The Need for Reformation in Sex Offender Treatment Programs

By Tammy Thompson

Assignment Description: Each student will write a minimum of five pages with a minimum of five sources in which they explicate an ethical issue in Criminal Justice and provide a possible solution. The assignment was completed for Dr. Kimberly Garchar and Dr. Deirdre Warren’s Ethics and Criminal Justice.

Many sex offenders are released from jail or prison and are shortly thereafter arrested again for committing another crime. The ethical issue is that rehabilitation programs could be much more effective in their methods to treat the offender before their release. While recidivism of sex offenders is not insignificant, I believe that it is not the ultimate reason for changing the structure of rehabilitation programs. Practically, we must set a standard for a rehabilitation program, but there should be variances in the program as there are variances in offenders and in offenses. In addition, we cannot ignore treating a person who has not yet committed a sexual offense, but is trying to seek preventative treatment. I will argue that in order to create a successful treatment program for sexual offenders (and non-offenders), we must pay less attention to the standard of treatment, and pay more attention to the individual (i.e. the offense, their age, their background, etc.). By understanding the nature of the person, we can create programs that treat the urges to commit these crimes as an illness, and as something that can be rectified by programs that work to build the character of the individual.

A popular argument for the reformation of sex offender treatment programs is to further reduce recidivism rates of offenders. According to the Ohio Department of Rehabilitation and Correction, the baseline recidivism rate of sex offenders followed-up for five years after release from prison was 28.3 percent, broken down as: The recommitment for a new crime was 13.9%, sex offense 5.3%, non-sex offense 8.6%. The recommitment for a technical violation was 14.4%, sex offense .8%, sex lapse 1.5%, non-sex related 12.1%. The total sex-related recidivism rate, including technical violations of supervision conditions, was 7.6% of the releases. Recidivism rates differed considerably based on a victim typology: 'rapists' (adult victims) 48.7%, teen victims (age 13-17) 31.1%, child victims (under age 13) 21.9%, all incest cases 8.6%.1

Paroled sex offenders completing basic sex offender programming (level 1) while incarcerated appeared to have a somewhat lower recidivism rate than those who did not have programming. This was true both for recidivism of any type (35.4% with programming recidivated compared with 48.1% without programming) and sex-related recidivism (6.3% with programming recidivated compared with 13.1% without programming).2

In these types of studies, recidivism can be a rather vague term. We should consider

that, although there is common acceptance that recidivism is the commission of a subsequent offense, there are many operational definitions for this term. For example, recidivism may occur when there is a new arrest, new conviction, or new commitment to custody.\textsuperscript{3} With this in mind, we could argue that recidivism rates should be lower, and that, perhaps in other states they are lower; however, I do not want to argue from the standpoint of recidivism. Of course, what we ultimately want is a decrease in the amount of repeat offenses, but I do not believe this is the main reason for a need to reform our rehabilitation programs. More importantly, it seems that we are overlooking the diversity among sexual offenders. As seen above, the victim typology drastically alters the success of the treatment program (the program worked for some, and did not work for others). Also, we are ignoring the treatment of potential sexual offenders entirely. There are individuals who may want to seek treatment for their urges before they offend, only to find that no such treatment exists. The problem seems to be that, no matter the degree of the sexual offense (whether it is the harshest sexual offense or the most minimal sexual offense), the typical rehabilitation program is presumed to be able to handle a tremendous amount of variety. For many of these programs, the only common denominator that is required among the offenders is that they have committed a sexual crime. This standard not only leaves a lot to be desired in the way of personalized treatment, but it also excludes non-offenders (who may have urges) from being considered at all.

The placement of standards in the criminal justice field is seemingly a reoccurring theme. We have standards in law, standards in policy, standards in punishment, etc. These standards are set with the idea that they will apply to everyone; however we know that they do not work in every case. That being said, it is necessary to have standards in order to form a system. We need them to set guidelines. I believe that it is important to recognize though, that these standards are in a sense, arbitrary. We need to acknowledge that the standard will not work in every case, and we must be able to make adjustments to it (have discretion) when necessary in order to have a good working system. Similarly, in regard to standardized rehabilitation programs for sexual offenders, we have to be able to make adjustments to accommodate different circumstances. When the standard treatment program is too general, meaning there is a wide mix of sex offenders that have various commitment to their criminality, the treatment in the program falls to the lowest common denominator. It seems improbable that every offender would be able to benefit from this level of treatment.

It seems obvious that treatment programs cannot be too general and at the same time remain successful. If we can focus more on the individual, and possibly separate treatment programs by grouping sexual offenders of similar kinds, this in itself would improve the efficiency of the treatment programs. One step further, I believe that sexual offenses should be treated as an illness, much like we treat drug abuse. This is not a novel idea. In the paper “Sexual Predators,” the psychiatrist James D. Reardon M.D. explored the possibility, and defended the notion that sexually violent

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predators may have a mental illness. If we accept this notion, and handle sexual offenses as something that can be treated and managed, then we can possibly reduce the stigma behind labeling individuals as sex offenders. Once an individual is labeled a sex offender, the public tends to dissociate them from society. They are placed in the category of the “other,” or seen as a person who is so different from ourselves that we dehumanize them in many ways, and we are disconnected from feeling empathy for them. If society has no empathy for the individual, then the incentive to provide them with appropriate treatment is extremely low. What typically results is the opinion that sex offenders are a lost cause, and that they cannot be rehabilitated. Even after rehabilitation, time served, and reintroduction into society, this opinion persists for most sexual offenders. In a recent study done on the families of registered sex offenders, it was found that even the “children of registered sex offenders reportedly experienced adverse consequences including stigmatization and differential treatment by teachers and classmates.” If we could remove this stigma and the notion of “othering” the offender, not only would society be more inclined to treat the offender, but the offender would seemingly have more incentive to succumb to treatment and change their habits, because they would not have been labeled with a life sentence that makes them a “bad” person in the eyes of society.

It seems to become more evident that sexual offenses should be treated as an illness when we consider treatment for individuals who have not yet committed a sexual offense (those who have an urge to commit a sexual offense, but have not yet done so). Intuitively, certain sexual urges appear to us to be a mental illness, particularly the kinds involving pedophilia. We cannot understand how or why anyone would ever have these types of thoughts. Similarly, we cannot understand why a pregnant woman would have the desire to use drugs and harm her unborn child. I am not condoning either scenario. Either person would deserve a just punishment for their actions if they were to carry out the desire. What I am claiming is that it is clear that both of these individuals would need treatment to manage their mental illness. The difference is that the pregnant women can check herself in to a drug rehabilitation clinic, and there are no such places for the person who has the urge to commit a sexual offense. It is essential that we create programs that can help people in this circumstance. It seems odd that there are no treatment programs for individuals who have urges to commit a sexual offense, especially when the urge to commit a sexual offense of certain types seems like a clear case of a mental illness. Starting the education and rehabilitation at this point (before offending) would seem to have the highest level of success. If the person is seeking out treatment before committing a crime, then their rehabilitation is self-motivated, and this person would be the best type of candidate for successful treatment.

The suggested treatment programs for sexual offenders and non-offenders outlined above are forms of character building. The aims of the programs are to educate individuals about their illness and train them to become more virtuous, or better people. If the treatment is implemented in a way that can help them manage their illness long term, then it can assist them in practicing their rehabilitated behavior as they are infiltrated back into society. This idea is similar to that of Aristotle’s virtue ethics, where we also see this type of character building through habituation. Aristotle states in the *Nicomachean Ethics* that “a person comes to be just from doing just actions and temperate from doing temperate actions; for no one has the least prospect of becoming good from failing to do them.”\(^6\) It is not the case that we are simply good or bad. These are not qualities that we just have. We learn to be virtuous through practice, and we become virtuous when what we practice becomes habit.

In conclusion, a popular argument for the reformation of sexual offender treatment programs is that recidivism rates could be lower. Upon further evaluation of this argument, it seems that it is not incredibly clear what recidivism even means or encompasses in most studies. I chose to abandon the recidivism argument and argue from the standpoint that the programs we currently have in place are clearly lacking in several aspects. This includes the broad scope of treatment that is much too general to successfully treat a vast variety of cases, the stigmatization that it placed on individuals who are labeled sex offenders that hinders their treatment and motivation to be rehabilitated, and the lack of a treatment program for non-offenders. Ultimately, in order to address the problems listed above, what we need are programs that take a more individualistic approach to treatment and help to build the character of the individual.

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Bibliography


