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Thursday, September 12, 2019

The purpose and outcomes of treatment

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As we prepare for this year's NOTA conference, we have been again discussing many of the controversies of our field, among these are the effectiveness of the work that we do. An important 2017 article by Karl Hanson and his colleagues is among the most recent to indicate that truly low risk/need people very often require no abuse-specific treatment at all. We certainly agree and continue to urge considerable thought in this area, as we did in 2017. However, it's important to distinguish abuse-specific treatment from other mental health services that can help people lead a more fulfilling lifestyle in which offending is undesirable and unnecessary. One concern we have in the subsequent discussions is that it may become easy to confuse "doesn't need treatment aimed at reducing his risk" with "doesn't need treatment, period." This leads to broader questions about what our goals are when providing treatment.

Criminal justice policy and practice, internationally, typically indicates that something should be done with people convicted of an offence, including sexual offences, parallel to their punishment/incarceration. These programs, including treatment and other interventions, are usually pro-social, educational and designed to help people integrate back into society and desist from future offending. However, it might behoove each us to ask ourselves honestly what our motivations are in believing in the effectiveness or ineffectiveness of abuse-specific treatment. Is it that we believe that an individual should receive treatment because it is the best outcome for them or is it because we feel that we are providing treatment to someone because something needs to be in response to their problematic behavior and treatment is the path of least resistance in the public as well as the political domain? Do we believe in treatment because we believe that people can change or because we want to be seen to be doing something and that treatment is an acceptable outcome? To what extent do we view treatment, and the accountability it brings, as part of required punishment and/or justice for the people who have been convicted of a sexual

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We are longtime members of ATSA dedicated to furthering the causes of evidenced-based practice, understanding, and prevention in the field of sexual abuse.

The Association for the Treatment of Sexual Abusers is an international, multi-disciplinary organization dedicated to preventing sexual abuse. Through research, education, and shared learning ATSA promotes evidence based practice, public policy, and community strategies that lead to the effective assessment, treatment, and management of individuals who have sexually abused or are risk to abuse.

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offence? Therefore, what is the purpose of treatment, especially “mandated” treatment?

Different readers will have different responses to the questions above. Much debate in our field has emerged from findings such as those by Schmucker and Lösel in 2015. That study found re-offense rates of 10.1 and 13.7 percent for treated and undertreated people convicted of sex crimes respectively. Although this represented a relative reduction of 26.3 percent, the numbers are clearly not what anyone would like them to be. Nonetheless, other studies have found that people who abuse very often believe that treatment is important and can be helpful. How should we understand all these findings?

A recent article in the New Yorker addressed problems in understanding statistics. Within the article, the author took note of a now-classic study:

Take a clinical trial on aspirin run by the Oxford medical epidemiologist Richard Peto in 1988. Aspirin interferes with the formation of blood clots, and can be used to prevent them in the arteries of the heart or the brain. Peto’s team wanted to know whether aspirin increased your chances of survival if it was administered in the middle of a heart attack.

"Their trial involved 17,187 people and showed a remarkable effect. In the group that was given a placebo, 1,016 patients died; of those who had taken the aspirin, only 804 died. Aspirin didn’t work for everyone, but it was unlikely that so many people would have survived if the drug did nothing. The numbers passed the threshold; the team concluded that the aspirin was working.

The story of these findings is a reminder that our findings are best understood when placed into a broader context. Obviously, there are differences between baby aspirin (where the benefits will nearly always outweigh the risks) and treatment for sexual abuse (where some clients have faced consequences from their treatment disclosures despite attempts to protect their rights against self-incrimination). Nonetheless, the numbers themselves remind us that even a small level of impact in sexual violence can produce dramatic improvements in the quality of life of both those who have abused and the people who won’t be abused thanks to our interventions. Marshall and McGuire compared various kinds of treatment in 2003, and in their conclusions suggested that *“using a harm reduction index to estimate effect sizes for treatment with sexual offenders would produce more meaningful results.”*

Although treatment for people convicted of a sexual offence is rooted in language around reducing reoffending, this may not be the only outcome we should consider. We must remember this! Treatment for people convicted of a sexual offence does not stop offending behavior, it provides individuals with the skills to understand and manage their behavior better. Treatment is a process and not an outcome! Hence, we need a “what works”, individualized approach that is orientated towards the client, what they need, what they respond too and what will help them change their lifestyle.

Whatever the finer points may be, we keep returning to what the research shows:

- Across time, place, and setting, people can benefit from talking to professionals to get on track and stay on track with their lives.
- Punishment-only responses have not worked in any of the large-scale analyses that have taken place (e.g., Smith, Goggin, & Gendreau, 2002)
- Treatment for sexual aggression can help to reduce re-offense and build better lives
- For those returning to the community, treatment combined with supervision can increase its

effectiveness

- As others have observed, the safest person who has abused is:
    - Stable
    - Occupied with work or education
    - Accountable to others in his or her life
    - Has Plans for the future
    - And has everything to lose by doing it again

As we move into conference season, with the NOTA and ATSA annual conferences occurring over the next couple of months, we can continue these discussions and consider how our policies can most effectively put these principles into action.