the clinicians) and were released without treatment after serving whatever criminal sanctions the court imposed (Cohen, Groth, & Siegel, 1978).[1]

Method

Both data sets consisted of men who had been found guilty of committing one or more sex offenses and had been sent to the Massachusetts Treatment Center for Sexually Dangerous Persons to determine if they were SD. Cohen *et al*. were comparing the recidivism rates of men found to be SD by the psychiatrists, but not the courts, versus men found to be not-SD by both the psychiatrists and the courts. They were trying to see if the method and expertise of the clinical evaluators had any validity when compared with decisions yielded by the courts, i.e., whether there was substantial incremental validity produced by clinical judgment.[2] The Prentky *et al*. study was an attempt to compare and contrast the recidivism rates yielded by the different methods of operationalizing the construct, "recidivism" (new charges, new convictions, versus additional prison sentences) and the observed recidivism rates versus those produced by survival analysis.

Both studies included all available data on those sex offenders who went through the commitment process during the same time period (starting in 1959), with the Cohen *et al*. study ending with men who had been released by 1967. In addition to the men who were released by 1967, the Prentky *et al*. study also included men who had been evaluated and committed up until the late 1970's; the criterion for inclusion was whether they were released into the community before or during 1984. There was a cohort analysis in the Prentky *et al*. study to see if, the men released during different time periods recidivated at a greater or lesser rate. The men were categorized into three time gates, the first of which corresponded to the time period in the Cohen *et al*. study (1959-1967, 1968-1975, and 1976-1984); a chi-square test revealed no evidence of differences (p = .915).

The treatment provided to the men in the Prentky *et al*. study utilized a psychodynamic, psychoanalytic model. In the early years, the treatment was primarily individual psychoanalytic psychotherapy, largely guided by the "ego psychology" school of psychoanalysis that dominated

Boston area psychiatry during that period. By the end of the study period, the treatment had gradually become a combination of psychoanalytically oriented group psychotherapy coupled with behavioral rewards and sanctions that, in addition to privileges within the institution, included "community access." Note that only a small number of men out of the 251 in the Prentky *et al* sample experienced any of these behavioral sanctions, which were only being fully implemented in the second half of the last cohort time gate (1980 to 1984).

Those participating in the Community Access Program during this last treatment period would be allowed to go out into the community, with or without an escort, depending on the level of risk the offender appeared to pose and the stage of the program (programs ranged from "therapeutic" only, all the way to "pre-release"). The Community Access Program was instituted under a federal court order that also forced the state to provide resources (cars, escorts, case managers, etc.). It became a very active component of the treatment program with a substantial number of participants. Indeed, before its gradual erosion, it was generally believed that almost all of the offenders would be allowed to participate, if their participation in treatment appeared to be ingenuous.[3]

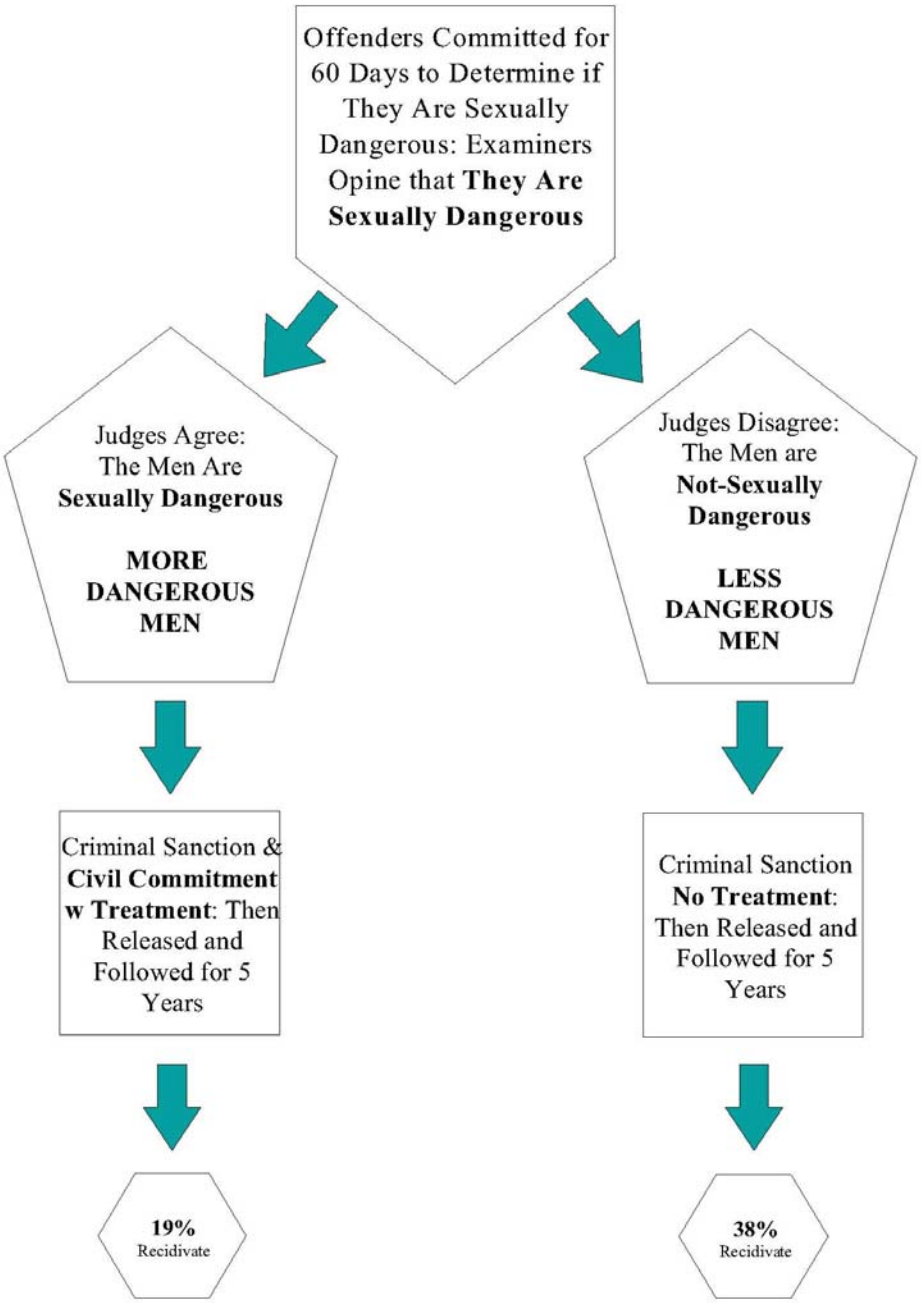
All such behavioral rewards and sanctions were meted out according to a psychodynamic understanding of the patient's treatment, i.e., did the patient need to "work through issues" with his family; did the patient need to work on developing and understanding his relationships with significant others (wife, girlfriend, employers and fellow employees); did the patient have a "working alliance" with the treatment providers, in which he was trying to analyze and understand the underlying ("unconscious" or unacknowledged) reasons for what he was feeling and doing. Patients were expected "to bring back into treatment" for "analysis" their experiences and feelings. If they did so and they followed the rules, their programs would be continued. If they behaved inappropriately or did not bring their experiences into their therapy, their programs would be kept limited, curtailed, or stopped.

Thus, while there were behavioral elements in the psychodynamic model, the program preceded the development of the now dominant cognitive-behavioral model and its application to sex offenders. The psychodynamic treatment model focused on the "analysis of transference" to the therapists, to the fellow group members, and to new relationships developed in the Community Access Program. The overriding, guiding goal was to develop *understanding and insight* into the dynamics underlying the patient's internal experience and patterns of interpersonal interaction, with the belief that this would lead to behavioral change. Only a small number of men in the Prentky *et al* sample were exposed to the "behavioral" elements that were only being fully implemented by 1980. And, in any case, with or without the behavioral elements, the psychoanalytic treatment program in place throughout the Prentky *et al* study was clearly *not* what would be considered "cognitive-behavioral treatment" today.

As noted, all men in the two studies had been found to be "sexually dangerous" (SD), pursuant to a 60-day commitment to assess "sexual dangerousness," by two "Qualified Examiners" However, the court agreed in 251 cases (the men were adjudicated SD) and disagreed in 31 cases (the men were adjudicated not-SD). Unless the judges' decisions were somehow perverse, i.e., they tended to find the more dangerous men not-SD, and the less dangerous men SD—a notion for the existence of which I could not generate any plausible supportive hypothesis—it seems reasonable to conclude that the 31 men who were adjudicated "not-SD" comprised a less dangerous group than the 251 cases in which the clinicians and the judges agreed that the men were "SD." At least, we can be fairly certain that, on average, the 31 men who were adjudicated not-SD were *no more dangerous* than the men adjudicated SD. All the

men were followed for five or more years post-release in both studies. Sexual offense recidivism data (any new sexual offense charges) were available for all of the men at the five year mark.[4] Figure One presents a flow chart with the parallels and differences between the samples. Table One presents the findings.

Figure One



Results

Commitment with psychodynamic treatment of ostensibly *more* dangerous offenders was followed by a five year recidivism rate of 19% (48/251). Incarceration and release without treatment of those who were ostensibly *less* dangerous was followed by a five year recidivism rate of 38% (12/31).

Table I	**The Number (%) of Men Who Committed a New Sexual Offense**	**The Number (%) of Men Who Did Not Commit a New Sex Offense**	**Total Number in the Category**
MORE DANGEROUS: WERE ADJUDICATED SDP & **RECEIVED TREATMENT**	**48 (19%)**	**203 (81%)**	**251** From Prentky, Knight, Lee, & Cerce (1997)
LESS DANGEROUS: WERE ADJUDICATED NOT-SDP & **DID NOT RECEIVE TREATMENT**	**12 (39%)**	**19 (61%)**	**31** From Cohen, Groth, & Siegel (1978)
TOTALS	**60**	**222**	**282**

P<.007 Chi squared equals 6.32 with 1 degree of freedom.
The one-tailed P value equals 0.006. Cohen's d = .30[5]

Discussion

What we see is a *lower* rate of recidivism for the *more dangerous* men who were committed and treated versus a *higher* rate of recidivism for the *less dangerous* men who were not committed and not treated. The most reasonable explanation for the results is that some aspect of the commitment with psychodynamic treatment reduced recidivism.

One possible reason why open ended, long term, intensive psychoanalytic psychotherapy has not been found to be effective in other studies is that it is a rather costly approach and has not been systematically applied and studied much, especially with the *most* dangerous sex offenders.[6] It appears that treatment has greater impact on the more dangerous offenders (Barbaree, Langton, & Peacock, 2003), or at least treatment effects are easier to demonstrate among such offenders. Thus, this analysis may simply provide more evidence for a "generic" treatment effect (or easier demonstration of such) with the most dangerous offenders.[7]

In the psychodynamic treatment model utilized, the goal was to develop insight and understanding that would enable the patient to have control over and to change his behavior. The specific areas of concern were similar to those that would later be targeted by cognitive-

behavioral treatment models, i.e., anger, sexualization, honesty and taking responsibility versus denial and blaming others, withdrawal from relationships versus development of social skills, empathic ability to listen to others' experiences and feelings (especially when in conflict), etc. Indeed, one of the reasons that the general research on psychotherapy may have failed to find a difference between theoretical models is that, in most reasonable helping relationships, elements of many treatment modalities are present despite the theoretical orientation of the therapist.

In any case, the data appears to indicate that commitment to a facility that provided psychodynamic treatment reduced recidivism. This presents additional evidence that commitment with treatment reduces recidivism. However, this evidence also brings into question whether the specific treatment model is a crucial factor. As with the finding of a general positive effect from psychotherapy—without any clear relationship to the model employed or the experience of the therapist—the reduction in sexual offense recidivism associated with active involvement in treatment and with completion of a reasonable treatment program may be due to a number of factors that have little to do with the specific model employed.

For example, instead of passively waiting for time to pass in prison, offenders committed to treatment programs must spend years actively and repeatedly labeling their sexual misconduct "a serious problem" that caused damage to the victim(s), as well as to the offender. Regardless of any treatment model employed, this may help some offenders come to view their own (and others) sexual misconduct in a manner that is more consistent with the way that most non-offenders view sex crimes, i.e., to change attitudes "tolerant of sexual crime" that are correlated with recidivism (Hanson & Morton-Bourgon, 2004). Another aspect of the psychodynamic treatment model that may have reduced risk is learning to tolerate unpleasant feelings without acting out, rebelling, or quitting. This is a part of "growing up" that is associated with a decrease in impulsivity and irresponsibility. Another aspect may be the self respect gained from the successful completion of hard work and from the approval of therapists who represent society. Such experiences may enable some offenders to feel like they need not always be social outcasts, living on or beyond the fringes of society and only able to get sexual/physical human contact if they can "steal" it by victimizing others.

Regardless of whether these specific notions are correct, the actual data of treatment related recidivism reduction can be understood utilizing many potentially valid alternatives to the reasonable theories underlying specific models of treatment, including the cognitive-behavioral model that is currently in vogue. While evidence of treatment related recidivism reduction is beginning to accumulate, we are still at the very beginning of the process of determining what aspects of treatment actually work.

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[1] I am claiming that though the groups were not randomly assigned, there is reason to believe that this makes this study's findings even stronger. Note that even with the non-random selection, there was *better* selection for a study of treatment impact—i.e., the selection in this study is far *less* likely to have introduced bias in a direction that would undermine the finding of treatment/commitment related recidivism reduction—than in the of studies presented in the

Hanson et al (2002) meta-analysis that is used to claim that CBT is effective. Almost all the Hanson et al studies had confounding variables in selection. Yet here we have a case where the confounding variables are highly unlikely to have introduced bias that would make the specific conclusions questionable.

[2] The judgments of the clinicians were found to be more accurate: The men they said were SD (but were deemed "not-SD" by the courts) recidivated at a higher rate than those they said were not-SD (and were deemed "not-SD" by the courts). However, this may not indicate the accuracy of "clinical judgment," per se; built into the law itself was a valid predictor.

The law required evidence of "repetitive or compulsive sexual misconduct," which was generally interpreted by the evaluators to mean two or more convictions (with intervening sanctions that did not prevent recidivism) for separate acts of sexual misconduct. Because of this, in almost all cases in which the clinicians opined that the offenders were SD, the men had relatively extensive prior sex offense histories,. Compared to the average sex offender, those deemed to be sexually dangerous by the clinicians also tended to be younger and have longer criminal histories. And there were few, if any, men considered for commitment who were incest-only offenders. Extremely violent or sadistic offenses and/or extensive criminal histories of interpersonal violence could override these features, though this only occurred in a small percentage of cases.

Rather than the existence of clinical expertise in risk assessment, what the Cohen et al study may have produced evidence for is the *undermining* of selection based on valid predictive factors when "clinical" judgment was introduced. Men with extensive histories of repetitive sexual misconduct directed against extra-familial victims were deemed not-SD by a judge using subjective, i.e., essentially "clinical," judgment. Thus, somewhat ironically, in that study we may have had evidence for the *invalidity* of subjective, clinical prediction when a judge introduced invalid predictive factors.

There were other reasons why the clinicians may have been more accurate than in other studies of clinical prediction. The three most important were (1) in the early days of the operation of the law in Massachusetts, clinical judgment and the selection of the clinical evaluators were far more insulated from politics (there was no strong bias toward the over-prediction of dangerousness), (2) the selection of offenders to be considered for commitment was not made by elected officials, who were therefore insulated from "front page errors" (i.e., headlines in newspapers) and were thus not prone to try to have as many sex offenders as possible committed without regard to actual risk, and (3) the offenders were usually evaluated near the time of their initial sentencing and/or sent for evaluation long before finishing their criminal sentences. Thus the valid, positively correlated predictors (e.g., prior sex offense history, extra-familial victims) weren't as degraded by aging (a valid, negatively correlated predictor) or the passage of time (with whatever unknown intervening variables may have been introduced).

[3] The program continues to exist today, but in name only. By the early 1990's, it had become a token program as federal oversight was reduced and eventually terminated. For a decade now, no offenders have gone out from the secure facility. Of interest when considering the validity of the clinical prediction of dangerousness and the validity reducing effect of politically induced bias, participation in the defunct Community Access Program is still cited by State experts as a milestone that needs to be accomplished before an offender can be safely released. Using the fact that the offender hasn't participated in the non-existent Community Access—still the official last phase of the treatment program—the "risk factor" titled by Hanson and Bussiere (1998), "Failure to Complete Treatment" is misinterpreted and specifically invoked to conclude that the offender is at "higher" or "heightened" risk to reoffend.

[4] The Prentky *et al*. study used survival analysis to produce reoffense rates for those men in the study who were not at risk long enough to know if they would have reoffended after a longer period in the community, i.e., to estimate rates of recidivism for the entire group after 15, 20, and 25 years. Actual recidivism data was not available at those time gates for the offenders released, for example, in the last cohort (1976 -1984). However, actual data was available for all offenders in the study for the early time gates, including the 5 year mark.

[5] With Yates' correction, Chi squared equals 5.204 with 1 degree of freedom, and the one-tailed P value equals 0.0113. One-tailed P<.02 using Fisher's exact test (P=.015). Two-tailed P<.02 using Fisher's exact test (P=.019).

[6] Even as the Treatment Center transitioned to a group model, the psychodynamic approach was one that: (1) continued to utilize a significant amount of individual treatment and case management, (2) looked for individual meanings in an offender's experience, (3) because each offender was understood differently, developed individualized treatment plans with unique goals for each offender, and (4) required extensive ongoing supervision and management of the therapists (and their "countertransferences"). Early on, sufficient funding was available for such intensive work when the census was low. When the numbers of committed offenders grew, a federal court order and oversight was necessary before the state supplied the funding necessary to maintain adequate treatment. Movement to a group model and a behavioral approach began in a search for ways to contain costs as the number of committed offenders continued to grow.

[7] While I do not have well documented data regarding the risk level of the average offender committed to the Treatment Center, there are some good reasons to believe that they tended to be among the most dangerous offenders (e.g., see footnote 1, above). In addition, since I began using the Static-99, I have evaluated dozens of men committed to the Treatment Center during the years largely covered by the Prentky study (prior to 1990). I do not recall any who scored below four. Almost all scored five and above. If treatment is more effective with high risk offenders, as suggested by Barbaree et al. (2003), this may explain why the data presented here suggests a treatment effect while other studies—that include large numbers of more common low risk offenders—do not find treatment related effects.

Of course, change is easier to see when there is more room for change. So could this be an artifact of our greater ability to perceive change in recidivism rates of high risk offenders? If our instruments are not very accurate and we can reliably measure only a 20 lbs or greater weight loss, then wouldn't a diet show much greater effectiveness with people who are 50 to 60 lbs overweight than with those who are 15 to 25 lbs overweight? This would be so even if the proportionate change in overeating produced by the diet were greater in those who were thinner to begin with. And we know that our recidivism "scales" have accuracy problems (e.g., undetected recidivism) and thus are not "very accurate."

Alternatively, change is easier to bring about when the phenomenon in question is farther from the norm. Weight training programs initially bring about dramatic strength improvement in "couch potatoes." Later, improvements require much greater effort. It is easier to lose 20 lbs if you are very overweight than it is to lose the last 10 lbs to bring your weight into the ideal range. This is not just a statistical artifact, i.e., regression toward the mean. Systems that tend toward a central point will typically show more normal deviations near the mean and will have to be "stretched" to reach rarer abnormal extremes: There are significant pressures operating that maintain organisms nearer their means. These pressures appear to increase significantly as one deviates further (thus keeping extreme deviations rare). Any form of treatment that has a real effect should be more effective when it is combined with a stronger pull toward the mean found in extreme deviations and/or is aimed at undermining unusual forces that can cause and maintain extreme deviation in the presence of the relatively strong pressures toward the mean that exist at the extremes.