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The Glass is Half Something, But What? Thoughts on the Does-Treatment-Work Debate

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by David S. Prescott, LICSW

At the beginning and end of each day, all professionals in our field want to prevent sexual violence. How successful we are is debatable, and sorting out our priorities can be confusing to both the public at large and ourselves (Hindman, 2007). The only thing that is clear is that doing nothing with people who have sexually abused is unacceptable.

Recent discussions among treatment providers for persons who have sexually abused have again focused on whether our treatment programs are actually successful at reducing sexual recidivism among adults clients. Concerns include that while people who complete treatment programs re-offend at lower rates than those who don't, professionals still don't have data from randomized trials showing that the actual treatment we are providing works. In fact, some studies of apparently good treatment programs seem to have produced few effects (e.g., Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005; Hanson, Broom, & Stephenson, 2004).

A meta-analysis by Karl Hanson and his colleagues (Hanson, Gordon, Marques, et al., 2002) found that people who completed treatment programs tended to have lower sexual re-offense rates (by about 25%) than comparison groups. The authors noted the limitations of the studies and that these figures don't account for those who refuse or drop out of treatment. For many, this simple fact is a deal-breaker; our numbers simply don't add up to optimism about our efforts. Three years later, the long-awaited randomized clinical trial (RCT) by Janice Marques and her colleagues found no difference between those who completed the treatment program and those in the control group. However, the authors concluded that those treatment participants who "got it" and meaningfully completed their treatment goals really did re-offend at lower rates. This single study has been used as a source of optimism for many, and for others remains the ultimate proof that we still don't know whether we can effectively treat sexual aggression. Spirited debate followed. Marshall and Marshall (2007) argued that RCTs are not the final word in scientific evidence. A host of others (e.g., Seto, Marques, Harris, et. al., 2008) disagreed. The end of the last decade saw the most recent treatment outcome meta-analysis (Hanson, Bourgon, Helmus, & Hodgson, 2009) suggesting that programs adhering to the principles of risk, need, and responsivity have the greatest effect on sexual re-offense.

Significant questions remain: What about those people who do complete treatment programs? Should our research and practice efforts be focused on creating what Marques et al., referred to as those who "got it"? Elsewhere, Prescott and Levenson (2009) have asked whether our field is actually asking the right questions. For example, beyond does treatment work, there are questions regarding with whom it works, under what conditions, with what kinds of providers, etc.? More recently, Prescott (2011) suggested shifting the focus to building willing partners in treatment programs. That is, what can professionals do to create programs in which those at risk for refusing treatment or dropping out do to "get it" and meaningfully change? Whatever the case, it's important to remember that treatment attrition is a serious problem in all of criminology. Olver, Stockdale, and Wormith (2011) found an overall attrition rate of 27.1 percent and concluded that:

> *The clients who stand to benefit the most from treatment (i.e., high-risk, high-needs) are the least likely to complete it. Offender treatment attrition can be managed and clients can be retained through an awareness of, and attention to, key predictors of attrition and adherence to responsivity considerations. (p. 6)*

This should come as no surprise, and recalls other important findings that have attracted little attention. For example, Parhar, Wormith, Derkzen, and Beauregard (2008) found that coercive methods of treatment are less successful.

In a recent debate on an email listserv, Florida's Jill Levenson suggested that the discussion ought to focus on what we all know. She, like others, has recently observed that psychotherapy research reminds us that there are factors common to all successful therapies that are easy to forget. These include the therapeutic alliance, and hope/expectancy that a better life is possible and attainable. These elements of treatment can easily be forgotten. Moulden and Marshall (2009) are the only authors to my knowledge who have written on the importance of hope in the treatment of sexual aggression. Likewise, the therapeutic alliance has been shown to be critical to successful psychotherapy in over 1,100 studies (Orlinsky, Ronnestad, & Willutski, 2004). How well are we really doing in our efforts to create therapeutic alliances, or other aspects of those who "get it"? Clearly, statements to the effect that "we have no conclusive evidence that treatment works" to prevent sexual violence are accurate. But, are they sufficient?

Perhaps, it is time to extend our inquiry further. Given what we know from criminology, psychotherapy, and sexual violence research, perhaps it's time to put the dichotomous question of "does treatment work" aside while we ask more immediate questions based on what research shows. For example:

- What is the quality of the admissions process? Is the agency or facility reserving treatment slots only for those who appear most motivated while refusing the higher risk/higher need clients that may need/benefit from treatment the most?
- What is the quality of the therapeutic alliance, and how are programs measuring it from the client's perspective?
- What is the quality of goals established in treatment. Are they desirable goals that the client can approach, or undesirable goals that the client should avoid?
- How are these goals established? By a collaborative process with the client or are they imposed by the treatment program?
- Are the goals of treatment driven by an individualized assessment or does the program expect that all clients will work on the same goals?
- Is there an assessment that drives the treatment process? If so, to what extent does it provide guidance? How clear is the linkage between assessment and treatment?
- While providing the "treatment of choice" is an obvious priority for any professional, what steps are taken to ensure that therapists are also providing the therapeutic relationship of choice?
- Is the treatment program collecting data on consumer satisfaction, or in key clinical areas, such as how the client is experiencing their ability to function within relationships?
- What are the qualities of the treatment program's culture and are they conducive to genuine change?
- Similarly, for inpatient programs, are the qualities of the institution's culture and are they conducive to genuine change?
- Can the program describe how meeting the challenges of the responsivity principle with each client?

Until our programs can answer these and related questions, perhaps the topic of "does treatment work" is less important than, "What is the evidence that what we are doing is helping this client, right here, right now"?

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