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Treatment Progress and Behavior Following 2 Years of Inpatient Sex Offender Treatment: A Pilot Investigation of Safe Offender Strategies

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Abstract

Emerging research highlights the role of self-regulation in the treatment of sexual offenders. Safe Offender Strategies (SOS) is a manualized sex offender treatment program that emphasizes the role of self-regulation and self-regulatory skills development in sex offender treatment, particularly for offenders with serious mental illness and intellectual/developmental disabilities. The current study involves 156 adult male sexual offenders in an inpatient psychiatric setting who received SOS treatment for a period ranging from 6 months to 1 year. Participants' baseline and treatment data were obtained from archival medical records describing 1 year pre-treatment and up to 2 years of treatment participation. Dependent variables included monthly count rates of verbal and physical aggression and contact and noncontact sexual offending, as well as sexual deviancy attitudes, self-regulatory ability, and cooperation with treatment and supervision, as measured by the Sex Offender Treatment Intervention and Progress Scale (SOTIPS). Data were examined via paired-samples *t* tests, regression, and multilevel modeling, examining the impact of overall percentage of SOS groups attended over time, comparing participants' baseline measures to data from 2 years of treatment. The impact of predicted risk was also evaluated. Significant treatment dose effects were identified for improvements in aggression, sexual offending, and indicators of treatment compliance and change. These findings suggest that the skills-based, self-regulation approach utilized in SOS may be effective

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in improving clients' aggressive and sexual behaviors, attitudes toward their offenses and treatment, and self-regulatory ability over time. Implications for further research and treatment generalizability are discussed.

Keywords
self-regulation models, sex offender treatment, treatment effectiveness, risk-need-responsivity

Sex offender treatment is ever evolving, reflecting changes in the way we view sexual behavior, variations in our understanding of the etiology of sexual violence, breakthroughs in empirical science, and also social and political influence in managing a controversial public concern. Within the broader context of the psychosocial treatment literature, the history of sex offender treatment research is comparatively brief, with initial studies emerging only decades ago and rapidly driving us to where we find treatment today.

Early behavioral treatments focused almost exclusively on decreasing deviant sexual arousal, as it was believed that this was the primary motivation for deviant sexual behavior. Although empirical research noted a moderate relationship between deviant or offense-specific sexual arousal and sexual recidivism among known sexual offenders (e.g., Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2005), some early treatment outcome studies failed to uniformly demonstrate that changes in sexual arousal patterns could sufficiently or effectively reduce sexual recidivism (e.g., Rice, Quinsey, & Harris, 1991). In addition, only a minority of offenders may show sexual arousal specific to their victims, and some groups of offenders may be less likely to demonstrate a link between deviant sexual arousal and sex offending behavior (e.g., juvenile sexual offenders; Hunter, Goodwin, & Becker, 1994). It is likely that there are significant moderators and mediators in this process, and deviant or offense-specific sexual arousal is only one component of a sexual offense.

Subsequent clinical attention focused on cognitive and affective processes in the development of sexual behavior problems and the treatment of sex offenders. With this shift, techniques such as social skills training, anger management, empathy training, sex values clarification, and developing age appropriate sexual relationships were incorporated into standard sex offender treatment programs that had previously emphasized the reduction of deviant sexual arousal (e.g., Abel, Mittelman, & Becker, 1985; Marshall, Anderson, & Fernandez, 1999; Marshall, Laws, & Barbaree, 1990). Empirical evaluation has demonstrated that cognitive-behavioral treatments are generally effective at reducing sexual recidivism (e.g., Hanson et al., 2002), although little is yet understood about specific treatment mechanisms that may facilitate client improvement.

Many of these cognitive-behavioral treatment components were later incorporated under the broad rubric of relapse prevention, an intervention that was initially developed to assist substance abusers with maintaining treatment gains, controlling urges, and managing drug and alcohol problems. Relapse prevention was applied to sex