To Treat or Not to Treat… What are the Questions? Considering the Effectiveness of Sexual Offender Treatment

David S. Prescott, LICSW
Jill S. Levenson, Ph.D.
ATSA Forum Newsletter, Summer 2009

Authors' note: This article draws from and extends Levenson, J.S., & Prescott, D.S. (2007). Considerations in evaluating the effectiveness of sexual offender treatment: Incorporating knowledge into practice. In D.S. Prescott (Ed.), *Knowledge and practice: Challenges in the treatment and supervision of sexual abusers* (pp. 124-142). Oklahoma City, OK: Wood'N'Barnes.

The authors are grateful to John Morin for his "modest proposal" of the mid-1990's, which sparked much ongoing dialogue and discussion amongst the authors, and laid the foundation for many of the ideas in this article and the chapter that preceded it. Readers may contact Mr. Prescott at vtprescott@earthlink.net or Dr. Levenson at jsljwm@bellsouth.net for copies of this article.

Introduction

A recent British media account (Cox, 2009) takes aim at an American civil commitment center, stirring up readers with unhelpful phrases such as "vile sex beasts." The author notes that many of the center's therapists "do not even believe the paedophiles can be 'cured'." The article's title, regarding the "day I met the paedophiles in paradise," illustrates the author's minimal experience. After all, most professionals agree that whether or not there is a "cure" for sexual offending is not the right question to ask. Nonetheless, the fact remains that most media accounts do not adequately describe the state of our knowledge of sexual offender treatment.

Even within our field, however, the effectiveness of sexual offender treatment remains ambiguous and controversial. Practitioners reviewing the literature and attending conferences (including ATSA plenary addresses as well as regional gatherings) encounter highly conflicting perspectives on this topic. Most are highly articulate and supported with research. Worse, the stakes are very high, and colleagues can provide frightening examples of apparent treatment success gone badly awry.

There is no shortage of documentation of society's attempts to come to terms with crime during the past several centuries. Debate around the merits of punishment and rehabilitation are not new (e.g., Ignatieff, 1978; Morris & Rothman, 1998; Rothman, 1971). An influential paper by Martinson (1974) set in motion the "nothing works" philosophy that has resonated among the public to the present, despite the author's later recantation (1979), subsequent analysis by others (e.g., Lipton, Martinson, & Wilks, 1975;

Thornton, 1987), and advances in both research and practice (Andrews & Bonta, 2003; Gendreau & Ross, 1987).

This article compares sexual offender treatment effectiveness with other areas of outcome study. This article also reviews many of the perspectives that practitioners encounter and offers thoughts on how best to interpret and understand the often ambiguous and conflicting literature. Finally, suggestions are offered for how practitioners can incorporate knowledge of evidence-based interventions into practice with sexual offenders.

Sexual offender Treatment Outcome Studies

Early studies of sexual offender treatment (Furby, Weinrott, & Blackshaw, 1989) led to pessimistic attitudes about the possibility of rehabilitation, though more recent research (including two meta-analyses) has suggested more promising outcomes (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002; Losel & Schmucker, 2005). Hanson et al. (2002) found reductions in both sexual recidivism and general recidivism with treatment based on cognitive-behavioral relapse prevention treatment approaches. Treated groups had a recidivism rate of 10%, compared with 17% of untreated sexual offenders, amounting to an effect size of about 40%. Losel and Schmucker (2005) also found a 40% reduction in recidivism following treatment. Among juveniles, a review of nine studies by Reitzel and Carbonell (2006) found that treated adolescents recidivated sexually at a lower rate (7.37%) than untreated adolescents (18.93%). Likewise, Walker, McGovern, Poey, and Otis (2004) analyzed 10 studies (N= 644) and found an effect size of 0.37, with cognitive-behavioral methods proving the most effective. Finally, Hanson and his colleagues have recently found that programs adhering to the principles of risk, need, and responsivity showed the largest reductions in sexual and general recidivism in their meta-analysis of 23 recidivism outcome studies (Hanson, Bourgon, Helmus, and Hodgson, in press).

However, there are still causes for concern. A 12-year follow up of 403 treated and 321 untreated Canadian sexual offenders published in 2004 found no significant differences in recidivism between the groups (Hanson, Broom, & Stephenson, 2004). Outcome studies from SOTEP (a methodologically rigorous long-term study conducted in an inpatient program in California) have revealed that, in general, sexual offenders who received treatment did not have significantly lower rates of reoffense than those who did not receive treatment (Marques, Day, Nelson, & Miner, 1989; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). Karl Hanson and his colleagues (2002) cautioned that, "It appears that evaluators are better able to identify high-risk sexual offenders than to change them" (p. 187). However, it is noteworthy that SOTEP clients who successfully met treatment goals (as opposed to simply receiving treatment) did recidivate less often than those who did not seem to "get it" (Marques et al., 2005, p. 97). Marshall and Marshall (2007a) highlight the importance of this finding and discuss the discrepancy between achieving the goals of treatment and completing a treatment program without achieving its goals.

Many methodological challenges exist in the study of sexual offender treatment. These include the difficulties in creating random assignment and controlled experimental conditions. Other methodological deficiencies include short follow-up periods, small sample sizes, unclear operationalization of important variables such as recidivism, low base rates, failure to evaluate data separately for different types of offenders, and widely variable treatment protocols. Recent articles by Marshall and Marshall (2007b) and Seto, Marques, Harris, Chaffin, Lalumière, Miner, Berliner, Rice, Lieb, and Quinsey (2008) highlight the fact that – as Anita Schlank observed in the Winter 2009 edition of this newsletter – "even highly trained, well-respected researchers can disagree about the quality of a research study" (p. 28).

How Does the Effectiveness of Sexual Offender Treatment Compare to the Effectiveness of Other Interventions?

The question of effect sizes in the treatment of sexual offenders has been examined in the context of the wider range of mental health and medical problems (Marshall & McGuire, 2003). Effect sizes measure the magnitude of the ability of an intervention to increase or decrease a specified outcome. The statistical significance of the effect size indicates whether the benefit of an intervention goes beyond what would be expected by chance. Generally, it is accepted that effect sizes less than .20 are small, those in the range of .50 are moderate, and those above .80 are considered large (Cohen, 1988). The statistical calculations of effect sizes are beyond the scope of this chapter. Rather, the comparison of effect sizes will be used to contextualize the pessimistic interpretation of sexual offender treatment.

Studies of sexual offender treatment outcome (typically measured by the occurrence of a new sexual offense arrest after any of a diverse range of interventions) have historically demonstrated small, if any, effects. Marshall and McGuire (2003) cite several studies in which effect sizes ranged from .10 to .47, with current cognitive-behavioral interventions demonstrating the largest effects (Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Hanson et al., 2002). As discussed in detail earlier in this chapter, some studies of sexual offender treatment outcome have demonstrated no significant effects, calling into question to ability to conclude that sexual offender treatment has an appreciable impact on the problem of sexual violence.

Comparatively, Marshall and McGuire (2003) illustrated the variability in effect sizes for psychotherapy, which they found to range from .32 for general psychotherapy, to larger effects of .51 for public speaking anxiety and .65 for depression. Still, these interventions fall into the moderate range of effectiveness. Consider, however, the small effect sizes of medical interventions widely used, endorsed by insurance companies, and commonly believed to be quite effective (reviewed in Marshall and McGuire, 2003): Bypass surgery for artery blockage (.15), chemotherapy for breast cancer (.08), and aspirin for heart problems (.03). Using correlation coefficients to demonstrate the strength of relationships between variables, other authors have illustrated the weakness of interventions that are commonly accepted as effective (Meyer, Finn, Eyde, Kay, Moreland, Dies, Eisman, Kubiszyn, & Reed, 2001). For instance, the correlation between antihypertensive medication and reduced risk of stroke has been found to be .03. The effect of relapse prevention on improvement in substance abusers is cited as .14. Anti-inflammatory drugs have only a .14 correlation with pain reduction. Nicotine patches demonstrate a correlation of .18 with smoking cessation. Clozapine's relationship to improvement in schizophrenia was cited as .20. Even Viagra, commonly thought of as a miracle drug, demonstrated only a moderate correlation with improved male sexual functioning ($r = .38$). Illustratively, the r squared (.14) indicates that Viagra accounts for only 14% of the variance in improvement in sexual functioning. In this context, statistical significance does not imply substantive significance.

Another important consideration in the evaluation of sexual offender treatment effectiveness is the implied expectation of long-term remission of symptoms. Recidivism studies have ranged in their follow-up periods from 5 to 25 years, and longer follow-up periods reveal larger frequencies of reoffense. Certainly, since sexual assault is quite harmful to victims, any reoffense can be considered one too many. On the other hand, is it realistic to assume that in order to be considered effective, treatment interventions must result in a lifelong absence of symptoms? Do we expect that a patient treated for depression or anxiety will a never have a recurrence of symptoms? Generally, the measurement of success with such typical mental disorders involves a relatively short-term follow-up period of reduction of symptoms and

improvement in functioning. Do we really know the long-term effectiveness of psychotherapy for depression or anxiety? Is it fair to compare the efficacy of sexual offender treatment after 25 years to the efficacy of anxiety interventions after 6 or 12 months? Harm reduction models (Laws, 1996) seem to be a more realistic approach to evaluating the effectiveness of sexual offender treatments, and are more comparable to the shorter-term treatment gains typically measured in both psychological and medical outcome studies.

Measurement of success in psychotherapeutic interventions has generally included a reduction in the frequency, duration, and intensity of distressing symptoms, or the increase of desirable behaviors. Such appraisals are *relative* measures. In contrast, sexual offender treatment outcomes use recidivism, which is an *absolute* measure. As a dichotomous variable, recidivism is not without limitations as a construct of improvement within sexual offender treatment. An all or nothing approach to success almost surely sets everyone up for failure – sexual offenders, clinicians, and the field as a whole.

Further, the term "treated" is often poorly defined in the sexual offender recidivism literature and generally refers to enlistment in sexual offender treatment with few, if any, concomitant measures of engagement, investment, participation, or successful integration of treatment concepts. In other words, "treated" groups, when compared to untreated groups, should – ideally – be described more meaningfully as those who successfully completed treatment. For instance, if a person voluntarily attends Weight Watchers meetings once a week for six months, but minimizes her weight problem and fails to incorporate healthy eating and exercise into her daily routine, would her attendance constitute completion at the end of the time studied? She would be considered a completer if the definition of "treated" referred simply to her attendance at meetings, but not her success at "working the program." If a very motivated dieter who worked the program and achieved his target weight engaged in one binge eating episode a year later, would he be considered a failure? After extended follow-up periods, do "treated" dieters (including those who did not "work their program") maintain significantly lower weights than non-dieters? Outcome measures must incorporate definitions of successful completion in order to provide meaningful results.

An additional problem related to the treatment of sexual offenders includes the question of motivation. At what point does a client decide that he or she is ready, willing, and able to change? Under what conditions? For example, those entering Weight Watchers are generally making a decision to do so (although they may experience some coercion from important people in their lives), while many sexual offenders have little real choice about entering a treatment program. Many have neither an opportunity nor an inclination to genuinely discuss their concerns about change. A person's internal motivation for change is a very real consideration.

There are other analogies for sexual offender treatment. Many clients behave as though sexual offender treatment is similar to an appendectomy where the doctor does all the work, or like taking one's car to the mechanic. In each case, it is the expert who does the work. In many of his trainings, Kevin Creeden has likened working with adolescents to being the manager of a Home Depot store. The business of change is up to the client. Like a house, one's treatment is an investment in their future. It is their house, their investment, and their responsibility. The role of the Home Depot manager is to provide tools, resources, and consultation. This may indeed be a more helpful way to envision treatment provision and change.

The recent SOTEP outcome study (Marques et al., 2005) found that the effectiveness of sexual offender treatment was insignificant in the overall comparison of "treated" offenders and "untreated" offenders. However, it is very important to highlight that sexual offenders who *successfully completed* their treatment goals and who demonstrated that they "got it" did

reoffend at significantly lower rates (p. 97). This finding is perhaps the most compelling issue to be thoughtfully addressed in future outcome studies: what does "treated" really mean? Therapy is not something to administer like medication – it involves a complex interaction that is largely dependent on the client's motivation and ability to change. Simple exposure to treatment in an experimental setting is quite different from engagement and investment in treatment that results in a demonstration of the ability to apply treatment concepts and new coping strategies in daily life. The definition of "treated" should be limited to those offenders who demonstrate the acquisition and application of cognitive behavioral skills in an ongoing fashion. Otherwise, the success of treatment becomes confused with the administration of treatment.

Implications for Practice

The current state of the research into sexual offender treatment often causes professionals to have more questions than answers. It is apparent that in order for those who have sexually abused to engage in meaningful personal change, their treatment providers should anchor themselves in the principles of general psychotherapy as well as "what works" in sexual offender treatment. In considering the research on sexual offender treatment efficacy, professionals may wish to consider:

- First, it may be time to begin asking more questions. Whether treatment is effective is certainly important. However, professionals might also ask under what conditions people who have sexually abused are most likely to change, how they are most likely to maintain change, and what professionals can do to best prepare people for change? Given the research into treatment provider style (e.g., Marshall, 2005), what lessons can those involved in community supervision draw? Given Hanson, Bourgon, Helmus, and Hodgson's recent findings (as well as the general criminological literature), how can programs best provide treatment in accordance with the principles of risk, need, and responsivity?
- By measuring only arrests and convictions as therapy outcomes, do we ignore information about other ways that an offender's risk may diminish with treatment? With research demonstrating that sexual offenders are at higher risk for other forms of criminal behavior, is the field missing valuable information about the direction of offender risk or density of future offenses (Dempster & Hart, 2002)? Researchers should consider ways to incorporate relative measures of behavioral change in addition to the absolute measure of recidivism. These might include: decreases in depression, anxiety, or other psychological symptoms; increases in the effective utilization of coping skills both in managing sexual behavior and in dealing with other psychosocial stressors; and improvements in the use of strategies to meet one's psychological and emotional needs in a healthy, non-harmful, and adaptive fashion.
- Does our current knowledge of treatment outcome adequately account for treatment fidelity? Are programs following their own policies, procedures, and manuals? Do their treatment protocols have an empirical base? Providers may wish to evaluate their own programs and emphasize the components that appear to be supported by research (i.e., cognitive behavioral components) and de-emphasize components with less empirical support (e.g., victim empathy).
- Might the absence of process variables found to improve treatment outcomes (e.g., a style that is warm, empathic, rewarding, and directive) account for some treatment programs' failure to reduce recidivism? Beyond providing treatment content, what do clinicians do to help sexual offenders engage in the treatment process, and consider that change is desirable, possible, and attainable? Engagement, warmth, empathy, and motivating approaches have been associated with treatment progress in general clinical

populations and with sexual offenders. Treatment providers are encouraged to utilize traditional counseling skills (e.g., active listening, validation of feelings, and non-judgmental responding) to build therapeutic alliance while administering empirically supported content in treatment programs. As well, therapists working with sexual offenders should utilize supervision to discuss negative counter-transference and "burnout" associated with working with non-voluntary and often resistant populations.

- Do the treatment outcome studies provide additional insight into decisions regarding community supervision (e.g., parole)? Might a shortage of resources or training in some areas contribute to outcome? What other community-related variables influence the offender beyond his therapists and supervising agents (see Wilson [2007] on Circles of Support & Accountability)? Certainly the current political atmosphere of shame and stigma associated with sexual offender registration status can affect clients' mood and hope for the future. Treatment providers should be cognizant of such influences and be willing to discuss with clients the psychosocial and practical obstacles to successful community reintegration facing sexual offenders. Empathy, support, and coping strategies can help minimize the likelihood that environmental stressors will contribute to dynamic risk factors for re-offense.
- Might treatment demonstrate improved outcomes when combined with an effective, collaborative, community supervision component? For instance, containment models emphasize collaboration between treatment providers and probation officers in an effort to utilize an array of tools (e.g., polygraph examinations, electronic monitoring) to monitor offenders' behavior. Treatment providers are encouraged to work collaboratively with probation agents to develop assessment-driven treatment and supervision plans that are based on offenders' individual patterns, motivations, and risk factors.
- Is recidivism reduction the only meaningful measure of treatment success, or the only goal of treatment? The "good lives" model focuses on identifying client strengths and facilitating support systems to help clients meet their psychological and social needs in healthy, adaptive ways rather than through violence, abuse, or criminal activity.
- Might some of the less successful programs also have been those who were under-funded, under-resourced, or that otherwise could have been identified as in need of further development before providing services to this most challenging population? To what extent do programs address such aspects as psychiatric comorbidity, learning disabilities, and other factors that interfere with offenders' meaningful participation in treatment? Treatment providers should advocate for adequate funding to provide the vast array of services required for many sexual offenders who have a multiplicity of complex and interacting problems.
- To what extent do clients receive assessment-driven treatment? Treatment programs should fully tailor treatment according to the principles of risk, need, and responsivity, rather than pursue a one-size-fits-all approach with only occasional accommodation for these factors.
- Are there other aspects of treatment outcome worthy of further study, such as the ability of treatment regimens to assist or provide amends to those affected by sexual abuse? Many authors (e.g., Ward, Yates, & Long, 2006) define the goal of sexual offender treatment as the reduction of risk, while others (Hindman, 2007) remind us that professionals should tailor treatment to meet the needs of those who survive the abuse.
- Finally, to what extent have we asked our clients about their experiences within treatment? Levenson and Prescott (2008), Levenson, Macgowan, Morin, and Cotter (2009) and Levenson, Prescott, and D'Amora (2009) found that clients often experience their therapeutic relationships as helpful, and that topic areas such as accountability and empathy are important to them, even if the direct relationship of those treatment concepts to recidivism is not firmly established in the literature.

In the end, perhaps future attempts to study sexual offender treatment outcomes will do better to account for a confluence of elements, including offender readiness and motivation for change, preparation for treatment, treatment models and manuals, co-morbid psychopathology, client strengths, community management strategies, and the capacity of programs to provide assessment-driven treatment. As well, other measures of change, and meaningful definitions of successful completion, are necessary in order to comprehensively assess the helpfulness of therapeutic interventions for sexual offenders.

Summary

Methodological debates notwithstanding, sexual offender treatment outcomes may not be as dismal as commonly portrayed. In the context of other types of interventions, sexual offender treatment effects might not lag as far behind as believed. Recent research suggests that many sexual offenders do benefit from treatment and that sexual offender therapy can help to reduce recidivism. Professionals are in a better position than ever to help those sexual offenders who are interested in change; perhaps, an important future area of study is investigation of the factors which can increase motivation to change. Recidivism is only one measure of success, and other variables that illustrate symptom reduction and improvement in functioning for sexual offenders should be included in our definition of treatment effectiveness. Surely, the quest for improvements in both our clinical practices and our evaluation methods should continue.

It is not clear that long-term sexual offender treatment outcomes are significantly worse than other interventions. Although recidivism is a critical indicator of successful treatment, it is by no means the only element of importance. A multi-dimensional set of outcomes, including recidivism, symptom reduction, lifestyle improvements, and application of new skills would provide a more realistic and richer picture of sexual offender treatment outcomes.

References

Andrews, D.A., & Bonta, J. (2003). *The psychology of criminal conduct, third edition.* Cincinnati, OH: Anderson.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences, second edition.* Hillsdale, NJ: Erlbaum.

Cox, E. (2009, April). *Day I met the paedophiles in paradise.* Newspaper article retrieved April 19, 2009 from: http://www.thesun.co.uk/sol/homepage/features/article2381264.ece.

Dempster, R.J., & Hart, S.D. (2002). The relative utility of fixed and variable risk factors in discriminating sexual recidivists and nonrecidivists. *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 121-138.

Furby, L., Weinrott, M., & Blackshaw, L. (1989). Sex offender recidivism: A review. *Psychological Bulletin, 105*(1), 3-30.

Gallagher, C.A., Wilson, D.B., Hirschfield, P., Coggeshall, M.B., & MacKenzie, D.L. (1999). A quantitative review of the effects of sex offender treatment on sexual reoffending. *Corrections Management Quarterly, 3*, 19-29.

Gendreau, P., & Ross, R.R. (1987). Revivification of rehabilitation: Evidence from the 1980s, *Justice Quarterly*, *4*(3), 349-407.

Hanson, R.K., Bourgon, G. Helmus, L., & Hodgson, S. (in press). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior.*

Hanson, R.K., Broom, I., & Stephenson, M. (2004). Evaluating community sex offender treatment programs: A 12-year follow-up of 724 offenders. *Canadian Journal of Behavioural Science, 36*(2), 85-94.

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 treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 169-194.

Hindman, J. (2007). The best of times, the worst of times: Sex offender specialists and their costumes. In D.S. Prescott (Ed.), *Applying Knowledge to Practice: Challenges in the Treatment and Supervision of Sexual Abusers* (p. 42-55). Oklahoma City, OK: Wood'n'Barnes.

Ignatieff, M. (1978). *A just measure of pain: The penitentiary in the industrial revolution, 1750-1850.* New York: Pantheon Books.

Laws, D.R. (1996). Relapse prevention or harm reduction? *Sexual Abuse: A Journal of Research & Treatment, 8*(3), 243-248.

Levenson, J.S., Macgowan, M.J., Morin, J.W., & Cotter, L.P. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: A Journal of Research and Treatment, 21*, 35-56.

Levenson, J.S., & Prescott, D.S. (2007). Considerations in evaluating the effectiveness of sexual offender treatment: Incorporating knowledge into practice. In D.S. Prescott (Ed.), *Applying knowledge to practice: Challenges in the treatment and supervision of sexual abusers* (p. 124-142). Oklahoma City, OK: Wood'n'Barnes.

Levenson, J.S., & Prescott, D.S. (2009). Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse: A Journal of Research & Treatment, 21,* 6-20.

Levenson, J.S., Prescott, D.S., & D'Amora, D.A. (in press). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology.*

Lipton, D.S., Martinson, R., & Wilks, J. (1975). *The effectiveness of correctional treatment: A survey of treatment valuation studies.* New York: Praeger Press.

Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology, 1*, 117–146.

Marques, J.K., Day, D.M., Nelson, C., & Miner, M.H. (1989). The sex offender treatment and evaluation project: California's relapse prevention program. New York: Guilford Press.

Marques, J.K., Wiederanders, M., Day, D.M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse: A Journal of Research & Treatment, 17*(1), 79-107.

Marshall, L.E., & Marshall, W.L. (2007a). Preparatory programs for sexual offender treatment. In D.S. Prescott (Ed.), *Knowledge and practice: Challenges in the treatment and supervision of sexual abusers* (pp. 108-123). Oklahoma City, OK: Wood'N'Barnes.

Marshall, W.L. & Marshall, L.E. (2007b). The utility of the random controlled trial for evaluating sexual offender treatment: The gold standard or an inappropriate strategy? *Sexual Abuse: A Journal of Research and Treatment, 19,* 175-191.

Marshall, W.L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research & Treatment, 17*(2), 109-116.

Marshall, W.L., Fernandez, Y.M., Serran, G.A., Mulloy, R., Thornton, D., Mann, R.E., & Anderson, D. (2003). Process variables in the treatment of sexual offenders: A review of the relevant literature. *Aggression and Violent Behavior, 8*, 205-234.

Marshall , W.L., & McGuire, J. (2003). Effect sizes in the treatment of sexual offenders. *International Journal of Offender Therapy and Comparative Criminology, 47*(6), 653-663.

Martinson, R. (1974). "What Works? - Questions and Answers About Prison Reform," *The Public Interest*, *35*, 22-45.

Martinson, R. (1979). "New findings, new views: A note of caution regarding sentencing reform". *Hofstra Law Review, 7*, 242-258.

Meyer, G.J., Finn, S.E., Eyde, L.D., Kay, G.G., Moreland, K.L., Dies, R.R., Eisman, E.J., Kubiszyn, T.W., & Reed, G.M. (2001). Psychological testing and psychological assessment: A review of evidence and issues. *American Psychologist, 56*(2), 128-165.

Morris, N., & Rothman, D.J. (1998). *The Oxford history of the prison: The practice of punishment in western society.* Oxford, UK: Oxford University Press.

Rothman, D.J. (1971). *The discovery of the asylum: Social order and disorder in the new republic.* Glenview, IL: Scott, Forseman and Company.

Schlank, A. (2009, Winter). The baby, the bathwater, and pendulum swings: The need to slow down and evaluate research critically. *ATSA Forum, 21,* 27-37.

Seto, M.C., Marques, J.K., Harris, G.T., Chaffin, M., Lalumière, M.L., Miner, M.H., Berliner, L., Rice, M.E., Lieb, R., & Quinsey, V.L. (2008). Good science and progress in sex offender treatment are intertwined: A response to Marshall and Marshall (2007). *Sexual Abuse: A Journal of Research and Treatment, 20,* 247-255.

Thornton, D. (1987) Treatment effects on recidivism: A reappraisal of the nothing works doctrine. In B.J. McGurk, D.M. Thornton, & M. Williams, (Eds.), *Applying psychology to imprisonment*. London: HMSO.

Walker, D.F., McGovern, S.K., Poey, E.L., & Otis, K.E. (2004). Treatment effectiveness for male adolescent sexual offenders: A meta-analysis and review. *Journal of Child Sexual Abuse, 13,* 281-294.

Ward, T., Yates, P.A., & Long, C. (2006). *The self-regulation model of the offense and relapse process, Volume 2: Treatment.* Victoria, British Columbia: Pacific Psychological Corporation.

Wilson, R.J. (2007). Circles of Support & Accountability: Empowering communities. In D. Prescott (Ed.), *Knowledge and practice: Practical applications in the treatment and supervision of sexual abusers* (pp. 280-309). Oklahoma City, OK: Wood'n'Barnes.