

THE JOURNAL OF

# Psychiatry & Law

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*This study examined 10-year sexual and non-sexual offense recidivism for sex offenders released from New Jersey's general prison system and from the Adult Diagnostic and Treatment Center (ADTC), New Jersey's correctional facility and treatment center for repetitive-compulsive sexual offenders. The study found that sexual offenders released from the ADTC had significantly lower rates of committing both non-sexual offenses and any offense, compared with the general prison population of sex offenders. For both groups, the 10-year sexual offense reconviction rates were relatively low, 8.6% for the ADTC offenders and 12.7% for the general prison sexual offenders, while reoffense rates for non-sexual offenses were 25.8% and 44.1% for ADTC and general prison sex offenders, respectively.*

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**AUTHORS' NOTE:** *The authors thank New Jersey Department of Corrections commissioner Devon Brown, Division of Operations director William Plantier, and Adult Diagnostic and Treatment Center administrator Grace Rogers for their support and encouragement in conducting this research. We also thank Christine Rapp and Jenifer Mullock for their assistance with data collection.*

Few crimes, if any, raise such strong ire and disgust as sex offenses,<sup>1</sup> and many in the public see sex offenders as a lost cause. The typical layperson imagines that sex offender recidivism is close to 100% and that treatment is ineffective. Those of us who specialize in evaluating and treating this population constantly hear the refrain "Why do you work with them? They can't really be helped, can they?" from educated, intelligent friends and even non-specialist colleagues.

Legislators often adopt this view as well. In New Jersey in 1994, a legislative task force evaluated New Jersey's sex offender treatment program for repetitive-compulsive sex offenders, the Adult Diagnostic and Treatment Center (ADTC), housed within the New Jersey Department of Corrections. This evaluation came after the murder in 1994 of Megan Kanka by Jesse Timmendiquas, a former inmate at the ADTC. The task force, not surprisingly, was skeptical of the ADTC's approach to offender treatment. Under New Jersey law, an individual found guilty of committing an enumerated sex offense can serve his term of incarceration at the ADTC "if the court finds that the offender's conduct was characterized by a pattern of repetitive, compulsive behavior."<sup>2</sup>

After a series of legislative hearings and site visits, the legislative task force recommended a number of changes, including that the treatment program at the ADTC be privatized, that the law be changed so that the ADTC house only inmates who are "amenable and willing" to participate in treatment, and that dangerous sex offenders who have not responded to treatment be civilly committed.<sup>3</sup> One recommendation most germane to this paper was the call for an evaluation study of the treatment program at the ATDC.

Concern over sexual offending in New Jersey mirrors that of the country generally. Since the 1980s the public has become increasingly aware that sexual victimization is a widespread

problem. Sexual abuse has also been referred to not only as a serious social problem, but as a public health problem and epidemic.<sup>4</sup> When attempting to establish the prevalence of sexual victimization, researchers have discovered that teenage and adult females have a 20%–30% chance of being the victims of an attempted or completed rape.<sup>5</sup> In addition, 8% of males admitted committing an act that met the legal definition of rape.<sup>6</sup>

Given the prevalence of sexual abuse, serious questions arise: What are those characteristics that best predict future offenses? How can dangerous sex offenders be recognized? Can their risk be lowered through treatment?

According to Freeman-Longo and Blanchard,<sup>7</sup> sexual abuse is not bound by race, socio-economic status or intelligence level. Marshall<sup>8</sup> contends that sexual offenders can appear deceptively average and can be found anywhere. These are not the demographics of general criminality, so sex offenders present a special challenge in identifying risk factors of continued offending.

### **Recidivism of sexual offenders**

Sex offenses are associated in the popular press with a high degree of mental aberration,<sup>9</sup> suggesting that it's unlikely the offender could control his actions. Popular media, newspapers, and even some academic journals suggest that sex offenders are untreatable and, when released, are free to offend again. Public officials are not immune to these views. For example, New York governor George Pataki has been cited as stating, ". . . studies have shown that sex offenders are more likely to repeat their crime than any other crime."<sup>10</sup>

The reader must approach these assertions with caution. What evidence exists concerning rates of sexual reoffending behavior?

Some studies have found recidivism levels as high as 50%, while other studies have found substantially lower levels of offending, approximately 0%–11%.<sup>11</sup> Perhaps the most comprehensive and current information is contained in a recent U.S. Department of Justice report<sup>12</sup> of 272,111 former prison inmates<sup>13</sup> tracked for three years after release. This study found that sexual offenders had, in fact, among the lower recidivism rates of those inmates released, with, for example, 11.2% of rapists committing a new sex offense within three years of release.<sup>14</sup> Not surprisingly, offenders who had originally been incarcerated for crimes against property had the highest reoffense rates.<sup>15</sup>

In another recent and influential study, Hanson et al.<sup>16</sup> did a meta-analytic review of treatment-effectiveness studies. They summarized 43 studies (combined  $n = 9,454$ ) comparing recidivism of treated sex offenders with comparison groups, and found that sexual offense recidivism was lower for treatment groups (12.3%) than for the comparison groups (16.8%). The study also found that current forms of therapy (cognitive-behavioral and systemic) are more effective in lowering both sexual and general recidivism than older forms of therapy, which appeared to have little effect.

The variability in sex offender recidivism rates among studies reflects methodological difficulties, including:

1. *Lack of a standard definition of recidivism:* Recidivism is variously defined as a new sex offense arrest, a new sex offense conviction, a new arrest of any kind, a new conviction of any kind, or even a technical violation of parole. Recidivism varies enormously, depending upon which definition is used. For example, the U.S. Department of Justice study of inmates released in 1994 notes that of the 3,138 released rapists tracked for three years, 46.0% were rearrested for a new crime, 18.6% were rearrested for a new violent offense, 2.5% were rearrested for another rape, 8.7% were rearrested for a new non-sexual assault, and

11.2% were rearrested for a drug offense. Similarly, Rice, Quinsey, and Harris<sup>17</sup> found that 58% of their sex offender sample were arrested for a new offense, while only 31% were arrested for a new sex offense. Finally, the U.S. Department of Justice study notes that of their entire inmate sample for 1994 (that is, including non-sex offenders), 67.5% were rearrested, 44.1% were reconvicted, and 25.4% were actually returned to prison with a new sentence.<sup>18</sup> Consequently, whether one defines recidivism as an arrest or a conviction, and whether one considers just new sex offenses or all offenses, can result in drastic changes in the assessed recidivism rate. Broader definitions of recidivism result in higher levels of recidivism.

2. *Underreporting of sex offenses:* Because sexual offenses are underreported, most measures of recidivism underrepresent the true offending rates.<sup>19</sup> Some have suggested that the present statistics on sexual abuse represent approximately one-third of the number of actual victimizations, forcing researchers and practitioners to estimate the true prevalence and incidence of sexual abuse.<sup>20</sup> Legal definitions, embarrassment, and a desire for privacy are the main contributors of the unwillingness of many victims to report their abuse. Conversely, it has been noted that some types of sexual abuse, such as stranger rapes, may be overrepresented to the police.<sup>21</sup>
3. *Lack of a homogeneous sample:* Recidivism studies sometimes fail to separate offenders into homogeneous subgroups by offense or taxonomic system. Because sex offenders are known to be extremely heterogeneous, it is important to make distinctions based on homogeneous subcategories.<sup>22</sup> Aggregation of groups can lead to confusing results because different types of sex offenders are known to reoffend at different levels. Of sex offenders who have made physical contact with victims (as opposed to, for example, voyeurs or exhibitionists), studies have found rapists to have the highest levels of recidivism, fol-

lowed by extrafamilial child molesters and, last, incest offenders.<sup>23</sup> When the different groups are combined, the statistics may be misleading. As a result it is difficult to answer the broad question *Do sex offenders recidivate and at what level?* To do so it is necessary to focus on specific groups of sex offenders.

4. *Lack of a comparison group:* The previously discussed U.S. Department of Justice study is one of the few that included a comparison group of non-sex offenders. Moreover, many studies of sex offender treatment efficacy do not include a sample of non-treated offenders. It is only by including appropriate comparison groups that one can determine whether a given recidivism rate is high, so generalizing about recidivism levels is difficult.
5. *Variation in the follow-up period:* Simply put, the longer the length of follow-up, the wider the window of opportunity for recidivism and the higher the rate of recidivism.<sup>24</sup> Largely, sex offender recidivism results should be analyzed with enough time passage to allow for meaningful interpretation. In most cases reviewers should allow for no less than a five-year time period.<sup>25</sup> Various studies have recorded substantial amounts of recidivism between five and 30 years post initial incarceration.<sup>26</sup> Longer follow-up periods allow for more accurate recidivism estimates. It follows that when comparing recidivism studies, follow-up periods must be similar, since the variation in follow-up periods leads to difficulties in interpreting study results.<sup>27</sup>

### **Treatment efficacy studies**

Sex offender efficacy studies have reflected, at various times, unflinching support for the rehabilitation of sex offenders juxtaposed with the belief that nothing works and that sex offenders therefore should be punished as severely as possible through lengthy incarceration. Few efficacy-study results have

consistently supported sex offender treatment, rendering the topic controversial. Since the mid-1970s influential organizations such as the Group for the Advancement of Psychiatry, the American Bar Association, and the President's Commission on Mental Health have posited that sex offender treatment is an ineffective tool that ". . . brings the illusion of benevolence."<sup>28</sup> Many years later, in 1989, Furby, Weinrott and Blackshaw,<sup>29</sup> in a widely cited meta-analysis, would suggest that sex offender treatment was ineffective, carrying the same dampening effect for sex offending treatment that the classic Martinson<sup>30</sup> work in the mid-1970s carried for general criminal rehabilitative ideology. Researchers and policy makers were left with a sense that "nothing works," a belief that has long influenced the field.<sup>31</sup>

In the 1990s researchers worked to increase the otherwise lacking empirical foundation of sex offender rehabilitation. Rebutting earlier negative findings, Nagayama Hall<sup>32</sup> performed a meta-analysis of all sex offender treatment studies since the 1989 Furby et al.<sup>33</sup> piece. Nagayama Hall suggested that many of the studies reviewed by Furby et al. had not used current treatment methods and therefore did not reflect current treatment effectiveness. Nagayama Hall's findings offer a slightly more optimistic view than the Furby et al. review. He concluded that treatment did result in a small improvement relative to comparison conditions.<sup>34</sup> While the effect size for treatment groups versus comparison groups was small ( $r = .12$ ), it was robust. Additionally, 19% of the treated sex offenders committed a sexual reoffense, while 27% of the comparison group, the untreated offenders, recommitted a sexual offense,<sup>35</sup> indicating roughly a one-third reduction in recidivism.

A recent study conducted by Nicholaichuk et al.<sup>36</sup> at the Correctional Service of Canada offers the optimistic result that treatment—specifically, cognitive behavioral treatment—can substantially reduce recidivism of sexual offenders. The authors compared 296 treated and 283 untreated offenders for an average follow-up period of six years. Almost 15% of

treated sex offenders were convicted of a new sexual offense, while 33.2% of untreated, matched sex offenders were convicted of new sex offenses, a 50% reduction in recidivism due to treatment.

In 2001 the Ohio Department of Rehabilitation and Correction<sup>37</sup> followed a large sample of released sex offenders for a 10-year follow-up period. Offenders involved in treatment programs had lower levels of recidivism than those not involved in treatment, 33.9% and 55.3%, respectively.<sup>38</sup>

### Treatment methods

The ADTC's treatment program can be placed within the broader context of similar programs throughout North America.<sup>39</sup> Treatment methods for sex offenders generally fall into two categories: pharmacologic and psychological.

#### Pharmacologic treatment

Current pharmacologic treatment involves two major classes of drugs, antiandrogen agents and antidepressants, usually from the selective serotonin reuptake family (SSRIs). Far more research has been conducted on antiandrogen agents than on SSRIs. Antiandrogen agents have two mechanisms: They block either production or uptake of testosterone, the male sex hormone, in its various forms, resulting in lowered plasma testosterone levels. In this manner, all sexual drive, both deviant and normal, is dampened. The two most common forms of antiandrogen treatment for sex offenders, both off-label uses, are the fat-soluble, injectable form of medroxyprogesterone acetate, more commonly referred to by its trade name, Depo Provera, and, more recently, leuprolide (Lupron). Some authorities believe that antiandrogen treatment for sex offenders must be continued indefinitely; others contend that it can be tapered off as the sex offender progresses in more psychological treatment methods.<sup>40</sup> Antiandrogens are not without side effects and medical risks,<sup>41</sup> so they must be used cautiously.

More recently, sex offender treatment specialists have begun prescribing antidepressants, particularly SSRIs, to reduce the level of sexual drive in sex offenders (as well as other paraphiliacs). SSRIs have no known effect on testosterone level, operating through a different, poorly understood mechanism. It is unclear whether these antidepressant agents work because of their reduction in libido—usually an unwanted side effect when administered to normals—or because of specific anticomulsive properties.<sup>42</sup> Although no known double-blind, placebo-controlled studies have been conducted to date on SSRIs, many case studies and uncontrolled group studies support their use.<sup>43</sup>

**Psychological  
treatment**

A recent survey of North American sex offender treatment programs found that the major treatment model, particularly for long-term treatment of incarcerated sex offenders, is a cognitive-behavioral/relapse-prevention model.<sup>44</sup> Originally developed to treat substance abusers, a relapse-prevention model has in recent years been applied to an increasing number of disorders, many sharing a common element of impulse-control difficulty.<sup>45</sup> Relapse prevention begins with the premise that despite their best intentions, a certain percentage of individuals with appetitive, impulse-control disorders, such as substance abuse or sex offending, will relapse. Practitioners of this approach have identified specific factors that lead to relapse, and these factors are the focus of treatment, designed to help the patients not only become abstinent but stay abstinent (or as close to abstinent as possible). The sequence that leads to relapse passes through seemingly unimportant decisions that lead the patient into (or allow him to remain in) high-risk situations, which in turn result in maladaptive behaviors and eventually in relapse. Much of relapse-prevention treatment involves raising the patient's awareness of each of these precipitating risk factors and helping the patient develop plans to manage these risk factors.<sup>46</sup> Relapse prevention has come to mean either a specific treatment component of identifying risk factors, or a broad treatment approach, designed to use any tool necessary

not only to help a sex offender to stop offending, but to keep the sex offender from relapsing in the future, after treatment has terminated.

The above relapse-prevention model is typically implemented through a series of psychoeducational modules, based on the idea that specific skill deficits can be remedied through straightforward education and experiential exercises.<sup>47</sup> These modules frequently involve a didactic presentation by a trainer or therapist, who uses written workbooks and homework assignments to enhance involvement and learning.<sup>48</sup> Typically, the modules are taught to groups of patients. Although modules vary to some extent among programs, a common core is presented by Green:<sup>49</sup>

1. *Sex offender characteristics*: This module is sometimes referred to as an introduction to treatment. It includes identification of types and motivations of sex offenders. The module allows patients to understand what treatment will involve and on what issues they will be working. It also provides hope and reduces isolation for patients who may see themselves as hopeless and isolated.
2. *Victim empathy/awareness*: The victim empathy module assists the offender in identifying the short- and long-term consequences of the sexual abuse on victims in general and, if possible, on the offender's victim in particular.
3. *Cognitive restructuring*: This module examines the justifications that offenders use to convince themselves that their sexually offensive behavior is not so reprehensible. The goal is to assist the offender in accepting more responsibility for his behavior.
4. *Deviant sexual acting-out*: The offender is helped to identify his unique sexual assault cycle of motives, emotions, thoughts, and behaviors. Relapse-prevention strategies for

managing personal risk factors are sometimes addressed in this module or in a separate module.

5. *Anger management*: Because some offenders have difficulties appropriately modulating and expressing anger, this module works on identifying the precipitants of anger, preventing anger from overwhelming the offender, and appropriately expressing anger.
6. *Assertiveness training*: This module identifies assertive, passive, and aggressive behavior styles and helps the offender to adopt a more assertive style.
7. *Social skills training*: Social skills training involves the concrete conversational skills needed to initiate and maintain friendships and business and romantic relationships.
8. *Autobiographical awareness*: Assigned autobiographies provide a means for the offender to explore his life and examine the determinates and decisions that shaped his life.
9. *Sex education*: Because many sex offenders are poorly informed regarding human sexuality, sex education concerning not only basic biology, but also sexual myths and cultural expectations about sexual performance, is a critical component of treatment.
10. *Stress reduction*: Relaxation training or meditation is a common component of sex offender treatment, based on the assumption that difficulty managing anxiety and stress is a common problem with this population, and that overwhelming stress, perceived as unmanageable, leads to behavioral acting-out.
11. *Chemical abuse*: Because a substance abuse disorder is commonly comorbid with the sex offending behavior, a component of treatment focusing on effectively managing substance use is commonly used with sex offenders.

Depending on the offender's particular set of problems, the above modules can be tailored to his needs. Given the heterogeneity of sex offenders, treatment programs must be flexible to allow different treatment emphases with different offenders.<sup>50</sup>

In institutional treatment programs, whether in prisons or psychiatric facilities, the above treatment components are typically implemented in a broader context of phases or levels.<sup>51</sup> As Cornwell, Jacobi, and Witt note:

These stages involve two characteristics: increasing level of responsibility and increasing complexity of therapeutic tasks (with a gradual shift towards development of a discharge plan as potential discharge nears). Both features of these stages are based on reasonable principles. Almost all secure facilities have a system by which patients or inmates acquire increasing levels of responsibility as they behave well. Increasing complexity of tasks as one masters simpler tasks is how most complex skills are acquired.<sup>52</sup>

**Treatment  
program at  
the ADTC**

The ADTC, a state correctional facility, as previously noted, was established in 1976 to treat repetitive, compulsive sex offenders in New Jersey. Upon the recommendation of the legislative task force in August 1996, treatment services at the ADTC were privatized. After some staff turnover and disruption during privatization, the treatment program stabilized, following a five-level program similar to that used in other institutional sex offender treatment programs.<sup>53</sup> The levels at the ADTC<sup>54</sup> are:

*Level I:* Patients receive basic information about sex offending, receive an orientation to treatment, and begin to acquire the skills needed to participate fully in more advanced psychotherapy. Level I treatment is provided in structured, didactic groups.

*Level II:* Patients begin to use a sex-offender-specific workbook and begin applying knowledge acquired in Level I to their own lives. Treatment focuses in particular on acknowledgment of responsibility and victim empathy.

*Level III:* Patients focus on acquiring comprehensive cognitive mastery of information gained at earlier levels. Didactic psychoeducational modules are supplemented heavily by a core treatment group with less structure. Relapse-prevention exercises begin.

*Level IV:* This level focuses on a more detailed relapse prevention plan and release preparation.

*Level V:* Patients begin a maintenance program to help them maintain earlier gains. Patients may be placed in a therapeutic community within the walls of the ADTC with additional responsibilities, such as limited self-government.

Within this five-level context, patients undergo a standard set of psychoeducational modules. These include those already mentioned, as well as three modules specifically focusing on relapse prevention and modules regarding forming healthy relationships, arousal reconditioning, and personal victimization.<sup>55</sup>

Prior to 1996, the time most relevant to this study, many of these modules were in place, although perhaps not in so coherent a manner as presently. Moreover, although there was no official level system, patients informally received increased responsibility and therapeutic tasks of increased difficulty as they progressed. The guiding treatment philosophy during the time of the present study was cognitive-behavioral/relapse prevention. Consequently, the current treatment program, while having features not present in the previous treatment program, will serve as a more explicit and detailed model for the treatment during the course of this study.

## Method

- Selection of subjects** The names and State Bureau of Identification (SBI) numbers of 460 men who were released from the Adult Diagnostic and Treatment Center in the years 1990, 1991, 1994 and 1995 were retrieved from records within the institution. The names and SBI numbers of 250 sex offenders released from all other New Jersey Department of Corrections institutions released in 1990 were gathered from the department's central records. Those cases that lacked identifying information were deleted from the study. Cases were also deleted from the study if we were aware that these men had died during the follow-up period. Otherwise, all men identified as releasees for the years in question were included in the study.
- Information retrieval** All ADTC files were located, and relevant data, such as age at release, gender and age of victims, presence of institutional charges, number of prior sex arrests and convictions, number of nonsexual prior convictions, and length of time in therapy, were recorded. Type of presenting offense was also recorded, broken down as rape (forced sexual contact with a victim age 16 or older), incest (sexual contact with a blood relative or a stepchild by an offender in a supervisory position in the family), and child molestation (sexual contact with a minor outside the family). A final category was "involvement in therapy." We created three designations based on a review of the treatment reports on file: full, partial, and minimal involvement in treatment. These designations were created to differentiate among those who failed to attend therapy, those who attended partially, and those who attended almost 100% of the time. The evaluation was further influenced by degree of involvement in treatment, in addition to attendance. The offenders were described with regard to degree of involvement in the treatment reports, which included Likert scales. Two research assistants independently evaluated 50 cases to determine interrater reliability (see *Results* section). All such evaluations were made prior to our receiving recidivism data on any case.

All cases thus identified were submitted to the New Jersey State Bureau of Investigation criminal records database. The system provided the researchers with state and Federal Bureau of Investigation (out of state, but within the US) criminal records and sex offender registration information. We then were able to ensure that each case was in fact an ADTC releasee by verifying the presenting offense and determining the rate of sexual offense reconviction and non-sexual offense reconviction. From this information, we determined which of the individuals in our state prison and ADTC sex offender samples had reoffended within five years or ten years of release from incarceration. A comparison group of state prison sex offender inmates was available for the 1990 and 1991 samples.

## Results

The authors sampled inmates who were released from the ADTC in the years 1990, 1991, 1994, and 1995. Table 1 shows the characteristics of the entire pooled ADTC sample.

Table 1 illustrates that the majority of the ADTC sex offenders had full or moderate participation in therapy. About 85% of the offenders had molested children, with roughly half of those being incest offenders. Three-quarters of victims were female, with a median age of 11 years old.

We first studied five-year recidivism rates in the 1994 and 1995 ADTC sample. Then, to provide a longer period during which recidivism could occur, we collected ten-year recidivism data from all ADTC inmates released in 1990 and 1991.<sup>56</sup> For the purpose of this study, we will report findings only on the 1990 and 1991 ten-year ADTC sample, which we consider a more valid reflection of recidivism than five-year figures (see Table 2).

TABLE 1 ADTC full sample—variables of interest

<i>Variable of Interest</i>	<i>ADTC—All Years 1990, 1991, 1994 and 1995</i>
<b>Therapy Involvement<sup>1</sup></b>	
<i>Full</i>	42.4%
<i>Moderate</i>	27.6%
<i>Minimal</i>	30%
<b>Offense Type<sup>2</sup></b>	
<i>Incest</i>	45.6%
<i>Child Molestation</i>	40.6%
<i>Rape</i>	13.8%
<b>Victim Gender</b>	
<i>Male</i>	24%
<i>Female</i>	76%
<b>Age of the Victim<sup>3</sup></b>	
<i>Mean</i>	25 years
<i>Median</i>	11 years
<b>Age at Release<sup>4</sup></b>	
<i>Mean</i>	41 years
<b>Number of Prior Non-Sex Convictions</b>	
<i>0</i>	63%
<i>1</i>	18%
<i>2</i>	9%
<i>3</i>	4%
<i>4-18</i>	6%
<i>Mean</i>	.98
<i>Median</i>	0

<sup>1</sup> Interrater reliability for two examiners on a sample of 50 offenders was 0.73.

<sup>2</sup> Statistics were computed on a second offense category; however, 97% of the sample did not have a second instant offense.

<sup>3</sup> This figure includes both rapists and child molesters, so the ages of the victims varied from 1 year old to 74 years old; however, the concentration was centered around the age of adolescence. Senior ages were skewing the sample, which is revealed by the large difference between the median and the mean. The median is therefore the more reliable measure of central tendency.

<sup>4</sup> Because the ages of the released offenders varied consistently between 22 and 77 years old, the mean was the most reliable measure.

TABLE 2 **ADTC 1990, 1991—10-year recidivism by offense type**

<i>Overall Recidivism</i>	<i>Index Offense Type</i>			<i>Total</i>
	<i>Incest</i>	<i>Child Molestation</i>	<i>Rapist</i>	
Sexual Recidivism	8 (9%)	4 (8%)	2 (8%)	14 (9%)
No Sexual Recidivism	77 (91%)	48 (92%)	24 (92%)	149 (91%)
Total	85 (100%)	52 (100%)	26 (100%)	163 (100%)
Non-Sexual Recidivism	20 (24%)	12 (21%)	10 (38%)	42 (26%)
No Non-Sexual Recidivism	65 (76%)	40 (79%)	16 (62%)	121 (74%)
Total	85 (100%)	52 (100%)	26 (100%)	163 (100%)

As indicated in Table 2, 9% (14 of 163) of the inmates released in these years had new sex offenses within ten years of release, while 26% (42 of 163) had new non-sex offenses during that ten-year period. In this ten-year sampling period, the type of original sexual offense (incest, extrafamilial pedophile, rapist) had no significant effect on sexual recidivism. Incest offenders had 9% sexual recidivism (8 of 85), extrafamilial child molesters had 8% (4 of 52), and rapists had 8% (2 of 26).

We then examined what variables were, in fact, associated with new sex and non-sex offenses in ADTC inmates released in 1990 and 1991. We found two variables to be related to non-sexual recidivism: institutional charges and victim gender. No variables were significantly associated with sexual recidivism. (See tables 3, 3a, 4, and 4a.)

TABLE 3 **ADTC 1990, 1991—10-year recidivism by institutional charges**

	<i>Institutional Charge</i>		<i>Total</i>
	<i>No</i>	<i>Yes</i>	
Sexual Recidivism	11 (10%)	3 (6%)	14 (9%)
No Sexual Recidivism	102 (90%)	47 (94%)	149 (91%)
Total	113 (100%)	50 (100%)	163 (100%)
Non-Sexual Recidivism	21 (19%)	21 (42%)	42 (26%)
No Non-Sexual Recidivism	92 (81%)	29 (58%)	121 (74%)
Total	113 (100%)	50 (100%)	163 (100%)

TABLE 3A **Relationship between institutional charges and non-sexual recidivism**

<i>Chi-square</i>	<i>df</i>	<i>Sig.</i>
9.94	1	.002

TABLE 4 **ADTC 1990, 1991—10-year recidivism by victim gender**

	<i>Victim Gender</i>		<i>Total</i>
	<i>Male</i>	<i>Female</i>	
Sexual Recidivism	4 (10%)	10 (8%)	14 (9%)
No Sexual Recidivism	35 (90%)	114 (92%)	149 (91%)
Total	39 (100%)	124 (100%)	163 (100%)
Non-Sexual Recidivism	5 (13%)	37 (30%)	42 (26%)
No Non-Sexual Recidivism	34 (87%)	87 (70%)	121 (74%)
Total	39 (100%)	124 (100%)	163 (100%)

TABLE 4A **Relationship between victim gender and non-sexual recidivism**

<i>Chi-square</i>	<i>df</i>	<i>Sig.</i>
4.49	1	.034

Inmates with a history of institutional charges had significantly higher non-sexual recidivism than inmates without such a history (Chi-square = 9.94,  $df = 1$ ,  $P < .01$ ). Regarding victim gender, offenders with a male victim had slightly higher sexual reoffense rates than offenders with female victims (Chi-square = 4.49,  $df = 1$ ,  $P < .05$ ).

To determine whether a multivariate combination of variables taken together would result in better prediction of non-sexual recidivism than taking each variable separately, we performed a logistic regression (see tables 5 and 5a).

TABLE 5 **Logistic regression—dependent variable—non-sexual recidivism**

<i>Model Summary</i>			
<i>Sig.</i>	<i>Nagelkerke R Square</i>	<i>df</i>	<i>Chi Square</i>
.000	.242	10	67.985

TABLE 5A **Significant variables in the model**

<i>Variables</i>	<i>B</i>	<i>S.E.</i>	<i>Sig.</i>	<i>Exp(B)</i>
Prior Sex Conviction	.166	.072	.020	1.181
Release Age	-.078	.016	.000	.925
Institutional Charge	.780	.281	.005	2.182

Table 5 indicates that three variables in combination—prior sex conviction, age at release (younger), and presence of at least one institutional charge—results in a significant association with a new, non-sexual offense after release.<sup>57</sup> In fact, looking at the odds ratio (expressed in Exponent B), having an institutional charge in itself doubles the odds ( $\text{Exp}(B) = 2.182$ ) of having a new, non-sexual offense in the ten years after release, while having a prior sex conviction increases the odds by 18% ( $\text{Exp}(B) = 1.181$ ). The offender's age was also a significant factor; each additional year increase in the offender's age resulted in almost an 8% decrease in the odds of the offender committing a new, non-sexual offense.

As useful as the above data are, they lack a comparison group. Consequently, we collected data on a large group of sex offenders from the general prison population. The sexual offenses of these general prison population inmates were not found to be part of a repetitive and compulsive pattern of sexual behavior when they were evaluated at time of sentencing. Additionally, these men received either no or very little sex-offender-specific treatment while incarcerated. To determine the comparability of the non-ADTC and the ADTC samples, we collected data on prior sexual offense arrests and convictions for both samples (see Table 6).

TABLE 6 **Prior sex arrest and conviction—ADTC and non-ADTC samples**

	<i>ADTC Prior Sex Arrest</i>		<i>ADTC Prior Sex Conviction</i>		<i>Non-ADTC Prior Sex Arrest</i>		<i>Non-ADTC Prior Sex Conviction</i>	
	f	%	f	%	f	%	f	%
0	254	64%	286	72%	176	75%	192	81%
1	73	18%	63	16%	39	17%	35	15%
2	39	10%	34	9%	15	6%	7	3%
3+	30	8%	13	3%	6	2%	2	1%
Total	396	100%	396	100.0	236	100%	236	100%
Mean	.82		.54		.37		.23	
Median	.00		.00		.00		.00	

Difference between ADTC and non-ADTC on prior sex convictions:  
 $t=2.872$ ,  $df=630$ ,  $p<.01$ .

Difference between ADTC and non-ADTC on prior sex arrest:  $t=3.025$ ,  
 $df=630$ ,  $p<.01$ .

Table 6 indicates that ADTC inmates had a higher number of prior sex offense arrests and convictions than general prison sexual offenders, as would be expected given the repetitive and compulsive finding for sexual offenders sentenced to the ADTC.

We then compared the ten-year recidivism rates (measured as reconstructions) of the ADTC 1990 and 1991 samples and the non-ADTC 1990 sample in three ways: sexual offense recidivism, non-sexual offense recidivism, and any recidivism (sexual or non-sexual). These findings are presented in Tables 7, 8, and 9, respectively.

Table 7 indicates that although ADTC ten-year sexual recidivism is lower than non-ADTC ten-year sexual recidivism (at 9% to 13%, respectively), it does not quite make traditional statistical significance (the probability is less than 0.20, but not less than 0.10). Table 8 indicates that ADTC ten-year non-sexual recidivism is significantly lower than non-ADTC ten-year non-sexual recidivism ( $P < .001$ ) (at

23% to 44%, respectively). Finally, Table 9 indicates that ADTC inmates have lower rates of any recidivism (sexual and nonsexual combined) than general prison sex offender inmates (at 34% and 57%, respectively).

**ADTC vs general population—sexual offense recidivism**

TABLE 7

	ADTC Population N= 163		General Population N= 236		Total
	F	%	f	%	
Sexual Recidivism	14	9%	30	13%	44
No Sexual Recidivism	149	91%	206	87%	355
Total	163	100%	236	100%	399

$\chi^2=1.68$  df=1,  $p>.05$ .

**ADTC vs general population—non-sexual offense recidivism**

TABLE 8

	ADTC Population N= 163		General Population N= 236		Total
	F	%	f	%	
Non-Sexual Recidivism	42	26%	104	44%	146
No Non-Sexual Recidivism	121	74%	132	56%	253
Total	163	100%	236	100%	399

$\chi^2=13.91$ , df=1,  $p<.001$ .

**ADTC vs general population—recidivism vs no recidivism**

TABLE 9

	ADTC Population N= 163		General Population N= 236		Total
	F	%	f	%	
Recidivism	56	34%	134	57%	190
No Recidivism	107	66%	102	43%	209
Total	163	100%	236	100%	399

$\chi^2=19.44$ , df=1,  $p<.001$ .

## Discussion

The present study examined two controversial questions: How frequently do sex offenders reoffend? Does specialized treatment reduce reoffense rates? As we noted earlier, the public seems to believe that reoffense rates are close to 100% and that treatment does little or nothing to lower these rates. Both these questions are subject to empirical analysis.

### Recidivism levels

In the present study, we were fortunate to be able to gather recidivism data on sex offenders released from the New Jersey Department of Corrections over a ten-year period, a considerable length of time. Previous studies were sometimes hampered by short follow-up periods. We conducted a pilot study of five-year recidivism before examining ten-year recidivism, and we found an increase in recidivism if one extends the follow-up period to ten years, consistent with other findings in the literature.<sup>58</sup>

Despite the substantial follow-up period, sexual offense recidivism rates, as measured by reconviction, were low for both the ADTC and the general prison sex offenders, 8.6% and 12.7%, respectively. This difference approached but did not quite reach a traditional level of significance. Although at first glance this lack of significance is disappointing, the reader must bear in mind that base-rates of sexual offending are low, and it is difficult to show differences when such low base-rates are present. By way of analogy, it is difficult to show differences in the effectiveness of two diets if the two groups who follow the diets are already thin (since any decrease in weight in either group is limited). However, from another perspective, the fact that the ADTC recidivism rate appears at least as low as (if not slightly lower than) the untreated general prison population is encouraging, since (as is discussed below) the ADTC group had a higher pre-incarceration level of sexual offending, as well as a finding that their illegal sexual behavior was part of a repetitive-compulsive behavior pattern.

The combined sexual recidivism levels for both groups are also encouraging, suggesting that, contrary to popular belief, sex offenders (even untreated sex offenders in the general prison population) do not necessarily reoffend sexually at extremely high rates. In fact, reoffense rates for non-sexual offenses were significantly higher than such rates for sexual offenses for both ADTC and general prison sex offenders, 25.8% and 44.1%, respectively. However, the reader should bear in mind that even relatively trivial non-sexual reoffenses were included, such as technical parole violations, so this non-sexual reoffense rate may be an overestimate of the non-sexual recidivism that is of concern to the public.

The finding that non-sexual recidivism was dramatically low for the ADTC group was pleasantly surprising, but consistent with the goals of sex-offender-specific treatment. As one can see from the detailed description of the treatment program in the introduction, sex-offender-specific treatment focuses not only on decreasing future sex offending, but also on helping sex offenders acquire the life skills to live productive lives, and the dramatically lower ten-year non-sexual recidivism rate of the ADTC sample suggests that in many cases treatment was successful in this regard. However, we need to be certain that this difference between the two groups is not an artifact of the differing base-rates of non-sexual offending in the two groups. Although we did not have access to previous non-sexual arrests and convictions in the general prison sample (information we hope to obtain for future studies), there is previous research suggesting that general prison sex offenders do indeed have higher rates of non-sexual prior difficulties. For example, a study of sex offender risk by Ferguson, Eidelson, and Witt found state prison sex offenders to score significantly higher than ADTC inmates on the risk criterion "history of antisocial acts."<sup>59x</sup>

The strongest positive association between offender characteristics and future offending was actually between three variables—previous sex conviction, age at release

(younger), and presence of at least one institutional charge—and non-sexual recidivism, not sexual recidivism. This provides support for the hypothesis that with at least some sex offenders, their sexual offense difficulties are part of broader self-control and psychopathy issues.<sup>60</sup> Like other studies, the present study found that increasing age of the offender decreases future offending, and that offenders with female victims have lower sexual recidivism rates than those with male victims. There is a substantial literature on the negative relationship between age of offender and decreased crime (of all kinds),<sup>61</sup> and within the sex offender risk assessment literature, male sex of victim is frequently found to be related to increased future sexual offending.<sup>62</sup>

Comparison  
group

Previous research on sex offender treatment effectiveness frequently lacked a comparison group. In the present study, we were able to obtain a large sample of untreated general prison population sex offenders against which we could compare the recidivism for the treated ADTC sample. Our finding that ADTC sex offenders had ten-year sexual offense recidivism slightly below the level of the general prison population's (although admittedly less significantly so than we might have hoped) is encouraging, particularly given that this program specifically and similar programs generally have been under heavy criticism in recent years. In a future study, we hope to match the two samples on demographic characteristics, to rule out the possibility that demographics act as a confounding variable.

The samples differ in one critical way: The ADTC sample is in many ways a more challenging population therapeutically, since their sex offenses were found to be part of a repetitive and compulsive illegal sexual-behavior pattern, whereas the general prison sample was not so found. Table 6 indicates that the difference between ADTC inmates and general prison sex offender inmates on previous sex arrests is in the expected direction—with the ADTC inmates having a significantly higher average number of previous sex offense

arrests. In addition, previous research on sex offender risk has found ADTC inmates to score significantly higher than general prison sex offenders on a risk criterion titled "number of [sex] offenses/victims."<sup>63</sup>

#### Future research

The present study is but the first of a series of planned studies to evaluate sex offender treatment in the New Jersey Department of Corrections. Applied research is always limited by constraints of data collection and retrieval systems and by policies that were not designed with research in mind, leading to gaps in the data. Research is needed to clarify the nature of differences between the ADTC and the general prison samples, so that we could say with more certainty that differences in recidivism we found were due not to differences between the two samples, but to the positive effect of treatment. The comparison between the two samples in the present study was not perfect. The samples were not matched on demographic data. In fact, we were unable to obtain full demographic data for the general prison sample, an effort that will await a future study in which we hope to obtain sufficient demographic data and a large enough sample size to match ADTC and general prison inmates on demographic features. In particular, for the present study we were unable to obtain a number of previous non-sexual offenses, an area of significant interest.

Recidivism data in the present study were limited to reconvictions, perhaps the least sensitive measure of actual recidivism. In future research, we hope to obtain rearrest data, a more sensitive measure of recidivism. Moreover, we hope to obtain more detailed information on reoffenses, particularly non-sexual reoffenses, so that we can more accurately determine the nature and seriousness of non-sexual recidivism.

We hope to examine the treatment process variables more closely. As noted, in the present study treatment involvement was determined by a global *post hoc* rating by the research team

long after the offender had completed treatment. This relatively insensitive measure may partly account for the lack of a significant effect of treatment involvement within the ADTC sample. That is, although placing an inmate at the ADTC, and presumably exposing him to an intensive treatment program, may lower recidivism, a higher level of therapeutic involvement at the ADTC did not seem to lower recidivism within the ADTC sample. However, the reader should bear in mind that there was a restricted range in this variable, with most ADTC inmates participating at least moderately in treatment, thus limiting potential results. In future research, we hope to use more sensitive rating scales administered by treating therapists contemporaneously during the course of treatment to track more closely this potentially important variable.

### Conclusion

In many ways the results of this study are within the mainstream of sex offender treatment studies. Sex offender management is a controversial area, with regular calls for long (perhaps indefinite) incarceration instead of treatment. The present study suggests that intensive treatment can bring down the sex recidivism rate in a repetitive and compulsive population to at least the level (if not slightly below it) of a non-repetitive and non-compulsive population. Moreover, the study indicates that treatment may well lower non-sexual recidivism among treated sex offenders, an unanticipated but welcome benefit of the treatment program. Finally, sexual offense recidivism for both treated and untreated sex offenders was relatively low, far from popular impressions and well within limits of similar studies. We hope to clarify these points and test alternative interpretations through future studies on these populations.

- Notes
1. The American Psychiatric Association (1999). *Dangerous Sex Offenders: A Task Force Report of the American Psychiatric Association*. Washington, DC.

2. N.J. Stat. Ann. § 2C:47-1. Prior to the enactment of this amended statute in 1998, only a finding of repetition and compulsion, without consideration of amenability or willingness, was required for incarceration at the ADTC.
3. Report of the Joint Legislative Task Force to Study the Adult Diagnostic and Treatment Center, June 19, 1995. New Jersey State Legislature.
4. Freeman-Longo, R.E. & Blanchard, G.T. (1998). *Sexual Abuse in America: Epidemic of the 21st Century*. Brandon, VT: Safer Society Press; Laws, R.D. (2000). "Sexual Offending as a Public Health Problem: A North American Perspective." *Journal of Sexual Aggression*, 5, (1), pp. 30-44; Henry, F. & Kaufman, K. (1999). "The Prevention of Sexual Abuse." *Sexual Abuse: A Journal of Research and Treatment*, 11, (4), pp. 255-325; Freeman-Longo, R.E. & Berliner, L. (1996). "Public Notification and Sexual Offender Release." *Sexual Abuse: A Journal of Research and Treatment*, 8, (2), pp. 89-104.
5. Furby, L., Weinrott, M.R. & Blackshaw, L. (1989). "Sexual Offender Recidivism: A Review." *Psychological Bulletin*, 105, pp. 3-30; Koss, M., Gidycz, C.A. & Wisniewski, N. (1987). "The Scope of Rape: Incidence and Prevalence of Sexual Aggression and Victimization in a National Sample of Higher Education Students." *Journal of Consulting and Clinical Psychology*, 55, (2), pp. 162-170.
6. Koss et al., supra note 5.
7. Supra note 4.
8. Marshall, W.L. (1996). "The Sexual Offender: Monster, Victim, or Everyman?" *Sexual Abuse: A Journal of Research and Treatment*, 8, (4), pp. 317-335.
9. The majority of research finds that sex offenders do not suffer from mental aberrations; e.g., American Psychiatric Association, supra note 1; Furby et al., supra note 5.
10. [www.state.ny.us/governor/press](http://www.state.ny.us/governor/press).
11. Maletzky, B.M. (1996). "Evolution, Psychopathology, and Sexual Offending: Aping Our Ancestors." *Aggression and Violent Behavior*, 1, (4), pp. 376-393; Ohio Department of Rehabilitation and Correction (2001). "Ten-year Recidivism Follow-up of 1989 Sex Offenders Releases"; the New Jersey Department of Corrections has conducted previous, unpublished recidivism studies that have yielded low rates of recidivism of treated sex offenders—approximately 10% recommit a sex offense. See New Jersey Department of Corrections, Office of Policy and Planning (2001). Release Outcome—1994

- Through 1997; Furby et al., *supra* note 5; Lieberman, D. (1996). "Megan's Law: An Asset or a Quick Fix?" *New York Law Journal*, January 17, 1996.
12. U.S. Department of Justice (2002). Recidivism of prisoners released in 1994: Bureau of Justice Statistics Special Report. Report NCJ 193427.
  13. *Id.* Constituting two-thirds of the inmates in the U.S. released that year.
  14. *Id.* at 9.
  15. *Id.*
  16. 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 Project on the Effectiveness of Psychological Treatment for Sex Offenders." *Sexual Abuse: A Journal of Research and Treatment*, 14, (2), pp. 169-194.
  17. Rice, M.E., Quinsey, V.L. & Harris, G.T. (1991). "Sexual Recidivism Among Child Molesters Released from a Maximum Security Psychiatric Institution." *Journal of Consulting and Clinical Psychology*, 59, pp. 381-386.
  18. U.S. Department of Justice, *supra* note 12, at 3.
  19. Belknap, J. (2000). "Sexual Victimization," in *Invisible Women: Gender, Crime and Justice*. Stamford, CT: Wadsworth; Nagayama, G.H. (1995). "Sexual Offender Recidivism Revisited: A Meta-Analysis of Recent Treatment Studies." *Journal of Consulting and Clinical Psychology*, 63, (5), pp. 802-809; Hanson, K.R. & Bussiere, M. (1998). "Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies." *Journal of Consulting and Clinical Psychology*, 66, (2), pp. 348-362.
  20. Chesney-Lind, M. (1997). *The Female Offender: Girls, Women and Crime*. Thousand Oaks, CA: Sage; Belknap, *supra* note 19.
  21. Belknap, *supra* note 19; Chesney-Lind, *supra* note 20.
  22. Furby et al., *supra* note 5; Prentky, R.A., Lee, A.F., Knight, R. & Cerce, D. (1997). "Recidivism Rates Among Child Molesters and Rapists: A Methodological Analysis." *Law and Human Behavior*, 21, (6), pp. 635-659; Hanson & Bussiere, *supra* note 19; American Psychiatric Association, *supra* note 1.
  23. Marshall, H.E. & Barbaree, W.L. (1988). "Deviant Sexual Arousal, Offense History, and Demographic Variables as Predictors of Reoffense Among Child Molesters." *Behavioral Sciences and the*

- Law, 6, (2), pp. 267-280; Malcolm, P.B., Andrews, D.A. & Quinsey, V.L. (1993). "Discriminant and Predictive Validity of Phallometrically Measured Sexual Age and Gender Preference." *Journal of Interpersonal Violence*, 8, (4), pp. 486-503; Freund, K., Watson, R. & Dickey, R. (1991). "Sex Offenses Against Female Children Perpetrated by Men Who Are Not Pedophiles." *Journal of Sex Research*, 28, (3), pp. 409-423.
24. Hanson, R.K., Steffy, R.A. & Gauthier, R. (1993). "Long-term Recidivism of Child Molesters." *Journal of Consulting and Clinical Psychology*, 61, (4), pp. 646-652; Soothill, K.L. & Gibbens, T.C.N. (1978). "Recidivism of Sexual Offenders." *British Journal of Criminology*, 18, (3), pp. 267-276; *American Psychiatric Association*, supra note 1; Furby et al., supra note 5; Prentky et al., supra note 22.
  25. Sturgeon, V.H. & Taylor, J. (1980). "Report of a Five-year Follow-up Study of Mentally Disordered Sex Offenders Released from Atascadero State Hospital in 1973." *Criminal Justice Journal*, 4, (3), pp. 31-63.
  26. Prentky et al., supra note 22; Hanson et al., supra note 24; Furby et al., supra note 5.
  27. Furby et al., supra note 5.
  28. The American Psychiatric Association, supra note 1.
  29. Supra note 5.
  30. Martinson, R. (1974). "What Works? Questions and Answers About Prison Reform." *Public Interest*, 35, pp. 22-54.
  31. See American Psychiatric Association, supra note 1; Furby et al., supra note 5; Nicholaichuk, T., Gordon, A., Gu, D. & Wong, S. (2000). "Outcome of an Institutionalized Sexual Offender Treatment Program: A Comparison Between Treated and Matched Untreated Offenders." *Sexual Abuse: A Journal of Research and Treatment*, 12, (2), pp. 139-153.
  32. Nagayama Hall, G. (1995). "Sexual Offender Recidivism Revisited: A Meta-Analysis of Recent Treatment Studies." *Journal of Consulting and Clinical Psychology*, 63, (5), pp. 802-809.
  33. Furby et al., supra note 5.
  34. See also discussion in Nicholaichuk et al., supra note 31.
  35. Nagayama Hall, supra note 32.
  36. Nicholaichuk et al., supra note 31.

37. Ohio Department of Rehabilitation and Correction (2001). "Ten-year Recidivism Follow-up of 1989 Sex Offender Releases."
38. The authors also bring up another point consistent with other sex-offender-specific research: the variable recidivism rates among sex-offending typologies. Within the Ohio study, rapists had recidivism levels of 17.5%, extrafamilial child molesters recidivated at a level of 8.7%, and incest offenders recidivated at a level of 7.4%. These findings are consistent with previous studies that have made distinctions between offender types. In a similar vein, Marshall and Barbaree, *supra* note 23, discovered that intrafamilial incest offenders recidivated at approximately 50% of the level of extrafamilial child molesters. Hanson & Bussiere, *supra* note 19, also reported similar results; the recidivism rate was 19% for rapists and almost 13% for child molesters.
39. Cornwell, J.K. Jacobi, J.V. & Witt, P.H. (1999). "The New Jersey Sexually Violent Predator Act: Analysis and Recommendations for the Treatment of Sex Offenders in New Jersey." *Seton Hall Legislative Journal*, 24, (1), pp. 1-42.
40. For a comprehensive review of pharmacologic treatment, see Bradford, J. (1997). Medical Interventions in Sexual Deviance. In Laws, D.R. & O'Donohue, W. (eds.), *Sexual Deviance: Theory, Assessment, and Treatment*, pp.449-464; and Land, W.B. In Schwartz, B.K. & Cellini, H.R. (eds.) (1995). *The Sex Offender: Corrections, Treatment, and Legal Practice*, Chapter 18.
41. For example, weight gain, decrease in the size of sexual organs, lethargy, hot/cold flashes, headaches, cramping, and irritability. Also, the medication may have carcinogenic properties when used long-term. See Land, *supra* note 40, at 18-2.
42. See Land, *supra* note 40, at 18-4-18-5; Bradford, *supra* note 40; Cornwell, Jacobi & Witt, *supra* note 39, at 13, 15.
43. For example, Kafka, M.P. (1991). "Successful Antidepressant Treatment of Nonparaphilic Sexual Addictions and Paraphilias in Men." *Journal of Clinical Psychiatry*, 52, pp. 60-65; Kafka, M.P. and Prentky, R.A. (1992). "Fluoxetine Treatment of Nonparaphilic Sexual Addictions and Paraphilias in Men." *Journal of Clinical Psychiatry*, 53, pp. 351-358; Kafka, M.P. (1994). "Sertraline Pharmacotherapy for Paraphilias and Paraphilia-related Disorders: An Open Trial," *Annals of Clinical Psychiatry*, 6, pp. 189-195; Kafka, M.P. (1995). "Current Concepts in the Drug Treatment of Paraphilias and Paraphilia-related Disorders," *CNS Drugs*, 3, pp. 9-21.
44. Freeman-Longo, R.E., Bird, S., Stevenson, W.F. & Fiske, J.A. (1994). *1994 Nationwide Survey of Treatment Programs and Models Serving Abuse-Reactive Children and Adolescent and Adult Sex*

*Offenders*; see also Witt, P.H., Rambus, E. & Bosley, T. (1996). "Current Developments in Psychotherapy for Child Molesters," *Sexual and Marital Therapy*, 11, pp. 173-185.

45. See Marlatt, G.A. & Gordon, J.R. (eds.) (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors*; Pithers, W.D. (1990). Relapse Prevention with Sexual Aggressors. In W. Marshall (ed.), *Handbook of Sexual Assault*, pp. 343-361.
46. See Cornwell, Jacobi & Witt, *supra* note 39, at 17.
47. See Green, R., Psycho-Educational Modules. In Schwartz, B.K. & Cellini, H.R. (eds.), *supra* note 40, Chapter 13.
48. *Id.*
49. *Id.*
50. Cornwell, Jacobi & Witt, *supra* note 39, at 17.
51. See Marshall, W.L., Fernandez, Y.M. & Ward, T. (1998). *Sourcebook of Treatment Programs for Sexual Offenders*.
52. Cornwell, Jacobi & Witt, *supra* note 39, at 17-18.
53. See Cornwell, Jacobi & Witt, *supra* note 39, for a review of similar programs in Minnesota and California.
54. The interested reader can refer to Cornwell, Jacobi & Witt, *supra* note 39, for a more detailed description. These levels, drawn from the ADTC program description dated April 24, 1998, are based on the writings of the program director, Barbara Schwartz, in Schwartz and Cellini, *supra* note 40, part 2.
55. See Schwartz, B., in Schwartz & Cellini, *supra* note 40, 13-3, 13-9.
56. In fact, five-year recidivism figures were substantially lower than ten-year figures, indicating that recidivism did occur during the five-to ten-year period. The interested reader can obtain all five-year pilot study results from the authors.
57. Treatment involvement, type of sex offense, and age of victim do not add to the positive association with recidivism in this prediction equation.
58. Prentky, R.A., Lee, A.F.S., Knight, R.A. & Cerce, D. (1997). "Recidivism Rates Among Child Molesters and Rapists: A Methodological Analysis." *Law and Human Behavior*, 21, 635-659; Romero, J.J. & Meyer-Williams, L.M. (1985). "Recidivism Among Convicted Sex Offenders: A Ten-year Follow-up Study." *Federal Probation*, 49, 58-64; Soothill, K.L. & Gibbens, T.C.N. (1978).

- "Recidivism of Sexual Offenders: A Reappraisal." *British Journal of Criminology*, 18, 267-276.
59. See Ferguson, G.E., Eidelson, R.J. & Witt, P.H. (1998). "New Jersey's Sex Offender Risk Assessment Scale: Preliminary Validity Data," 62, *J. Psychiatry & Law*, 327, at 336.
60. See Gottfredson, M. & Hirschi, T. (1990). *A General Theory of Crime*. Stanford: Stanford University Press.
61. Hanson, R.K. (2001). Age and Sexual Recidivism: A Comparison of Rapists and Child Molesters. (User Report No. 2001-01). Ottawa: Department of the Solicitor General of Canada; Moffit, T.E. (1997). Adolescence-Limited and Life-Course Persistent Offending: A Complementary Pair of Development Theories. In Terence P. Thornberry (ed.), *Developmental Theories of Crime and Delinquency: Advances in Criminological Theory, Volume 7*, pp 11-54. New Brunswick, NJ: Transaction Publishers
62. Hanson & Bussiere, supra note 19.
63. Ferguson et al., supra note 59.