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Sex offenders' perceptions of mandated group treatment

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SEX OFFENDERS' PERCEPTIONS OF MANDATED GROUP TREATMENT

A clinical dissertation submitted in partial satisfaction

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Doctor of Psychology

by

Ashley Knipp, M. A.

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Cary Mitchell, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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DEDICATION

This dissertation is dedicated to Patrick, my husband. Thank you for your patience and encouragement and for picking up my slack when I needed you. There is no doubt that without your support, I could not have completed this process.

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First and foremost, I would like to express my immense gratitude to my dissertation chair, Dr. Cary Mitchell, for your guidance throughout all stages of this process and for always being supportive in your feedback and suggestions. I would also like to acknowledge my committee members, Dr. Carolyn Keatinge and Dr. Lea Chankin, for sharing your time and expertise; it has been a privilege to work with you. Dr. Keatinge, I greatly appreciate your mentorship, not only throughout the dissertation process, but in helping me shape and realize my professional ambitions. Dr. Chankin, thank you for allowing me to access your clinic and group materials, for checking my facts, and for your invaluable feedback. In addition, a special thanks is necessary to the staff at the research site for making the data collection process possible.

Thank you to my parents for your infinite support and encouragement, and for instilling in me the values of hard work and perseverance. To my siblings, Sara, Danielle, Brittany, Emily, Aron, Willie, CJ, Holly, and Andrew: thank you for your support. To my friends, all of you, thank you for standing behind me in my struggles and cheering me on. Finally, a very special thank you is due to Yoshimi and Roxie for always reminding me take a break.

VITA

EDUCATION

Pepperdine University, Los Angeles, CA
Doctor of Psychology in Clinical Psychology
2009-Present Expected Graduation: May 2013

- Dissertation Preliminary Examination Passed: May 2, 2011
- Dissertation Final Defense Passed: October 8, 2012
- Clinical Competency Examination Passed: June 22, 2011
- Assessment Competency Examination Passed: August 31, 2011

Pepperdine University, Malibu, CA
Master of Arts in Clinical Psychology, with an emphasis in Marriage and Family Therapy
2007-2009 Degree Conferred: May 2009

Ohio Northern University, Ada, OH
Bachelor of Arts in Psychology & Sociology
2003-2006 Degree Conferred: November 2006

- Graduated with Distinction

CLINICAL EXPERIENCE

Metropolitan Detention Center, Los Angeles, CA
Clinical Psychology Intern
2012-Present

- Complete forensic evaluations to make recommendations to the courts regarding competency to stand trial, responsibility at the time of the offense, and violence risk
- Complete suicide risk assessments to determine need for suicide watch
- Conduct crisis interventions to address acute psychological symptoms and adjustment issues for pre-trial populations
- Conduct long-term individual psychotherapy to address symptoms of mental illness and plan for reentry into the community
- Facilitate psychoeducational group therapy to target substance abuse and reentry planning
- Attend didactic trainings on correctional and forensic psychology topics

Metropolitan State Hospital, Norwalk, CA
Clinical Psychology Extern, Forensic Admissions Rotation
2011-2012

- Conducted cognitive screenings for individuals upon admission
- Completed psychodiagnostic assessments to inform treatment planning
- Provided individual therapy based on the Recovery Model with criminally committed patients
- Co-facilitated a process group focused on substance abuse recovery
- Co-facilitated a psychoeducational group focused on symptom management
- Attended Wellness Recovery Plan meetings to review patients' treatment progress
- Maintained clinical documentation to comply with Department of Mental Health standards

CLINICAL EXPERIENCE

California Department of Corrections and Rehabilitation
Division of Juvenile Justice
Southern Youth Correctional Reception Center and Clinic, Norwalk, CA
Clinical Psychology Extern, Intensive Treatment Program Rotation
2010-2011

- Conducted diagnostic interviews to determine the appropriate level of mental health care services and recommend placement changes
- Administered brief cognitive screenings for new admissions to evaluate the need for educational accommodations
- Conducted comprehensive psychological assessment batteries for the purposes of diagnostic clarification and treatment planning
- Provided individual therapy to incarcerated juveniles and adults with severe mental illness to assist in symptom reduction and reentry planning
- Conducted crisis interventions to address suicidal ideation and psychosis
- Developed and facilitated a ten-week psychoeducational group focused on the identification and modification of criminal thinking errors
- Developed and facilitated a ten-week process group focused on grief and loss for individuals who had experienced loss due to gang violence
- Developed and facilitated a four-week group focused on stress-management
- Attended case conferences with a multidisciplinary treatment team to track inmate progress

Bienvenidos, Montebello, CA
Clinical Psychology Extern
2010-2011

- Conducted intake interviews with children and families to determine medical necessity for treatment and develop individualized treatment plans
- Provided therapy to children, adolescents, and families from a cognitive-behavioral framework to target treatment goals
- Attended didactic training seminars focused on the administration and interpretation of a variety of assessment measures
- Administered assessments with diverse children and adolescents within the foster care and court systems who presented with attention and learning difficulties and emotional and behavioral disturbances
- Conducted assessment feedback sessions with families and psychotherapists to communicate recommendations for symptom reduction
- Participated in Individualized Education Plan (IEP) meetings to present assessment findings and advocate for educational accommodations

Pepperdine University West Los Angeles Community Counseling Center, Los Angeles, CA
Clinical Psychology Extern
2009-2012

- Conducted intake interviews with couples, adults, and adolescents to inform case conceptualization and treatment planning
- Provided therapy to couples, adults, and adolescents to alleviate mental health symptoms and promote healthy functioning
- Administered and interpreted brief assessment measures to track client progress
- Served as an on-call therapist and conducted crisis interventions during client emergencies

CLINICAL EXPERIENCE

The Richstone Family Center, Hawthorne, CA
Marriage and Family Therapy Trainee
2008-2009

- Conducted structured intake interviews to inform diagnosis and treatment planning
- Provided cognitive-behaviorally oriented therapy to ethnically and socio-economically diverse individuals to target symptoms related to trauma and family violence
- Attended a training seminar on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Collaborated with a multidisciplinary team to execute court mandated treatment requirements and communicate client progress
- Maintained clinical documentation

Family Resource Center of Lima, Ohio, Lima, OH
Intern
2006

- Participated in individual and group therapy sessions with juvenile first-time sexual offenders to promote self-management and relapse prevention using the Pathways model
- Conducted educational seminars at a juvenile detention center to teach incarcerated adolescents about consent laws
- Participated in Individualized Education Plan (IEP) meetings to advocate for client services

TEACHING EXPERIENCE

Pepperdine University West Los Angeles Community Counseling Center, Los Angeles, CA
Peer Supervisor
2011-2012

- Supervised novice therapists, including teaching therapeutic techniques, processing counter-transference, addressing legal and ethical issues, and critiquing video-taped sessions
- Facilitated and participated in case conferences focused on guiding therapists through diagnosis and case conceptualization
- Educated therapists about clinic policies and operations, assessment measures, and emergency procedures
- Audited therapist files to ensure adherence to clinic standards
- Attended training focused on supervising student therapists

Pepperdine University, Los Angeles, CA
Teaching Assistant for Drs. C. Keatinge, S. Himelstein, and S. Sazgar
2011-2012

- Assisted instructors with Cognitive Assessment, Personality Assessment, and Advanced Assessment classes
- Reviewed student scoring for the cognitive, neuropsychological, personality, and projective measures
- Conducted workshops on the administration of the Wechsler Intelligence Scale for Children –Fourth Edition (WISC-IV), Wechsler Adult Intelligence Scale –Fourth Edition (WAIS-IV), and Rorschach Inkblot Test
- Evaluated student progress in the administration of the WISC-IV, WAIS-IV, and Rorschach Inkblot Test

RESEARCH EXPERIENCE

Pepperdine University, Malibu, CA
Principal Investigator Faculty Supervisor: Carrie Canales, Ph.D.
2009-2011

- Designed a study to investigate family of origin and roommate relationships of emerging adults
- Adapted the Family Adaptability and Cohesion Evaluation Scale –Fourth Edition (FACES-IV) for use with roommate relationship evaluations
- Surveyed 400 emerging adults to examine similarities and differences between the values and interpersonal behaviors in family of origin and roommate relationships
- Analyzed survey data using the Statistical Package for Social Sciences (SPSS)
- Concluded that emerging adults relate to roommates and families of origin in a similar manner, particularly when an emerging adult perceives the family of origin to be enmeshed

The RAND Corporation, Santa Monica, CA
Survey Administrator
2009-2010

- Completed administrative duties to establish survey participation eligibility and verify informed consent and assent documentation
- Assembled survey materials and collaborated with middle school staff and research personnel to prepare for data collection
- Administered drug and alcohol use surveys to middle school children to evaluate a pilot drug and alcohol education program
- Organized and validated data to ensure completeness and accuracy

University of California, Los Angeles, Los Angeles, CA
Research Assistant for Katherine Baucom under Dr. Andrew Christensen
2008-2009

- Transcribed couple interactions to investigate the role of language in the satisfaction of spousal interactions
- Conducted quality assurance checks and edited transcriptions
- Analyzed characteristics of social support interactions to rate satisfaction
- Participated in laboratory trainings and educational discussions focused on Integrative Behavioral Couple Therapy

Ohio Northern University, Ada, OH
Research Assistant for Dr. Steven Hundersmarck
2005-2006

- Collaboratively designed a research study to investigate how high school students' peer affiliations and school activities related to their future goals
- Conducted field observations and carried out structured interviews to examine peer relationships, school activities, and future aspirations
- Developed a coding system to categorize peer affiliation groups based on B. Bradford Brown's theory of peer cultures
- Coded data and determined that involvement in school activities was positively related to higher aspirations for the future

RESEARCH EXPERIENCE

Ohio Northern University, Ada, OH
Research Assistant for Dr. Keith Durkin
2005-2006

- Participated in a research laboratory that focused on evaluating deviant behavior and substance abuse among undergraduate students
- Evaluated the application of Travis Hirschi's social bond theory to the uptake of binge drinking behaviors in undergraduate students
- Analyzed survey data using the Statistical Package for Social Sciences (SPSS) to determine types of social attachment that influence drinking
- Established that identification with any type of religious group mediated binge drinking and other deviant behaviors in our sample

SCHOLARLY PUBLICATIONS

- Hundersmarck, S., Albright, C., **Knipp, A.**, & Hammel, G. (2008). Everyone is the basically same, some people are different: Peer association in a rural Ohio high school. *Journal of Psychology and Behavioral Sciences*, 20, 1-11.

PROFESSIONAL PRESENTATIONS

- Young, S., **Knipp, A**., & Rowe, D. (2010). A critique of how the Eurocentric bias has influenced the philosophy underlying psychological science and practice: Fresh insights from the developing scientist-practitioner. Poster presented at the Los Angeles County Psychological Association Convention and the Pepperdine University Multicultural Research and Training Lab.

- **Knipp, A.**, & Burke-Maynard, Q. E. (2010). Mindfulness meditation and relaxation skills. Experiential workshop presented at Jenesse battered women's shelter in Los Angeles, California.

- Albright, C., **Knipp, A**., & Hammel, G. (2006). Everyone is basically the same, some people are different: Peer affiliation in a rural Ohio high school. Paper presented at the Ohio Northern Research Colloquium and the Ohio Undergraduate Psychology Research Conference.

- Horstman, C., **Knipp, A.**, & Shuck, J. (2006). An application of Travis Hirschi's social bond theory to the uptake of binge drinking. Paper presented at the Ohio Northern Research Colloquium and the Mid-South Sociological Association's 32nd Annual Meeting.

CONFERENCES AND TRAININGS

- Los Angeles County Psychological Association Convention
  October 2010 in Culver City, California
- Smart Marriages Conference, Volunteer
  July 2008 in San Francisco, California
- Trauma-Focused Cognitive Behavioral Therapy Certification
  June 2008 in Hawthorne, California
- Mid-South Sociological Association's 32nd Annual Meeting
  October 2006 in Lafayette, Louisiana
- Ohio Northern University Undergraduate Research Colloquium
  April 2006 in Ada, Ohio
- Ohio Undergraduate Psychology Research Conference
  April 2006 in Berea, Ohio

PROFESSIONAL AFFILIATIONS

- Forensic Mental Health Association of California, Student Affiliate
  2011-Present
- Forensic Psychology Association, Pepperdine University, Co-Founder
  2011-Present
- International Association of Correctional and Forensic Psychology, Student Affiliate
  2011-Present
- Multicultural Research and Training Lab, Pepperdine University
  2009-Present
- Association for Behavioral and Cognitive Therapies, Student Affiliate
  2008-Present
- American Psychological Association, Student Affiliate
  2007-Present
- California Association for Marriage and Family Therapists, Student Affiliate
  2007-2009
- Spanish Language Enhancement Association for Therapists, Pepperdine University
  2007-2009
- Research and Practice Team, Pepperdine University
  2007-2009

AWARDS AND HONORS

- Pepperdine University Colleagues Grant
  September 2007 to June 2012
- Psi Chi, The International Honor Society in Psychology
  May 2006
- Alpha Kappa Delta, The International Sociology Honor Society
  May 2006
- Sigma Alpha Pi, The National Society of Leadership and Success
  May 2006
- Graduated with Distinction from Ohio Northern University
  November 2006
- Dean's List at Ohio Northern University
  November 2003 to November 2006

ABSTRACT

The objective of this study was to examine the perceptions of sex offenders about their mandated outpatient group treatment. The investigator developed an 81-item questionnaire that inquired about respondent characteristics and history; curriculum content; group therapy process; group facilitator characteristics; program policies and procedures; and offender perspectives on program strengths and weaknesses. The sample consisted of 31 male sex offenders who had all served prison sentences for a sexual offense and were involved in mandated outpatient treatment at 1 of 3 private, community-based clinics. The participants were diverse in regard to ethnicity, level of education, and marital status; they had a mean age of 44.90 years. Participants' offenses included indecent exposure, possession and/or distribution of child pornography, rape, and molestation. The majority of participants were state offenders. Participants were generally satisfied with their group treatment and viewed most treatment components as reducing their risk of recidivism. In particular, they valued curriculum related to maintaining healthy relationships and creating satisfying, fulfilling lives. Additionally, offenders viewed several components of relapse prevention and victims' issues as helpful to recovery. Group process components that were viewed as most important included hearing perspectives of other group members and receiving support from others, while confrontation by fellow group members was seen as less beneficial. Sex offenders were particularly satisfied with the fairness, genuineness, and nonjudgmental stance of group leaders; they were also receptive to confrontation by group leaders. Sex offenders were less satisfied with the extent to which the treatment was relevant to their personal needs, and with the amount of personal growth experienced as a result of treatment. They also

objected to having to disclose their sexual fantasies/behaviors at weekly "check-ins," they complained about the inconvenience of mandated treatment, and they had mixed reactions to homework assignments. Participants recommended more direct feedback and confrontation by group leaders, and suggested more time be spent discussing victims' issues, relapse prevention, and "good lives" concepts. A positive outcome was that the questionnaire displayed excellent internal consistency reliability. Additional findings, limitations, and recommendations for future research are also discussed.

Introduction and Review of the Literature

There are over 700,000 registered sex offenders in the United States (National Center for Missing and Exploited Children, 2010). Although the definition of what constitutes a sex offender varies from state to state, a sex offender is generally defined as someone who has committed an illicit action or criminal offense involving sex (Oxford University Press, 2010). Examples of such offenses include sexual assault, child sexual abuse or molestation, child pornography distribution or possession, lewd behavior, or statutory rape.

Research indicates that of the convicted sex offenders, 13.4 % will sexually recidivate within 4 to 5 years of being released from prison (Hanson & Bussiere, 1998) and between 30% and 40% will sexually recidivate within 20 years of release (Hanson, Steffy, & Gauthier, 1993; Prentky, Lee, Knight, & Cerce, 1997). Bolen and Scannapieco (1999) found that 13% of all male children in the United States are sexually abused, while 30 to 40% of female children are sexually abused during childhood. These numbers indicate that sexual crimes have become an epidemic in need of swift, comprehensive intervention.

Of late, a plethora of research has focused on determining the accuracy of risk assessment tools, developing and refining treatment models for use with sex offenders, and exploring the characteristics of effective interventions and effective therapists in order to address the public safety concerns stirred up by the vast number of sexual offenses committed in the United States. The purpose of the present study was to consider the perspectives of sex offenders in evaluating the usefulness and impact of mandated group therapy. Before describing the methods used in the present

investigation, it is necessary to consider the relevant literature. The discussion that follows is a detailed analysis of the literature related to male sex offenders and includes a thorough discussion of (a) risk assessment, (b) sex offender treatment models, and (c) characteristics of effective treatment.

Risk Assessment

Risk assessment measures are used in a variety of contexts. Clinicians and mental health treatment teams use risk assessments to inform treatment planning and evaluate progress; probation and parole officers use the measures to evaluate suitability for community supervision and management; courts use the measures to inform civil commitment and criminal sentencing; and law enforcement officers use risk assessment for profiling, investigating, and registering sex offenders, as well as for notifying community members about sex offenders (Harris, 2006).

Dozens of risk assessment measures have been developed, including the Rapid Risk Assessment of Sexual Offense Recidivism (RRASOR), Static-99 and Static-2002, Minnesota Sex Offender Screening Test (MnSOST) and Minnesota Sex Offender Screening Test-Revised (MnSOST-R), Sex Offender Risk Appraisal Guide (SORAG), Violence Risk Appraisal Guide (VRAG), Sex Offender Needs Assessment Rating (SONAR), Vermont Assessment of Sex Offender Risk (VASOR), and the Sexual Violence Risk-20 (SVR-20) and Risk for Sexual Violence Protocol (RSVP; Doren, 2004). The most commonly used of these measures are the Static-99, RRASOR, MnSOST-R, and SVR-20 (Kroner et al., 2007).

While most of the existing instruments are empirical actuarial assessments that measure static, unchangeable factors, the SVR-20 and RSVP use a guided clinical

approach to assessment, which considers the offenders' response to treatment and other dynamic variables (Harris, 2006). The measures that use this guided clinical approach are reflective of the trend toward including dynamic factors in risk assessment of sex offenders (Wong, Olver, & Stockdale, 2009). Hanson (2006) suggested that the best practice in sex offender risk assessment is to use an *adjusted actuarial approach* which he described as a combination of the traditional actuarial assessment and guided clinical approaches in which one gains the most thorough picture of risk by superimposing clinical judgment onto actuarial assessments. However, existing legislation that allows for indefinite civil commitment of dangerous sex offenders makes the use of empirical risk assessment tools with sound research support a necessity, and Mercado and Ogloff (2007) suggest the role of the clinician must be limited in risk assessment.

Static versus dynamic factors in risk assessment. Although many risk assessment measures evaluate static factors to predict the likelihood that one will offend again, there has been a strong movement toward including both static and dynamic factors in risk assessment (Kroner et al., 2007). Static factors include unchangeable, historical variables, such as offense history and demographic characteristics that are correlated with increased risk of recidivism (Hanson & Bussiere, 1998). While past behaviors are good predictors of future behavior, it is important to also consider the changeable, dynamic factors that may contribute to future sexual offenses (Wong et al., 2009). These factors shed light onto the current functioning of the sex offender, which may inform rehabilitative treatment that can target and modify dynamic factors, while static factors remain unalterable. Because no single factor is sufficiently diagnostic

(Hanson, 2000), it is valuable to understand both static and dynamic risk factors as they relate to the assessment, prediction, and treatment of sex offenders.

Static factors. Static factors are most useful in the prediction of future sexual offenses, but less helpful to treatment providers and those in charge of managing offenders upon reentry, as they cannot be modified (Hanson & Bussiere, 1998). Static factors include demographic variables and historical variables such as sexual offense history, general criminal history, family history, and treatment history.

Demographic variables. Many male offenders who sexually recidivate have demographic variables in common including young age (Barbaree, Langton, Blanchard, & Cantor, 2009; Hanson & Bussiere, 1998; Hanson & Harris, 2000), low socioeconomic status (Hanson & Bussiere, 1998), and single marital status (Hanson & Bussiere, 1998).

General criminal history. Those who lead criminal lifestyles, committing nonsexual offenses at high rates, tend to sexually recidivate at higher rates as well (Hanson & Harris, 2000; Nunes & Cortoni, 2008). Thus, sex offenders who have a high number of prior nonsexual offenses are predicted to have higher rates of sexual recidivism (Hanson & Bussiere, 1998). Additionally, those who have also committed domestic battery are at higher risk of recidivating with a sexual crime (Stalans, Hacker, & Talbot, 2010). Substance abuse has a unique interaction with sexual recidivism risk in that sex offenders with nonsexual violent prior offenses who were under the influence while committing their sexual offense and *non*violent sex offenders who were *not* under the influence while committing their sexual offense are more likely to recidivate than their counterparts.

Sexual offense history. Individuals who have sexually offended diverse victims, whether children, adults, males, females, strangers, or family members, and engaged in diverse sexual crimes, whether contact, non-contact, violent, or paraphilic, are at a higher risk for sexually offending again (Hanson & Bussiere, 1998; Hanson & Harris, 2000). Non-contact offenders, such as those who engage in voyeurism or exhibitionism or those who are involved in viewing or producing child pornography, are at highest risk for offending again (Hanson & Morton-Bourgon, 2004).

Family history. A difficult early family background, including having been sexually or emotionally abused or neglected, having experienced long-term separation from one's parents, having a negative relationship with one's mother, or having been taken into the care of child protective services, has been cited in some studies as being correlated with a higher rate of sexual recidivism (Hanson & Bussiere, 1998; Hanson & Harris, 2000). However, a meta-analysis revealed that a sex offender's childhood environment has a weak relationship with recidivism, and a history of child sexual abuse is not significantly correlated with sexual recidivism at all (Hanson & Morton-Bourgon, 2004).

Treatment history. Sex offenders who have dropped out of treatment, or who for some reason have been considered a treatment failure, are at higher risk for reoffending (Hanson & Harris, 2000). Moreover, poor reentry planning following incarceration, specifically poor employment planning contributing to unemployment (Hanson & Bussiere, 1998; Hanson & Harris, 2000; Willis & Grace, 2009), and poor housing and accommodation planning prior to release (Willis & Grace, 2009), puts one at higher risk for sexually offending again.

Dynamic factors. Dynamic factors are most useful in the treatment of those who commit sexual offenses. While dynamic factors may be less valuable as predictors of recidivism, dynamic factors are crucial to understanding what variables to target in treatment that will yield the best outcome (Wong et al., 2009). There are two subcategories of dynamic factors: (a) stable dynamic factors that are expected to remain unchanged for long periods of time, and (b) acute dynamic factors that may change rapidly (Hanson & Harris, 2000). Stable dynamic factors can be further divided into dimensions including sexual deviancy, antisocial orientation, attitudes, and intimacy deficits. Acute dynamic factors are generally related to psychological maladjustment that occurs immediately prior to and during an offense (Hanson & Bussiere, 1998).

Sexual deviancy. Deviant sexual interests are one of the most commonly cited stable dynamic risk factors for sexual recidivism (Barbaree et al., 2009; Hanson, 2006; Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2004, 2005; Nunes & Cortoni, 2008). Furthermore, sexual arousal that is elicited by children, particularly boys, is a deviant sexual interest that is strongly associated with higher risk for recidivism (Hanson & Bussiere, 1998). Other dynamic risk factors related to sexual deviancy include engaging in deviant sexual activities such as prostitution, excessive masturbation, or any number of deviant fantasies and urges (Hanson & Harris, 2000). Additionally, those who have used anti-androgens to control deviant sexual interests tend to have higher rates of recidivism, likely because use of such substances may be a reflection of the severity of the sex offender's inappropriate sexuality.

Antisocial orientation. Pervasive personality characteristics associated with antisocial personality disorder are considered stable dynamic risk factors for sexual

recidivism (Barbaree et al., 2009; Hanson & Bussiere, 1998; Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2004, 2005). In fact, an antisocial or chaotic lifestyle, without necessarily meeting the threshold for antisocial personality disorder, puts one at high risk for sexually reoffending (Hanson, 2006; Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2004). Specific antisocial traits and behaviors related to recidivism include lack of remorse for victims (Hanson & Harris, 2000), substance abuse, and lack of cooperation with supervision, which is a reflection of an antisocial orientation toward authority (Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2004). Furthermore, disengagement in treatment and supervision, for example, deception and manipulation of officers and missing appointments, has reliably been shown to predict recidivism (Hanson & Harris, 2000; Levenson & Macgowan, 2004).

Attitudes. An offender's attitudes related to his offense history and treatments are also factors that have been shown to influence rates of recidivism. High risk offenders often feel entitled to express their strong sexual drive (Hanson & Harris, 2000). Often they view themselves as low risk, and as a result, take few precautions to avoid reoffending. Furthermore, high risk sex offenders are more likely to use justification as a means to absolve their responsibility for their offense history. Some studies have also suggested that an attitude of denial is a significant risk factor (Levenson & Macgowan, 2004). However, a meta-analysis found denial to be unrelated to recidivism rates (Hanson & Morton-Bourgon, 2004). Similarly, some studies have found a lack of motivation for treatment to be associated with higher rates of recidivism (Barrett, Wilson, & Long, 2003), while a meta-analysis revealed that motivation was not consistently

related to recidivism when examining multiple studies (Hanson & Morton-Bourgon, 2004).

Intimacy deficits. Difficulty developing and maintaining intimacy with others, experiencing conflict in an intimate relationship, or emotionally identifying with children put a sex offender at higher risk of committing another sexual offense (Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2004). Additionally, negative social influences and poor social support have been linked with higher rates of sexual recidivism (Hanson & Harris, 2000; Willis & Grace, 2009). However, a meta-analysis revealed that social skills deficits, in general, are not related to recidivism (Hanson & Morton-Bourgon, 2004).

Psychological maladjustment. Factors related to psychological maladjustment can generally be placed in the acute dynamic risk factor category. For instance, offenders often report increased feelings of anger and decreased mood just before committing a sexual offense (Hanson & Harris, 2000). This psychological maladjustment may influence or otherwise be related to the offender's decision-making or impulsivity that leads to inappropriate sexual behavior.

Sex Offender Treatment Models

Rehabilitative treatment for sex offenders targets the dynamic risk factors outlined above in order to optimally reduce recidivism risk, as static risk factors cannot be modified. Early treatments for sex offenders utilized a Relapse Prevention (RP) approach that was borrowed from the field of addictive disorders to address the maintenance of abstinence from sexual offending (Laws, 1989; Laws, 2003). RP has its origins in social learning theory and assumes that past learning experiences, situational antecedents, reinforcement contingencies, cognitions, and biological factors influence one's offending

behavior, and that the offending behavior is a maladaptive coping response (Bandura, 1986; Laws, 1989; Laws, 2003; Ward & Hudson, 1996). As such, cognitive and behavioral interventions are the hallmark of the RP model, and the implementation of RP generally includes the identification of high-risk situations and cognitions and the development of alternative coping strategies to avoid relapse (Laws, 1989; Pithers & Cumming, 1995).

Two newer theoretical models were born out of the RP model and are commonly used in the current treatment and rehabilitation of sexual offenders. These two models are the Risk Needs Responsivity model (RNR; Andrews, Bonta, & Hoge, 1990) and the Good Lives Model (GLM; Ward, 2002). Although the models emphasize different theoretical frames from which to conduct treatment, in practice, both models continue to use cognitive behavioral techniques to target dynamic risk factors and prevent relapse (Moster, Wnuk, & Jeglic, 2008; Schaffer, Jeglic, Moster, & Wnuk, 2010; Ward & Gannon, 2006).

Risk Needs Responsivity Model. The Risk Needs Responsivity (RNR) model was developed by Andrews, Bonta, and Hoge (1990), although it stems from research by Lee Sechrest, Ted Palmer, and others from the 1960s and 1970s (Taxman & Thanner, 2006). Andrews, Bonta, and Hoge (1990) outline the basic principles to which offender treatment must adhere, namely that elements of sex offender interventions be suited to the needs of the client, and the most costly and intensive services be reserved for the most seriously mentally ill and those who present the highest threat to public safety. Thus, RNR is based on three principles of offender treatment: the risk principle, the need principle, and the responsivity principle. The risk principle states that the intensity of

interventions should match the level of risk posed by the offender; higher risk offenders should receive more intensive interventions (Andrews et al., 1990). The need principle states that treatment should target those areas most related to offending (i.e., criminogenic needs). While not all needs are criminogenic, treatment should focus on the dynamic risk factors of the offender that are most likely to contribute to reoffending. The responsivity principle states that treatment providers must consider the offender's characteristics (i.e., cognitive ability, motivation, maturity, and circumstances) in creating treatment plans and implementing interventions.

Although the use of RNR principles has been shown to effectively reduce rates of recidivism, there are several criticisms of the model. First, RNR's notion of need as composed primarily of criminogenic needs has been criticized as overlooking important aspects of basic needs focused on human well-being (Ward & Stewart, 2003). While a focus on criminogenic needs is necessary, it is not sufficient; individual needs, culture, and environmental contexts must also be attended to (Wilson & Yates, 2009). Additionally, treatment must attend to the motivational concerns and therapist characteristics that influence treatment efficacy (Frost, Ware, & Boer, 2009; Wilson & Yates, 2009). In sum, the general criticism, and the criticism that led to the development of the alternative Good Lives Model, is that RNR focuses on avoidance goals in which the offender gains skills throughout treatment that help to avoid those circumstances that put them at higher risk to reoffend, while excluding approach goals which urge the offender to seek out factors that contribute to a positive and fulfilling life.

The Good Lives Model. Marshall et al. (2005) suggest that effective treatment needs to be responsive to the offender's needs and learning style, focus more on

optimism and capacity to change rather than negative issues, and collaboratively lead offenders toward goals that will provide them with a fulfilling and prosocial life. The Good Lives Model (GLM) incorporates the values and goals of the offender into treatment and focuses treatment on developing a satisfying life based on the offender's unique values and goals (Ward & Stewart, 2003). In this way, GLM addresses the criticisms of RNR by attending to the offender's personal goals and context, thereby eliciting increased motivation to comply with treatment.

GLM is based on the premise that sex offenders, as humans, are naturally predisposed to seek out primary human goods, which are goals that contribute to a happy, fulfilling life (Ward & Stewart, 2003; Ward & Gannon, 2006). Classes of primary human goods have been proposed by Ward and Gannon (2006) to include life, knowledge, excellence in play, excellence in work, excellence in agency, inner peace, friendship (including intimate, romantic, and family relationships), community, spirituality, happiness, and creativity. GLM would theorize that sex offenders often use maladaptive means, or inappropriate secondary goods, to attain primary human goods, primarily related to friendship or intimacy, and must be taught the skills and competencies needed to attain primary goods in more adaptive and healthy ways (Wilson & Yates, 2009). Unlike RP and RNR treatment goals, which focus on the avoidance of situational and psychological factors that trigger offending behavior, GLM additionally incorporates approach goals, goals in which the offender seeks out factors that lead to a satisfying and adaptive life (Ward & Gannon, 2006).

Limitations of GLM have also been identified, primarily related to a lack of empirical evidence that a focus on human needs versus criminogenic needs yields

rehabilitative results (Andrews, Bonta, & Wormith, 2011). Additionally, the focus on human needs and fulfilling lives may lead to an oversight of crime prevention as the primary goal of treatment.

An integrated approach. As rehabilitation theories, both RNR and GLM bring strengths to sex offender treatment. RNR has been shown to reduce recidivism rates, while GLM has been shown to improve engagement and motivation in treatment and increase coping skills (Wilson & Yates, 2009). Thus, integrating the two models may prove to be doubly successful at reducing sexual recidivism, while facilitating the development of fulfilling lives.

There are several ways in which the two theoretical models compliment each other. For instance, RNR places primary focus on the modification of dynamic risk factors to reduce recidivism; in GLM, these dynamic risk factors may be seen as the red flags that indicate difficulty related to the ways in which primary human goods are sought (Ward & Gannon, 2006). Furthermore, both models agree that the offender's degree of risk indicates the severity of social and psychological problems. Lastly, GLM incorporates a good lives plan that contains strategies for dealing with stressors, which is compatible with the risk or relapse prevention plan used in RP and RNR.

Research related to sex offender treatment outcome is discussed below.

Treatment Effectiveness

Studies that focus on the effectiveness of sex offender treatment programs, defined by the reduction of sexual recidivism rates, have shown mixed results. Hanson, Broom, and Stephenson (2004) found that community treatment for offenders released between 1980 and 1992 was no more effective at reducing rates of recidivism than no

treatment at all. However, the mixed results from this early research may reflect methodological problems. Barbaree (1997) argues that prior studies that have found treatment to be ineffective committed Type II errors that were due in part to small sample sizes. In other words, Barbaree suggests that faulty data analysis, namely the failure to consider statistical power, may have led to the abandonment of treatment outcome research just as effective interventions were beginning to develop, resulting in increased use of harsh and punitive interventions to address offending behavior. Additionally, the majority of outcome studies to date have looked at recidivism rates retrospectively without having adequately defined the treatment, which leads to the combined inclusion of effective, modestly effective, and ineffective treatments that may then contribute to varying results. To address these problems, the California Sex Offender Treatment and Evaluation Project was initiated, and a longitudinal investigation with a randomized clinical trial was conducted (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). The results of the study suggested that the use of cognitive-behavioral techniques within the RP framework was no more effective than no treatment.

In contrast, other contemporary studies have found that institutionalized treatment for sex offenders is effective at reducing rates of recidivism. For example, Duwe and Goldman (2009) found that sex offenders who were treated in prison were 15% less likely to commit any offense upon release, including sexual, violent, or general criminal offenses than those who were not treated. Likewise, Barbaree (1997) conducted an analysis of three often cited recidivism studies and found that the treatment effect was previously overlooked due to insufficient sample sizes and that institutional treatment is likely somewhat effective at reducing rates of recidivism, but that additional research

with increased sample sizes is needed. Hanson et al. (2002) conducted a meta-analysis of treatment for sex offenders and found that, on average, offenders who had participated in psychological treatment had a 12.3% rate of sexual recidivism, while 16.8% of sexual offenders who had no treatment recidivated with a sexual crime. The meta-analysis included data with follow up periods between 12 months and 16 years, with a median follow up period of 46 months for both treatment and comparison groups.

Based on the discrepant findings in past research on the efficacy of sex offender treatment, it is clear that additional research and development is needed to determine how to most effectively reduce the recidivism of sex offenders in order to maintain the safety of our society, while also helping offenders develop more fulfilling and prosocial lives. A discussion of specific treatment characteristics that are associated with positive results follows.

Group therapy characteristics. Group therapy is the treatment of choice for sex offenders (Jennings & Sawyer, 2003), and group therapy from a cognitive-behavioral perspective tends to be most effective with sex offenders (Petersilia, 2003). There are several possible reasons why group therapy may be considered the gold standard treatment for sex offenders, namely cost effectiveness, the benefits of confrontation by others and shared learning, and the intimacy and relational aspects of group work.

Jennings and Sawyer (2003) outlined the characteristics of effective group therapy for sex offenders, and their suggestions included drawing attention to the interaction between group members, emphasizing shared emotional experiences among group members, consistently using *group* language, redirecting one-to-one communications to address the whole group, and demonstrating active engagement through the use of

nonverbal communication. Additionally, suggestions specific to male groups include tempering immediate confrontation, confronting group members with acceptance and without humiliation, reframing bad behavior as skill-deficits and hyper-masculine displays as fear-control and esteem-protection, using face-saving techniques such as the use of tentative statements and combining threatening comments with empathy, encouraging confrontation by peers rather than by the therapist, and facilitating male bonding. Frost et al. (2009) added that the group must provide an environment conducive to openness, directness, and honesty to promote self-disclosure because self-disclosure is a motivating factor that breaches defenses. Additionally, the group must provide an environment conducive to addressing interpersonal relationships because sex offenders tend to have disturbed relationships and seek to meet intimacy needs by sexually offending. Furthermore, the therapeutic environment must be based on trust, acceptance, and inclusion, countering feelings of shame, alienation, helplessness, and isolation; therefore, it is necessary to balance confrontation with support. Such a group environment is likely to instill hope in its members.

Therapist characteristics. Certain characteristics of the therapist and the type of therapeutic group environment that the therapist facilitates are correlated with higher rates of success in group therapy for sex offenders. Therapists who exhibit flexibility, interpersonal warmth and empathy, encouragement, and directiveness tend to have the best outcomes (Frost et al., 2009; Marshall, 2005). Furthermore, therapists who are genuine, give interpersonal feedback, and bring social-emotional phenomena into the group tend to be more successful (Frost et al., 2009). Overall, Frost et al. suggest that a more humanistic approach is best for group therapy with sex offenders, and the authors

warn against "authoritarian expert-driven rigidity" (p. 31). Beech and Hamilton-Giachritsis (2005) agree, stating that leader support is related to cohesion and expressiveness, while leader control leads to anger and aggression among group members.

Consumer satisfaction studies. Mann (2000) suggested that risk management in sex offender treatment is unlikely to be successful unless the participants accept the goals, models, and methods of the treatment program. To address the concerns that sex offenders might have about treatment, there have been recent studies that have looked at sex offenders' perceptions of treatment in terms of utility and importance in reducing recidivism. The first study of its kind found that sex offenders had an overall positive experience in group treatment, were able to recall the issues addressed in treatment, and felt that treatment enhanced their understanding of their offense (Garrett, Oliver, Wilcox, & Middleton, 2003). The same study participants suggested that more time be spent focusing on motivation to offend and victims issues.

Similar studies have found that sex offenders view the most important aspects of treatment in reducing recidivism to be the use of cognitive behavioral techniques focused on accountability and victim empathy (Levenson, Macgowan, Morin, & Cotter, 2009; Levenson & Prescott, 2009; Levenson, Prescott, & D'Amora, 2010). Offenders have also reported that sessions focused on creating satisfying lives and meeting needs in healthy and adaptive ways were the most helpful (Levenson et al., 2009; Levenson & Prescott, 2009; Levenson et al., 2010). Other treatment factors that were viewed by participants across settings to have utility included identifying and modifying thinking errors, the use of relapse prevention concepts, and deviant arousal control (Levenson et al., 2009;

Levenson & Prescott, 2009). Some participants viewed exploring their motivation to offend (Levenson et al., 2009; Levenson et al., 2010) and understanding the development of deviant behavior (Levenson et al., 2010) to be valuable, and some viewed offense patterns, triggers and risk factors, grooming, and relationship skills as important topics to cover in treatment (Levenson & Prescott, 2009). The factors related to the value of group treatment included group support and peer confrontation (Levenson et al., 2009), as well as social skills training, conflict resolution, and the opportunity to relate to others in a meaningful way (Levenson & Prescott, 2009). In terms of suggestions for treatment improvement, there were differences in the perceptions of offenders who attended treatment in inpatient versus outpatient settings. Participants in outpatient treatment suggested that more time be spent on communication skills and relationship skills (Levenson et al., 2009), while inpatient participants reported that treatment was too long, there were unclear expectations for completion, there were concerns related to confidentiality, and they were more likely than outpatients to view treatment staff as having judgmental attitudes (Levenson & Prescott, 2009).

Research Objectives

In considering the importance of reducing recidivism rates to increase public safety, and given the ongoing debate about the ability of current treatments to reduce recidivism, gaining additional insight into how offenders view treatment could prove valuable. Prior research has suggested that offender perspectives on treatment are helpful in identifying important targets of intervention (Garrett et al., 2003; Levenson et al., 2009; Levenson & Prescott, 2009; Levenson et al., 2010). Moreover, understanding the impact of group treatment on offenders may be useful in developing treatments that

enhance and strengthen the rehabilitation process. The purpose of the present study, therefore, was to explore offender perspectives on mandated outpatient group therapy for male sex offenders, all of whom were convicted of sexual offenses and served prison sentences for those offenses. The research questions addressed in this study were:

1. What are sex offenders' perspectives on the usefulness, effectiveness, and importance of their mandated group treatment?

2. What recommendations and suggestions do sex offenders have for improving the effectiveness of their mandated group treatment?

Although client satisfaction is not an ideal or complete measure of clinical improvement or symptom change (Sperry, 2004), client perspectives are important to consider and may provide valuable insights. While the existing aforementioned studies have made substantial contributions toward understanding the perceptions of sex offenders regarding their treatment, further research is needed. Data collected at the local level may be used to inform treatment providers about possible modifications or enhancements to their sex offender treatment programs. As such, the purpose of the present study was to examine offenders' perceptions about the nature and effectiveness of outpatient group therapy for sex offenders. Included among the goals of the study was to identify perspectives in a local sample of sex offenders about the most helpful and least helpful aspects of their treatment, particularly in regard to reducing recidivism and enhancing their overall wellbeing.

Method

Participants

Thirty-one adult male high risk sex offenders participated in the study. For a descriptive and exploratory study of this nature, it was determined that a sample of at least 30 subjects would be sufficient to provide useful feedback to the host clinic (Isaac & Michael, 1997; Israel, 1992). Each participant had a sexual offense history for which he served a prison sentence. Additionally, each subject was participating in mandatory outpatient group therapy at the facility at the time of the study. Federal offenders accounted for 13% of the participants (n = 4) and 87% were convicted at the state level (n = 27).

The ages of participants ranged from 19 to 68, with a mean of 44.90 years (SD = 14.01). Of the 31 participants, 10% were age 25 or younger, 48% were between 26 and 49 years old, 26% were between 50 and 65 years old, and 13% were over the age of 65. For the several participants who did not indicate age on the questionnaire, age was calculated using the responses to items asking the year of the first offense and the age at which the respondent was convicted of the instant offense; age was therefore indicated by or approximated based on questionnaire responses for all but one participant. In terms of ethnicity, 13 of the participants were Caucasian (42%), seven were African-American (23%), six were Latino (19%), three were Native American (10%), and one identified as multiracial (3%); one participant did not indicate ethnicity. In terms of relationship status, 42% percent of participants were single and not in a committed relationship, 10% were single and in a committed relationship, 10% were married, 3% were never married, 10% were separated, and 19% were divorced; two participants did not indicate marital

status. Ninety percent (90%) of participants self-identified as heterosexual and 10% identified as gay; no participants identified their sexual orientation as bisexual. In terms of highest level of education attained, 36% of participants did not complete high school, 26% achieved a high school diploma or equivalent, 23% completed some college courses, and 13% completed a bachelor's degree; one participant did not indicate educational attainment.

In terms of offense history, 58% (n = 18) of participants had a history of a single sexual offense conviction and 42% (n = 13) indicated a history of two or more sexual offense convictions. Of these convictions, 42% (n = 13) of participants indicated they had a conviction involving physical contact with a victim, 39% (n = 12) of participants indicated they had a conviction that did not involve physical contact with a victim, and 19% (n = 6) of participants indicated they had both hands-on and non-contact convictions. Twenty-nine percent (29%) of participants indicated their most recent offense was non-contact. Of the participants who disclosed the details of their most recent sexual offense (n = 30; 98%), 16% (n = 5) indicated that they were involved in the possession and/or distribution of child pornography and 16% (n = 5) indicated their offense involved use of force or violence, use of a weapon, and/or injury to a victim. Additionally, 37% (n = 11) of participants indicated they committed the offense alone, 16% (n = 5) indicated they had no physical contact with a victim, one participant indicated he committed the offense alone and had no contact with a victim, and one participant indicated he committed the offense with another perpetrator and had no contact with a victim.

Of the participants who disclosed the nature of their sexual offenses that occurred prior to their most recent offense (*n* = 21; 68%), 10% (*n* = 2) indicated involvement in the possession of child pornography and 24% (*n* = 5) indicated that their offense involved use of force or violence or use of a weapon. Additionally, 33% (*n* = 7) of the participants indicated they committed their prior offense(s) alone, 14% (*n* = 3) indicated they had no physical contact with a victim, and 19% (*n* = 4) indicated both that they committed their prior offense(s) alone and had no contact with a victim. Of the participants who disclosed the age of the victim of their most recent offense (*n* = 23; 74%), 78% (*n* = 18) indicated the victim was under the age of 18 and 22% (*n* = 5) indicated the victim was over the age of 18. Of the participants who disclosed the nature of their relationship with the victim of their most recent offense (*n* = 9; 29%), 67% (*n* = 6) indicated the victim was a stranger, 22% (*n* = 2) indicated the victim was a family member, and one participant indicated the victim was an acquaintance.

In terms of treatment history, 36% (*n* = 11) of respondents reported they had participated in mental health treatment in the past and 23% (*n* = 7) indicated they were currently participating in treatment for a mental health problem. Additionally, 16% (*n* = 5) of respondents indicated a history of prior substance abuse treatment; no respondents reported current participation in a substance abuse treatment program. In terms of prior sex offender treatment, 32% (*n* = 10) indicated a history of participation in community-based treatment only, one participant indicated a history of prison-based treatment only, and 10% (*n* = 3) indicated a history of both community-based and prison-based sex offender treatment. Fifty-five percent (55%) of respondents (*n* = 17) reported no prior sex offender treatment. Of those respondents who indicated a history of community-

based treatment, the number of months in treatment ranged from one to 16 (M = 7.83, SD = 5.69). For those respondents who indicated a history of prison-based treatment, the number of months in treatment ranged from one to 12 (M = 7.25, SD = 5.62).

Research Setting

Participants were recruited from a government-funded private forensic mental health treatment provider that operates several community clinics in Southern California. Participants were recruited from three of these clinics. The facilities are private-sector mental health service providers that specialize in the treatment of forensic populations with behavioral and mental health concerns. The facilities use primarily cognitive behavioral interventions in the treatment of sex offenders who show diversity in regard to ethnicity, age, and sexual orientation. To remain in the treatment program, the offenders must adhere to policies of the facility, including a maximum of no more than three absences from their treatment groups.

Group psychotherapy. The psychotherapy group curriculum uses cognitive behavioral techniques to address dynamic risk factors and teach offenders alternative, healthier ways to meet emotional, physical, and relational needs. The group covers relapse prevention topics including stages of change, offense cycles, the use of cognitive distortions, and sexual and behavioral regulation. Additionally, the group teaches offenders how to meet their needs in healthier ways by implementing psychoeducational interventions aimed at addressing: social skills and communication skills; emotional expression and emotional coping skills; understanding intimacy and how to attain healthy intimacy; and evaluating psychological health, physical health, and community health.

The therapy groups for state sex offenders are conducted twice per week and are intended to last 18 months at minimum. For federal sex offenders, there are three group levels in which the frequency of group meetings is determined by risk and need. One group meets once per week and a second intensive group meets three times per week. The group members in the intensive group were either formerly in the group that met one time per week and were moved to the intensive group due to increased risk or need, or will be transferred to the group that meets one time per week after it is determined that they are stabilized. A third low functioning federal group meets twice per week; individuals are placed in the low functioning group to address intellectual needs. The amount of time offenders are in treatment is determined by individual progress in the group and the length of their probation or parole. Thus, some group members may attend the same group for up to five years, with an average length of group treatment being three years. The number of months in treatment for the present sample ranged from one to 40 (M = 10.48, SD = 8.95). The number of group sessions attended by participants ranged from two to 240 (M = 71.33, SD = 56.50).

Each group is made up of an average of eight members, though some treatment groups may have up to 13 members. The groups have open enrollment and members may enter the group at any time. The length of each group session is 1.5 hours. Groups are led by Marriage and Family Therapists, Licensed Clinical Social Workers, or Clinical Psychologists. Groups are generally led by one therapist, but may also have a co-facilitator who is a psychology practicum student or a pre-doctoral psychology intern.

In addition to group treatment, state offenders meet for individual sessions on a monthly basis, while federal offenders meet for individual therapy on an as needed basis.

Group members in the present sample had engaged in zero to 20 individual sessions at the time of data collection ($M = 7.52$, $SD = 6.13$).

Instrumentation

An investigator-developed questionnaire that included demographic questions and questions related to treatment experience, with a particular focus on group therapy, was used. It was necessary to develop a unique questionnaire due to a lack of published questionnaires related to sex offenders' perceptions of their treatment experience. Additionally, the creation of a questionnaire specific to the group treatment curriculum in question allowed for a greater level of specificity in the development of items. The questionnaire was created by drawing from previous similar studies in the literature (Garrett et al., 2003; Levenson & Prescott, 2009); from meetings and discussion with the director of the community clinic at which the data was collected; and from meetings and discussions with the writer's dissertation committee and other experts in the field.

The questionnaire included 81 multiple choice and open-ended items that inquired about respondent characteristics and addressed a variety of themes relevant to outpatient group treatment for sex offenders, including content of group curriculum, group process, group structure, and characteristics of group leaders, as specified in the research related to the qualities of effective offender group work (Beech & Hamilton-Giachritsis, 2005; Frost et al., 2009; Jennings & Sawyer, 2003; Marshall, 2005). These domains are described in detail below, and the internal consistency reliability of two domains among the present sample is reported (Cronbach's alpha).

The first domain included 25 items that addressed demographic variables, offense history, and treatment history specific to each respondent, using fixed choice and open-

ended formats. This section allowed the researcher to describe the study participants in detail and determine whether differences in treatment perceptions existed between participants with various demographic and historical backgrounds.

The second domain consisted of 30 items asking the respondent to rate selected components of group treatment in terms of their importance to the respondent's recovery, using a 5-point Likert scale (very important, somewhat important, unsure, somewhat unimportant, very unimportant). The internal consistency of this portion of the questionnaire was evaluated by calculating Cronbach's alpha and determined to be .86. According to Cicchetti (1994), this represents good internal consistency reliability. The domain was further categorized into two subgroups. The first subgroup in the domain included 24 items related to the importance of treatment content and interventions; this section showed internal consistency similar to that of the entire domain (Cronbach's alpha = .85). Intercorrelations between all items in the first subgroup can be found in Table 8. The second subgroup of this domain included six items related to the importance of the process elements of the treatment group. A Cronbach's alpha coefficient of .89 was obtained, indicating good to excellent internal consistency reliability. Intercorrelations between all items in the second subgroup can be found in Table 9.

The third domain consisted of 23 items asking the respondent to rate satisfaction with various aspects of the therapy group. Good to excellent internal consistency reliability was indicated for this portion of the questionnaire (Cronbach's alpha = .89). Four subgroups of items were identified within the larger domain. The first subgroup consisted of four items related to the qualities of group leaders and staff members that

have been linked in previous research to treatment effectiveness (Beech & Hamilton-Giachritsis, 2005; Frost et al., 2009); respondents were asked to rate whether they agreed or disagreed that group leaders and staff possessed these qualities, using a 5-point Likert scale (strongly agree, somewhat agree, unsure, somewhat disagree, strongly disagree). This subset of items showed excellent internal consistency reliability (Cronbach's alpha = .92). Intercorrelations between all items in this subgroup can be found in Table 10. The second subgroup in the domain consisted of nine items related to the level of comfort with the group atmosphere and engaging with other group members and leaders, rated on a 5-point scale. Once again, the measured internal consistency reached a level that can be regarded as excellent (Cronbach's alpha = .90). Intercorrelations between all items in the second subgroup can be found in Table 11. The third subgroup in the domain consisted of three items related to satisfaction with policies and procedures. Good internal consistency reliability was demonstrated for this portion (Cronbach's alpha = .80). Intercorrelations between all items in the third subgroup can be found in Table 12. The fourth subgroup consisted of seven items related to overall satisfaction with treatment; this subgroup included items related to motivation for treatment and whether respondents perceived positive changes as a result of treatment. The Cronbach's alpha coefficient of .76 obtained for this portion of the questionnaire can be regarded as acceptable or fair (Cicchetti, 1994). Intercorrelations between all items in the fourth subgroup can be found in Table 13.

The fourth domain included three open-ended items that asked the respondent to identify: the most helpful aspects of treatment, the least helpful aspects of treatment, and

any suggestions for improvement. Based on the Flesch-Kincaid readability test, the questionnaire required an 8th grade reading comprehension level.

Procedures

This project was approved by the institutional review board at Pepperdine University and by the administration of the treatment program where data were collected. All relevant guidelines for the ethical treatment of human subjects were followed. The researcher posted informational flyers about the study at strategic locations throughout all three facilities. To recruit participants, presentations were conducted at the end of group therapy sessions. All interested persons were invited to stay after group to hear about the study. At each presentation, the researcher briefly introduced and described the purpose of the study and invited group members to voluntarily participate. During the presentations, participants were given an informed consent document that outlined the voluntary nature of participation in the study and described the provisions for confidentiality. The informed consent document was covered in its entirety during the researcher's presentation. However, to ensure that confidentiality and anonymity were protected, participants were not asked to sign and return the informed consent document, and completion of the questionnaire was considered to imply informed consent.

Participants were clearly advised of the voluntary nature of participation. They were also told that there would be no adverse consequences whatsoever for declining to participate in the study. No staff members were physically present in the room during the recruitment presentations to help ensure confidentiality and reduce the possibility group members may have felt any indirect pressure to participate. Those who wished to participate in the study were asked to complete the questionnaire after the presentation;

those who wished not to participate were thanked anyway and dismissed. Data was collected over seven days; a total of 19 group presentations were conducted by the researcher to potential subjects over the seven days.

In order to increase the rate of participation among potential subjects, a $5 gift card incentive was introduced part-way through the data collection, and 16 of the participants (52%) received the incentive. The justification for this change was to ensure that a sufficient number of subjects could be recruited within the time parameters of data collection. A comparison of demographic and historical data for participants who received an incentive versus those who did not can be found in Table 16. As Table 16 indicates, the two sub-groups appeared very similar in most characteristics, though those who received the incentive were slightly younger (M = 42.06 years) than those who did not (M = 48.14 years), and all four of the federal offenders in the sample were in the no-incentive sub-group. Because of the small sample size and the apparent similarity of the two sub-groups on most dimensions, they were combined into one group for all the substantive analyses. This issue is explored further in the Limitations section of the Discussion chapter.

Following the brief presentations, the questionnaires were handed out along with an envelope in which the participants were asked to place their completed questionnaires and seal. For additional security, a locked box was provided for participants to return their completed questionnaires at the community clinic. The locked box remained at the clinic in order for questionnaires to be securely returned from those who decided to complete the questionnaire at another time. Completion of the questionnaire took approximately 20-30 minutes.

All participants were provided contact information for the principal investigator and her faculty supervisor for any questions or concerns they may have wanted to discuss further. Additionally, a toll free telephone number was provided for the purpose of participant comments or concerns.

Data Analysis

Frequencies and descriptive statistics were calculated for the Likert-scale items and the multiple choice items to illustrate participant perceptions of their experiences in group and individual therapy, as well as their appraisals of treatment staff and the components of the treatment program. Correlations were run to determine the relationship between several components of treatment and respondents' motivation for and overall satisfaction with treatment. The content of responses to open-ended questions was categorized on rational grounds.

Results

Two research questions were addressed in the present study. First, the researcher sought to examine sex offenders' perspectives on the usefulness, effectiveness, and importance of their mandated group treatment. This research question was measured with Likert scale items asking respondents to rate the level of importance of treatment aspects to their recovery (domain two), items asking respondents to rate their level of agreement with aspects of treatment satisfaction and effectiveness (domain three), and two open-ended items asking respondents to list the most helpful and least helpful aspects of treatment (domain four). The second research question sought to explore the suggestions sex offenders had for improving their treatment program. This question was answered with a single open-ended item within domain four asking respondents to list up to three ways in which the program could be improved. Each research question is examined in detail below, by questionnaire domain. Additional analyses related to motivation for treatment are also reported.

Questionnaire Domain Two: Importance of Treatment Components

Domain two was divided into two subgroups; the first subgroup included items related to treatment content and the second subgroup included items related to treatment process. The most important and least important components of each subgroup, as perceived by participants, are discussed separately below.

Table 2 presents the perceived level of importance to recovery of 24 components of treatment content, according to the sex offenders in this study. The majority of content areas were perceived as very important or somewhat important; level of importance was rated on a 5-point Likert scale, with higher scores indicating higher levels of importance.

The following components were perceived as the most important components of treatment content: understanding the impact of sexual abuse on victims and others (item 30; *M* = 4.8, *SD* = .664); avoiding drug and alcohol abuse (item 55; *M* = 4.77, *SD* = .685); understanding emotional needs and learning to meet them in healthier ways (item 39; *M* = 4.76, *SD* = .435); learning new relationship and communication skills (item 42; *M* = 4.75, *SD* = .518); accepting responsibility (item 27; *M* = 4.73, *SD* = .640); learning how to create a more satisfying life (item 43; *M* = 4.73, *SD* = .691); understanding triggers and high risk situations (item 32; *M* = 4.73, *SD* = .785); understanding healthy emotional and physical intimacy (item 40; *M* = 4.70, *SD* = .466); learning about the stages and processes of change (item 26; *M* = 4.70, *SD* = .794); and identifying ways to become a contributing member of society (item 44; *M* = 4.70, *SD* = .837). The following components were perceived as the least important components of treatment content in terms of usefulness to recovery, as evidenced by their lower mean ratings: taking prescription medication (item 52; *M* = 3.64, *SD* = 1.598); and completing homework assignments (item 53; *M* = 4.04, *SD* = 1.022).

Table 3 presents the level of importance to recovery of six components of treatment process, as perceived by sex offenders. The most important components of treatment process included hearing other perspectives and viewpoints (item 47; *M* = 4.50; *SD* = .861); and getting help and support from others (item 48; *M* = 4.43, *SD* = 1.103). The least important components of group process included confronting other group members (item 49; *M* = 3.90, *SD* = 1.398); sharing experiences with other sex offenders (item 45; *M* = 4.00, *SD* = 1.217); and being confronted by other group members (item 50; *M* = 4.03, *SD* = 1.149).

Questionnaire Domain Three: Satisfaction with Treatment Components

Domain three was comprised of items generally related to treatment satisfaction and was divided into four subgroups of satisfaction items: satisfaction with group leaders and staff members; comfort with the group atmosphere and engaging with others; satisfaction with policies and procedures; and overall satisfaction with treatment, including motivation and perceived positive changes. Satisfaction ratings for each subgroup are presented in Tables 4-7. Table 4 presents the qualities possessed by group leaders and staff members that are related to treatment effectiveness. Table 5 presents the level of comfort with the group atmosphere and with engaging with other group members and leaders. Table 6 presents satisfaction with the policies and procedures of the facility. Table 7 presents overall satisfaction with treatment, motivation for treatment, and perceived positive changes resulting from treatment.

While respondents were generally satisfied with the treatment program, satisfaction with particular elements of the program was variable. The components of the treatment program with which respondents were most satisfied were primarily from the first and second subgroups of domain three and were generally related to satisfaction with group leaders and staff, including the nonjudgmental stance of staff members (item 63; M = 4.52, SD = .890); the nonjudgmental stance of group leaders (item 62; M = 4.48, SD = .962); the fairness of group leaders (item 60; M = 4.48, SD = .926); and comfort with receiving feedback from group leaders (item 68; M = 4.48, SD = .811).

The components of the treatment program with which respondents were least satisfied were primarily components from subgroups three and four and included: the amount of homework (item 69; M = 3.41, SD = 1.469); the amount of personal growth

perceived as a result of the treatment (item 76; *M* = 3.57, *SD* = 1.289); the relevance of treatment to the personal needs of the group members (item 75; *M* = 3.70, *SD* = 1.409); and the amount of change perceived by significant others as a result of the treatment (item 77; *M* = 3.79, *SD* = 1.264). Thus, perceived positive change in the respondent as a result of treatment was among the components with which group members were least satisfied. Furthermore, many group members showed ambivalence about whether they needed treatment at all (item 72; *M* = 3.34, *SD* = 1.738). Additional components from the second subgroup of domain three with which respondents were less satisfied included: the structure of the group environment (item 57; *M* = 3.94, *SD* = 1.181); and the nonjudgmental stance of other group members (item 59; *M* = 3.97, *SD* = 1.224).

A total satisfaction score was calculated by adding the 23 responses in all four subgroups within the satisfaction domain (*M* = 96.25, *SD* = 12.635; range, 23-115). A higher total satisfaction score represented a higher level of satisfaction, while a lower total satisfaction score represented a lower level of satisfaction. The mean total satisfaction score suggests that group members were generally satisfied with the overall treatment program. In addition, total satisfaction was found to be significantly correlated with number of group sessions, $r = .717$, $p < .01$ (see Table 15). In other words, the more sessions attended by the respondent, the higher the level of total satisfaction with the treatment program.

When asked to provide an overall rating of one's group treatment experience (item 78), most participants responded positively (*M* = 4.29, *SD* = .864). The overall mean score for this item fell between the scale descriptor of *extremely positive*, which represented a rating of 5, and *fairly positive*, which equaled a rating of 4. This overall

rating of one's treatment experience was significantly and inversely correlated with the number of convictions of the respondent, $r = -.564$, $p < .01$ (see Table 15). The greater the number of convictions for sex offenses, the lower the overall rating of satisfaction, i.e., the more likely the respondent was to view the program negatively. A history of fewer sex offense convictions was therefore associated with a more positive overall rating of one's group treatment experience. Interestingly, the overall rating of treatment experience was not significantly related to age, $r = -.020$, $p = .917$.

Several correlations were run to determine whether relationships existed between respondents' ratings of their overall experience of the treatment program (item 78) and their ratings of the perceived importance of and satisfaction with other treatment components across domains. Results suggested that the overall experience of the treatment program was related to the level of comfort and satisfaction with components of the group environment and the group process (see Table 15). Specifically, an overall positive experience of treatment was related to higher levels of comfort receiving feedback from group members (item 67), $r = .670$, $p < .01$; comfort helping others in group (item 65), $r = .635$, $p < .01$; satisfaction with the group structure (item 57), $r = .607$, $p < .01$; comfort participating in group (item 64), $r = .500$, $p < .01$; comfort with the group atmosphere (item 56), $r = .496$, $p < .01$; comfort receiving feedback from group leaders (item 68), $r = .459$, $p < .01$; a nonjudgmental stance of group leaders (item 62), $r = .427$, $p < .05$; and openness and honesty of other group members (item 58), $r = .411$, $p < .05$. Overall treatment experience was also significantly correlated with satisfaction with the amount of homework (item 69), $r = .539$, $p < .01$; and the length of group sessions (item 70), $r = .461$, $p < .05$.

Similarly, those who described a more positive group experience also placed a higher importance on components of the group process and environment to their recovery (see Table 15). For instance, the overall experience of treatment was positively correlated with importance placed on hearing the viewpoints of other group members (item 47), $r = .759$, $p < .01$; with relating to other sex offenders (item 46), $r = .756$, $p < .01$; with sharing experiences with other sex offenders (item 45), $r = .572$, $p < .01$; with getting support from others (item 48), $r = .529$, $p < .01$; and with being confronted by others (item 50), $r = .387$, $p < .05$.

The importance placed on specific elements of group content that were positively correlated with a positive overall experience of treatment included: understanding triggers and high risk situations (item 32), $r = .563$, $p < .01$; learning about different types of denial and resistance (item 28), $r = .542$, $p < .01$; understanding the development of sexual behavior problems (item 37), $r = .476$, $p < .01$; learning to change or control deviant arousal (item 36), $r = .473$, $p < .01$; and learning how cognitive distortions and core beliefs contributed to the offense (item 33), $r = .446$, $p < .05$.

Additionally, intercorrelations between overall treatment experience and items within the same domain subgroup were run. Although the internal consistency reliability of the subgroup was determined to be acceptably high (Cronbach's alpha = .76), the correlation between a positive treatment experience and the perception of the relevance of treatment components to the needs of the offender (item 75) was found to be a particularly salient relationship within the domain, $r = .610$, $p < .01$.

Questionnaire Domain Four: Open-Ended Questions

The final domain of the questionnaire consisted of three open ended items. The first item asked respondents to list up to three most helpful aspects of the treatment program. The second item asked respondents to list up to three least helpful aspects of the treatment program. The final item asked respondents to list up to three suggestions for how to improve the treatment program. Each item is discussed in detail below.

The most helpful and least helpful aspects of treatment. Open-ended questions asking participants to list the overall most helpful and least helpful aspects of their treatment experience were categorized into subgroups based on similarity of content (see Table 14 for complete responses). Twenty-eight participants responded to item 79: Overall, what have been the most helpful aspects of your current treatment experience? In terms of the most helpful aspects of the group, many group members made comments related to the group process. Specifically, four of the 28 who responded to this item (14%) felt that the supportive group environment was most helpful (e.g., "Having a supportive group," and, "Being there when you need them"). Three respondents (11%) commented on relational aspects of the group (e.g., "Associating with others in my situation," and, "Hearing others' experience and knowing that I'm not alone"); four respondents (14%) indicated communication within the group was most helpful (e.g., "[Having a] chance to talk openly," and, "Being able to relate my story"); and three respondents (11%) made comments related to receiving feedback (e.g., "Feedback (from leaders and members)," and, "Learning to 'take it in' and stop responding to advice or criticism impulsively or defensively").

Several areas of group content were also mentioned as the most helpful aspects of treatment; specifically, seven of the group members who responded to the item (25%) made comments related to cognitive interventions (e.g., "Reflecting on my beliefs and cognitive distortions," and, "Help[ing] me change some of my core beliefs"); five respondents (18%) indicated "good lives" interventions were most helpful (e.g., "[Addressing] personal needs and concerns," and, "Help[ing] me focus on my future"), and five respondents (18%) commented on psychoeducational aspects of treatment (e.g., "Learn[ing] about addictions," and, "Understanding the different terms of sexual abuse"). Additionally, several group members mentioned that openness (four of 28; 14%) and honesty (three of 28; 11%) within the group was helpful; five of 28 (18%) reported that the group helped them achieve responsibility and accountability.

Twenty-three participants responded to open-ended item 80: Overall, what have been the least helpful aspects of your current treatment experience? Seven of the 23 who responded to this item (30%) commented on aspects of the structure, format, or agenda of the group (e.g. "Answering the same check-in questions week after week," and, "Introductions"). Check-in questions refer to a form each group member is asked to fill out once per week and present to the group that includes questions related to the frequency of sexual activity, content of fantasies, and any high risk situations. Introductions are made by new group members during their first group meeting in which they are asked to disclose the reason they are in the group, including the nature of their convictions, which would include information such as whether their sexual offense was against an adult or a child. Four of the 23 respondents (17%) commented on issues of inconvenience and personal cost related to time and money (e.g., "The hours interfere

with work," "It's a financial setback having to come here," and, "Hav[ing] to work around class times to fit my schedule"). Four respondents (17%) identified the length of the program as the least helpful aspect (e.g., "How many times I have to attend," and, "18 months is too long for this program"). Four respondents (17%) commented on problems with other group members as the least helpful component (e.g., "People who are still in denial," and, "Having to listen to outrageous lies by a couple of the group members…"). Lastly, content areas related sexuality were mentioned by two of the 23 respondents (9%; e.g., "Sex education," and, "Some topics covered seemed like stating the obvious or common sense topics, e.g. sex ed[ucation], inappropriate sexual behavior…").

Suggestions for improvement. The third and final open-ended question (item 81) was important in that it addressed the second research question, i.e., it sought to determine what recommendations and suggestions sex offenders had for improving the effectiveness of their mandated group treatment. This question was measured by categorizing participants' responses to the open ended item: Please list up to three changes you would make to improve your current sexual offender treatment program. Seven of the 27 respondents (26%) who answered the question gave one or more suggestions related to logistical aspects of meeting time, meeting location, or other aspects of meeting comfort or convenience (e.g., "Have classes on weekends with a lunch break," "Being able to choose what time fits my schedule," and, "More offices for less travel time"). Of the 27 respondents, four (15%) also requested more time be spent reviewing content related to relapse prevention (e.g., "Understanding the triggers and high risk situations," and, "Understand the risk of a sex crime"); three respondents (11%) requested more content related to improving relationships (e.g., "More communication

skills," and, "Healthy sexual choices"); and two respondents (7%) requested more content related to victim issues (e.g., "Humanization of victims," and, "Understanding the impact of sexual abuse on victims"). Three of the 27 respondents (11%) made comments welcoming more challenges and feedback from group leaders and other group members (e.g., "Feedback [from] group leaders," and, "More challenges from other participants during group sessions…"). One respondent (4%) suggested less classroom style teaching and an increased focus on real life problems and situations. Five group members who responded to the item (19%) commented on personal goals they would like to address outside of the group treatment that could positively impact their recovery (e.g., "Not have more than one girlfriend," and, "Be honest to the person I am with about my criminal history"). Three of the 27 respondents (11%) commented that they would not change anything about the treatment program.

Additional Analyses

Additional correlations were run to examine the relationships between participants' level of agreement with item 73 (I am motivated for treatment) and items related to offense history and the level of importance placed on different components of the treatment program (see Table 15). Analyses showed that professed motivation was inversely related to the number of convictions, $r = -.489$, $p < .01$, in that respondents with a higher number of convictions reported less motivation for treatment. More specifically, a higher number of non-contact convictions, for instance, possession and distribution of child pornography and indecent exposure, was related a lower level of motivation for treatment, $r = -.635$, $p < .01$, while the number of hands-on offenses, including rape and molestation, was not significantly correlated with motivation, $r = .329$, $p = .081$.

Further correlations were run to determine whether relationships existed between motivation and components of treatment across domains. Self-professed motivation was shown to be significantly correlated with the importance placed on several of the aspects of treatment content within the first subgroup of domain two. For instance, motivation for treatment was found to be positively correlated with the level of importance placed on several relapse prevention components of treatment, including understanding triggers and high risk situations (item 32), $r = .617$, $p < .01$; learning how cognitive distortions and core beliefs contributed to the offense (item 33), $r = .601$, $p < .01$; learning about different types of denial and resistance (item 28), $r = .589$, $p < .01$; learning to change or control deviant arousal (item 36), $r = .548$, $p < .01$; and developing a relapse prevention plan (item 35), $r = .525$, $p < .01$. The level of importance placed on several treatment components related to approach goals was also significantly correlated with professed motivation, specifically, understanding emotional needs and learning to meet them in healthier ways (item 39), $r = .707$, $p < .01$; learning how to create a more satisfying life (item 43), $r = .511$, $p < .01$; identifying ways to become a contributing member of society (item 44), $r = .480$, $p < .01$; and learning new relationship and communication skills (item 42), $r = .401$, $p < .05$. The importance of insight oriented components, including understanding the development of sexual behavior problems (item 37), $r = .785$, $p < .01$; and understanding the effects of early experiences and family life (item 38), $r = .648$, $p < .01$, were also positively correlated with motivation for treatment. The perceived importance of individual therapy (item 51), $r = .649$, $p < .01$, and homework (item 53), $r = .459$, $p < .05$, was also correlated with motivation for treatment.

The level of importance placed on several of the aspects of group process within the second subgroup of domain two was also related to professed motivation for treatment, specifically, relating to other members of the treatment group (item 46), $r = .701$, $p < .01$; hearing other perspectives and viewpoints (item 47), $r = .611$, $p < .01$; sharing experiences with other sex offenders (item 45), $r = .543$, $p < .01$; getting help and support from others (item 48), $r = .452$, $p < .05$; and being confronted by other group members (item 50), $r = .399$, $p < .05$.

Correlations between professed motivation and satisfaction components from the separate subgroups of domain three were also calculated. Satisfaction components that were significantly correlated with treatment motivation included comfort with the group atmosphere (item 56), $r = .466$, $p < .05$; comfort receiving feedback from group members (item 67), $r = .440$, $p < .05$; satisfaction with session length (item 70), $r = .434$, $p < .05$; and comfort helping others in group (item 65), $r = .381$, $p < .05$.

Motivation for treatment was categorized within the fourth subgroup of domain 3, and the internal consistency reliability for that subgroup was determined to be acceptable or fair (Cronbach's alpha = .76). However, correlations between motivation for treatment and other items within that subgroup were particularly salient. For instance, those who perceived that others in their lives had seen positive changes in them since beginning treatment (item 77) described themselves as more motivated for treatment, $r = .766$, $p < .01$. Additionally, those who perceived treatment to be relevant to their personal needs (item 75) tended to rate their motivation higher, $r = .468$, $p < .05$. Lastly, an overall positive experience with the group treatment program was positively related to motivation for treatment (item 78), $r = .653$, $p < .01$.

Discussion

The first research question addressed in the present study was: What are sex offenders' perspectives on the usefulness, effectiveness, and importance of their mandated group treatment? Overall, participants in this study viewed their mandated sex offender group therapy in generally positive terms and were satisfied with most components of the treatment experience.

Group members rated several components of their treatment program as important to their recovery. Among the components perceived as highly important by group members were several "good lives" interventions related to learning about healthy emotional experience, healthy intimacy, and how to create a more satisfying life as a contributing member of society. A number of elements of group process were also cited as quite helpful, including the supportive group environment and the opportunity to hear the perspectives and viewpoints of others.

Similarly, many group members referred to the supportive group environment as being among the most helpful aspects of the treatment program in the open-ended question responses, and several comments were made regarding the openness and honesty of group members and the usefulness of associating with others in similar situations. Interestingly, group members' satisfaction with the openness and honesty of other group members was positively correlated with their overall experience of the treatment program. Each of these components identified by participants as most helpful are consistent with previous literature related to elements of effective group treatment for sex offenders (Frost et al., 2009). Additional components identified in open-ended items as the most helpful treatment aspects included cognitive interventions, "good lives"

concepts, and psychoeducational interventions. These findings were comparable to findings of previous consumer satisfaction studies (Garrett et al., 2003; Levenson et al., 2009; Levenson et al., 2010; Levenson & Prescott, 2009).

Participants perceived the least helpful aspects of group treatment to include sharing experiences with other group members, confrontation among group members, and completing homework assignments. Interestingly, sharing experiences with other group members was identified as less helpful to recovery, while associating with others in similar situations was identified as among the most helpful elements of group treatment. It seems that adding a self-disclosure element to interpersonal interactions with fellow sex offenders may be challenging for some group members, explaining the seeming discrepancy between these two findings. Further, comments on open-ended items suggested that some participants viewed certain group members as lacking credibility, which may contribute to some group members' reluctance to self-disclose to other members who may be regarded as dishonest or untrustworthy. These findings were inconsistent with other consumer satisfaction studies in that previous research has found that group members viewed peer confrontation as a positive element of the group process (Levenson et al., 2009).

There were also notable discrepancies between group members' ratings of process elements on Likert scale items and group members' responses to open-ended questions. Namely, process items as a whole, i.e., sharing experiences with others and getting support from other group members, were identified as less important than content components of treatment, i.e., learning about stages of change and developing a relapse prevention plan, on the Likert scale items, while several of the most helpful aspects of the

treatment program noted in the open-ended responses were related to the group process and support in the group environment.

In terms of participants' ratings of satisfaction with several elements of the treatment experience, most group members indicated they were satisfied with the overall treatment program, rating their experience as either extremely or fairly positive. Satisfaction with group leaders was particularly salient, and group members identified their facilitators as fair, genuine, and nonjudgmental. On the other hand, some group members were less satisfied with the relevance of treatment to their personal needs and their perception of how much positive change occurred as a result of treatment.

The second research question addressed in the present study was: What recommendations and suggestions do sex offenders have for improving the effectiveness of their mandated group treatment? In general, the suggestions for improvement were related to issues involving the inconvenience of group times and integrating group attendance into work schedules, the number of group sessions members were expected to attend, and the financial burdens of mandated treatment. About one fourth of the sample discussed one or more of these personal costs and inconveniences associated with participating in long-term, outpatient, mandated group treatment at designated community clinics. From these statements it was clear that some participants regarded treatment as burdensome and they recommended finding ways to lessen the impact or personal costs of treatment. While group members did not pay any fees for their mandated treatment, they incurred transportation costs and may have faced the possibility of lost wages due to time away from work to attend therapy. Several group members had experienced current or recent periods of homelessness, making attendance more difficult.

Additionally, group members were confronted with all the levels of stigma associated with the sex offender label. They may have viewed participation in mandated sex offender treatment as extending or exacerbating the impact of that stigma.

There were also a variety of content components that group members would have liked to spend more time on, including relapse prevention topics, topics related to healthy relationship skills, and victims issues. Additionally, group members recommended that group leaders take a more active role in redirecting other group members, confronting group members, and giving feedback.

Clinical Implications

Several positive aspects of the group treatment program were identified, including the positive qualities of group leaders, the importance of a supportive group environment, and the value of group session content related to "good lives" concepts. Additionally, ways to improve the experience of group members and increase the overall effectiveness of the group treatment program were identified. Each of these is elaborated upon below.

First, facilitating a less judgmental stance among other group members may increase comfort with confrontation between group members. While group leaders were viewed to be nonjudgmental and genuine, participants found their fellow group members to have a more judgmental stance and generally found sharing with other group members and confrontation among group members to be among the least helpful aspects of their treatment experience. On the other hand, some group members indicated that more confrontation from both group leaders and group members would contribute to a more effective treatment program. Jennings and Sawyer (2003) list confrontation, particularly confrontation by fellow group members, as a characteristic of effective group work, and

Frost et al. (2009) suggest that a balance of support and confrontation contributes to effective group treatment. In fact, the present study found that comfort receiving feedback from other group members and value placed on hearing other group members' viewpoints were among the factors most significantly correlated with an overall positive group experience. Thus, it appears that facilitating nonjudgmental attitudes between group members may increase group members' perceptions of the usefulness of confrontation and their comfort with being confronted and confronting others. However, the ability to confront without an undertone of moral judgment may be a fairly complex or refined skill; therefore, the skill may need to be specifically taught and modeled by group leaders.

Second, there were several findings related to the level of motivation of group members. In the present sample, higher numbers of noncontact offenses were associated with lower levels of motivation for treatment, and noncontact offenders have been shown to have the highest risk for recidivism (Hanson & Morton-Bourgon, 2004). Research related to lack of motivation and risk for recidivism has been conflicting (Barrett et al., 2003; Hanson & Morton-Bourgon, 2004); however, improving or heightening motivation may lead to higher levels of compliance with the treatment process. Increasing the focus of treatment on the components that were shown to have a strong relationship with level of motivation, including learning how to meet emotional needs in healthy ways, gaining insight into the development of sexual behaviors and the contributions of early experiences, and learning about triggers, high risk situations, cognitive distortions, and core beliefs, may increase engagement in treatment and improve the overall effectiveness of treatment. Furthermore, the level of motivation and readiness for change should be

carefully assessed for each new group member in order to assist facilitators in addressing the critical factor of motivation among high risk offenders.

Additionally, about one fourth of the sample reported they did not perceive group therapy as contributing to their personal growth, or as relevant to their personal needs. A similar criticism is cited in the literature in relation to the Risk Needs Responsivity treatment model, which focuses solely on the avoidance of recidivism. To address this criticism, "good-lives" concepts were introduced into treatment programs, with the purpose of incorporating the unique values of the offender into treatment and attending to the offender's personal goals and context in order to create a more satisfying life. Thus, it may be beneficial to incorporate more "good-lives" interventions into the present treatment program to improve group member satisfaction and increase motivation to comply with treatment, for example, learning about healthy emotional and sexual intimacy and learning how to create a more satisfying prosocial life.

Fourth, there were inconsistencies between group members' views of the role of homework in the treatment program. Eight of the 31 participants indicated homework was not applicable, suggesting homework was not assigned in some groups, or if it was assigned, was somehow insignificant or not relevant. However, of those who rated the importance of homework to their recovery, most indicated homework was at least somewhat important. Therefore, more consistency within and between therapy groups in regard to the assignment of homework may have an impact on the effectiveness of the program. Based on the current findings, treatment programs should carefully consider the role and use of homework assignments in sex offender group therapy and perhaps

modify homework to increase the relevance and usefulness of the assignments to offender recovery.

Lastly, nearly one third of group members suggested that changes to the structure of the group, which included the elimination or modification of group check-ins, would improve their overall experience of the treatment program. Check-ins referred to a form filled out weekly by each group member that included questions related to frequency of sexual activities and content of sexual fantasies. These were required for the purpose of identifying high-risk sexual behaviors. At every therapy session, group members were required to discuss their responses to the check-in form.

There are several possible explanations for why group members disliked the check-ins. Perhaps they found the questions to be redundant or filling out the form to be tedious. Presenting the check-ins in group may have brought up discomfort among group members in having to face their sexual deviancy problems and share them with others. Group members may have also perceived lying or under-reporting on the part of other group members during their weekly check-ins, which was previously commented on as a negative aspect of many members' group experience. However, sexual deviancy, including deviant fantasies and activities, is the most commonly cited risk factor for recidivism (Hanson & Harris, 2000), and the monitoring of recidivism risk allows the treatment program to respond appropriately to the needs of the individual offender. Therefore, completing weekly check-in forms and discussing them in the group meetings, while not comfortable for some group members, may contribute to the effectiveness of the treatment program and the ability of group leaders to identify the needs of group members. Group leaders might alternatively consider allowing group members to

complete the check-in forms confidentially and give them directly to the group leaders; however, consideration must be given to how this alternative may impact the effectiveness of the treatment group, especially given the importance of self-disclosure in the group context.

The questionnaire developed for this study appeared promising and may lend itself to a variety of future research and clinical applications. The questionnaire demonstrated strong internal consistency reliability and the open-ended items elicited a broad range of comments. Certainly the questionnaire's usefulness and reliability needs to be demonstrated with other samples and in other settings. Potential future clinical applications might include integrating the questionnaire into treatment as a pre-test and post-test measure to evaluate the perceived effectiveness of group treatment programs. Additionally, it may be useful to utilize the questionnaire as a template for training staff members on the many dimensions of group treatment with sex offenders.

Methodological Limitations

There are methodological limitations related to the nature of a self-report questionnaire, namely that it relies on the honesty and accuracy of the participants' responses. However, steps were taken to ensure the confidentiality of the participants in order to minimize this concern. Questionnaires such as that used in the present study typically do not have any way of gauging social desirability responding. Social desirability responding refers to providing culturally approved or sanctioned responses, including the responses the respondent perceives would make the best impression upon the researcher. Concerns about the threat of social desirability responding to the internal validity of the study were reduced by the fact that participants had nothing to gain by

responding in particular ways. An additional limitation relates to selection factors, given that individuals who are either very satisfied or very dissatisfied with treatment may have been more motivated to participate in the study. Future researchers might do well to find ways to increase participation in this type of program evaluation research among sex offenders in group treatment, such as by increasing the incentives for participation and/or by making participation in such research more convenient.

In the present study, an incentive was introduced mid-way through the data collection period and was not constant across all subjects, further impacting the selection of participants. While this was deemed necessary to facilitate completion of the data collection in a timely manner, it represented a factor that could have had affected the data collected in unintended ways. The fact that the incentive was rather small, i.e., a gift card with a value of $5, may have limited the negative consequences of the incentive.

Upon examining the similarities and differences of the subjects who received the gift card and those who did not (see Table 16), it was noted that the two groups appeared generally comparable, specifically in terms of ethnicity, sexual orientation, education level, offense history, and substance abuse treatment history. However, it is important to note that the subjects who received the incentive were somewhat younger in age than those who received no incentive, were more likely to be single and less likely to be divorced, had spent fewer months in the current treatment program, and had a history of more prior sex offender treatment in prison and other community settings. Additionally, those who received the incentive were less likely to be currently participating in other mental health treatment than those who did not receive the incentive. Lastly, there were no federal offenders among those who received the incentive. Given that subject

recruitment can be difficult, future researchers are encouraged to consider building in participation incentives from the beginning.

It should be noted that a substantial number of correlations were calculated with the present data, raising the possibility that some statistically significant correlations were obtained solely due to chance. However, because this was an exploratory study and specific hypotheses were not being tested, all correlations were reported and should be viewed only as suggestive, The present findings are in need of replication and confirmation with other samples.

Other limitations included the fact that the sample consisted solely of male sex offenders, which impacts the extent to which the results can be generalized to the general sex offender population. Generalizability was further limited by factors such as the relatively small sample size and by the fact that data was collected in only one metropolitan area. Lastly, a limitation of the study was that the participants had not completed their group treatment at the time of data collection and therefore may not have been in an optimal position to understand or evaluate all aspects of the intervention program.

There were also several strengths of the present study. First, there was a broad range of diversity of the group of participants in terms of age, ethnicity, educational attainment, and offense history. Additionally, the fact that an under-studied group was afforded the opportunity to provide their perspectives on treatment is a rarity that may be considered a strength of this research. Furthermore, there is evidence for strong internal consistency reliability of the questionnaire administered in the study. Based on its demonstrated reliability and the fact that there are currently no published questionnaires

of its kind, this instrument potentially may be used by other researchers in the investigation of sex offender treatment.

Suggestions for Future Research

Consumer data, while not necessarily an optimal indicator of treatment success, sheds light on aspects of treatment impact and may represent information that can be used to contribute to the improvement of sex offender treatment. Currently, few studies exist that highlight sex offender perceptions of their group treatment. Additional data could be used to further inform the development and improvement of rehabilitative treatment for sex offenders. First, future research would benefit from a larger sample size and a geographically diverse sample. Based on the challenges the present researcher faced in recruiting participants, it is recommended that future research studies incorporate incentives for participation from the beginning. As sex offenders often have multiple expectations and demands placed on them while participating in mandated treatment, an incentive may increase motivation for participation, allowing researchers to recruit larger, more diverse samples. Additionally, it may be helpful to recruit participants who have completed treatment, as they may be in a better position to more fully evaluate all aspects of the program.

Further, additional research on the similarities and differences between federal and state offenders may be beneficial. In considering federal and state offenders are often in separate treatment groups with differing legal regulations and expectations, it may be beneficial to determine if these offenders have differing needs in order to better tailor their treatment. Similarly, additional research on offenders with divergent sex

offenses may be beneficial, as there may be important differences between the type of offender and the most suitable treatment.

Lastly, the present study found that group members had a relatively low rating of satisfaction with the amount of homework assigned as part of their treatment, and there appeared to be differences among treatment groups in terms of whether homework was assigned as part of treatment at all. Therefore, additional research may be beneficial to determine the value and usefulness of homework, including the role the completion of homework plays in offender rehabilitation and recidivism rates and role homework plays in the generalization of skills and concepts learned in therapy to the offenders' every day lives.

REFERENCES

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17*(1), 19-52. doi:10.1177/0093854890017001004

Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention? *Criminal Justice and Behavior, 38*(7), 735-755. doi:10.1177/0093854811406356

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice-Hall.

Barrett, M., Wilson, R. J., & Long, C. (2003). Measuring motivation to change in sexual offenders from institutional intake to community treatment. *Sexual Abuse: A Journal of Research and Treatment, 15*(4), 269-283. doi:10.1177/107906320301500404

Barbaree, H. (1997). Evaluating treatment efficacy with sexual offenders: The insensitivity of recidivism studies to treatment effects. *Sexual Abuse: A Journal of Research and Treatment, 9*(2), 111-128. doi:10.1177/107906329700900204

Barbaree, H. E., Langton, C. M., Blanchard, R., & Cantor, J. M. (2009). Aging versus stable enduring traits as explanatory constructs in sex offender recidivism: Partitioning actuarial prediction into conceptually meaningful components. *Criminal Justice and Behavior, 36*(5), 443-465. doi:10.1177/0093854809332283

Beech, A. R., & Hamilton-Giachritsis, C. E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment, 17*(2), 127-140. doi:10.1177/107906320501700204

Bolen, R., & Scannapieco, M. (1999). Prevalence of child sexual abuse: A corrective meta-analysis. *Social Service Review, 73*, 281-313. Retrieved from http://www.jstor.org/stable/10.1086/514425

Cicchetti, D. V. (1994). Guidelines, criteria, and rules of thumb for evaluating normed and standardized assessment instruments in psychology. *Psychological Assessment, 6*, 284-290. doi:10.1037/1040-3590.6.4.284

Doren, D. M. (2004). *Bibliography of published works relative to risk assessment for sexual offenders.* Retrieved from: http://www.atsa.com/pdfs/riskAssessmentBiblio.pdf

Duwe, G., & Goldman, R. A. (2009). The impact of prison-based treatment on sex offender recidivism: Evidence from Minnesota. *Sexual Abuse: A Journal of Research and Treatment, 21*(3), 279-307. doi:10.1177/1079063209338490

Frost, A., Ware, J., & Boer, D. P. (2009). An integrated groupwork methodology for working with sex offenders. *Journal of Sexual Aggression, 15*(1), 21-38. doi:10.1080/13552600802593535

Garrett, T., Oliver, C., Wilcox, D. T., & Middleton, D. (2003). Who cares? The views of sexual offenders about the group treatment they receive. *Sexual Abuse: A Journal of Research and Treatment, 15*(4), 323-338. doi:1079-0632/03/10000323/0

Hanson, R. K. (2000). Will they do it again? Predicting sex-offense recidivism. *Current Directions in Psychological Science, 9*(3), 106-109. doi:10.1111/1467-8721.00071

Hanson, R. K. (2006). Stability and change: Dynamic risk factors for sexual offenders. In W. L. Marshall, Y. Fernandez & L. Marshall (Eds.), *Sexual offender treatment: Controversial issues* (pp. 17-31). Hoboken, NY: Wiley.

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), 87-96. doi:10.1037/h0087220

Hanson, R. K., & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*(2), 348-362. doi:10.1037/0022-006X.66.2.348

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report on the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 169-194. doi:10.1023/A:1014624315814

Hanson, R. K., & Harris, A. J. R. (2000). Where should we intervene?: Dynamic predictors of sexual offense recidivism. *Criminal Justice and Behavior, 27*(6), 6-35. doi:10.1177/0093854800027001002

Hanson, R. K., & Morton-Bourgon, K. E. (2004). *Predictors of sexual recidivism: An updated meta-analysis 2004-02.* Retrieved from www.publicsafety.gc.ca/res/cor/rep/_fl/2004-02-pred-se-eng.pdf.

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*(6), 1154-1163. doi:10.1037/0022-006X.73.6.1154

Hanson, R. K., Steffy, P. A., & Gauthier, R. (1993). Long-term recidivism of child molesters. *Journal of Consulting and Clinical Psychology, 61*(4), 646-652. doi:10.1037/0022.006X.61.4.646

Harris, A. J. (2006). Risk assessment and sex offender community supervision: A context-specific framework. *Federal Probation, 70*(2), 36-43. Retrieved from http://content.ebscohost.com.lib.pepperdine.edu/pdf18_21/pdf/2006/FEP/01Sep06/24036749.pdf?T=P&P=AN&K=24036749&S=R&D=a9h&EbscoContent=dGJyMNLr40SeprU4v%2BvlOLCmr0qep7NSs624S6%2BWxWXS&ContentCustomer=dGJyMPGuslCuqLFQuePfgeyx44Dt6fIA

Isaac, S. & Michael, W. B. (1997). *Handbook in research and evaluation: For education and the behavioral sciences* (3rd ed.). San Diego, CA: Educational and Industrial Testing Services.

Israel, G. D. (1992). Determining sample size. *University of Florida, Institute of Food and Agricultural Sciences Extension.* Retrieved from http://edis.ifas.ufl.edu/pdffiles/PD/PD00600.pdf

Jennings, J. L., & Sawyer, S. (2003). Principles and techniques for maximizing the effectiveness of group therapy with sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 15*(4), 251-267. doi:10.1177/107906320301500403

Kroner, D. G., Mills, J. F., Reitzel, L. R., Dow, E., Aufderheide, D. H., & Railey, M. G. (2007). Directions for violence and sexual risk assessment in correctional psychology. *Criminal Justice and Behavior, 34*(7), 906-918. doi:10.1177/0093854807301559

Laws, R. D. (1989). *Relapse prevention with sex offenders*. New York, NY: Guilford Press.

Laws, R. D. (2003). The rise and fall of relapse prevention. *Australian Psychologist, 38*(1), 22-30. doi:10.1080/00050060310001706987

Levenson, J. S., & Macgowan, M. J. (2004). Engagement, denial, and treatment progress among sex offenders in group therapy. *Sexual Abuse: A Journal of Research and Treatment, 16*(1), 49-63. doi:10.1177/107906320401600104

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*(1), 35-56. doi:10.1177/1079063208326072

Levenson, J. S., & Prescott, D. S. (2009). Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse: A Journal of Research and Treatment, 21*(1), 6-20. doi:10.1177/1079063208325205

Levenson, J. S., Prescott, D. S., & D'Amora, D. A. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology, 54*(3), 307-326. doi:10.1177/0306624X08328752

Mann, R. E. (2000). Managing resistance and rebellion in relapse prevention intervention. In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders* (pp. 187-200). Thousand Oaks, CA: Sage.

Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment, 17*(2), 109-116. doi:10.1007/s11194-005-4598-6

Marshall, W. L., Ward, T., Mann, R. E., Moulden, H., Fernandez, Y. M., Serran, G., & Marshall, L. E. (2005). Working positively with sexual offenders: Maximizing the effectiveness of treatment. *Journal of Interpersonal Violence, 20*(9), 1096-1114. doi:10.1177/0886260505278514

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 and Treatment, 17*(1), 79-107. doi:10.1007/s11194-005-1212-x

Mercado, C. C., & Ogloff, J. R. P. (2007). Risk and the preventive detention of sex offenders in Australia and the United States. *International Journal of Law and Psychiatry, 30*(1), 49-59. doi:10.1016/j.ijlp.2006.02.001

Moster, A., Wnuk, D. W., & Jeglic, E. L. (2008). Cognitive behavioral therapy interventions with sex offenders. *Journal of Correctional Health Care, 14*(2), 109-121. doi:10.1177/1078345807313874

National Center for Missing and Exploited Children. (2010). *Map of registered sex offenders in the United States*. Retrieved from http://www.missingkids.com/en_US/documents/sex-offender-map.pdf

Nunes, K. L., & Cortoni, F. (2008). Dropout from sex-offender treatment and dimensions of risk of sexual recidivism. *Criminal Justice and Behavior, 35*(1), 24-33. doi:10.1177/0093854807309037

Oxford University Press. (2010). Oxford English Dictionary (3rd ed.). Retrieved from http://www.oed.com.lib.pepperdine.edu/viewdictionaryentry/Entry/176989

Petersilia, J. (2003). *When prisoners come home: Parole and prisoner reentry.* New York, NY: Oxford University Press.

Pithers, W. D., & Cumming, G. F. (1995). Relapse prevention: A method for enhancing behavioral self-management and external supervision of the sexual aggressor. In B. K. Schwartz & H. R. Cellini (Eds.),*The sex offender: Corrections, treatment and legal practice* (pp. 20.1-20.32). Kingston, NJ: Civic Research Institute.

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*(6), 635-659. doi:10.1023/A:1024860714738

Schaffer, M., Jeglic, E. L., Moster, A., & Wnuk, D. (2010). Cognitive-behavioral therapy in the treatment and management of sex offenders. *Journal of Cognitive Psychotherapy: An International Quarterly, 24*(2), 92-103. doi:10.1891/0889-8391.24.2.92

Sperry, L. (2004). Ethical dilemmas in the assessment of clinical outcomes. *Psychiatric Annals, 34*(2), 107-113. Retrieved from http://content.ebscohost.com.lib.pepperdine.edu/pdf17_20/pdf/2004/7IV/01Feb04/20372894.pdf?T=P&P=AN&K=20372894&S=R&D=hch&EbscoContent=dGJyMNLr40SeprU4v%2BvlOLCmr0qep7NSs6u4SbKWxWXS&ContentCustomer=dGJyMPGuslCuqLFQuePfgeyx44Dt6fIA

Stalans, L. J., Hacker, R., & Talbot, M. E. (2010). Comparing nonviolent, other-violent, and domestic batterer sex offenders: Predictive accuracy of risk assessment on sexual recidivism. *Criminal Justice and Behavior, 37*(5), 613-628. doi:10.1177/0093854810363794

Taxman, F. S., & Thanner, M. (2006). Risk, need, and responsivity (RNR): It all depends. *Crime and Delinquency, 52,* 28-51. doi:10.1177/001112870528175

Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. *Aggression and Violent Behavior, 7*, 513-528. doi:10.1016/S1359-1789(01)00076-3

Ward, T., & Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. *Aggression and Violent Behavior*, *11*(1), 77-94. doi:10.1016/j.avb.2005.06.001

Ward, T. & Hudson, S. M. (1996). Relapse prevention: A critical analysis. *Sexual Abuse: A Journal of Research and Treatment, 8*(3), 177-200. doi:10.1007/BF02256640

Ward, T., & Stewart, C. (2003). Criminogenic needs and human needs: A theoretical model. *Psychology, Crime & Law, 9*(2), 125-143. doi:10.1080/1068316031000116247

Willis, G. M., & Grace, R. C. (2009). Assessment of community reintegration planning for sex offenders: Poor planning predicts recidivism. *Criminal Justice and Behavior, 36*(5), 494-512. doi:10.1177/0093854809332874

Wilson, R. J., & Yates, P. M. (2009). Effective interventions and the Good Lives Model: Maximizing treatment gains for sexual offenders. *Aggression and Violent Behavior, 14,* 157-161. doi:10.1016/j.avb.2009.01.007

Wong, S. C. P., Olver, M. E., & Stockdale, K. C. (2009). The utility of dynamic and static factors in risk assessment, prediction, and treatment. In J. T. Andrade (Ed.), *Handbook of violence risk assessment and treatment: New approaches for mental health professionals* (pp. 83-120). New York, NY: Springer.

Table 1

Means (M) and Standard Deviations (SD) Questionnaire Items 26 - 78

Item	*M*	*SD*
26. Learning about the stages and processes of change	4.70	.794
27. Accepting responsibility for my offense	4.73	.640
28. Learning about different types of denial and resistance	4.53	.860
29. Understanding my tendency to distort, deny, and make excuses	4.34	1.143
30. Understanding the impact of sexual abuse on victims and others	4.80	.664
31. Understanding my offense chains, cycles, and patterns	4.60	.724
32. Understanding my triggers and high risk situations	4.73	.785
33. Learning how cognitive distortions and core beliefs contributed to my offense	4.65	.709
34. Learning what motivated me to offend	4.61	.786
35. Developing a relapse prevention plan	4.62	.82
36. Learning to change or control my deviant arousal	4.57	.997

(continued)

Item	*M*	*SD*
37. Understanding the development of my sexual behavior problems	4.52	.871
38. Understanding how early experiences and family life affected me	4.54	.859
39. Understanding my emotional needs and learning to meet them in healthier ways	4.76	.435
40. Understanding healthy emotional and physical intimacy	4.70	.466
41. Learning about healthy sexuality	4.66	.67
42. Learning new relationship and communication skills	4.75	.518
43. Learning how to create a more satisfying life for myself	4.73	.691
44. Identifying ways to become a contributing member of society	4.70	.837
45. Sharing my experiences with other sexual offenders	4.00	1.217
46. Feeling as though I can relate to the other members of my treatment group	4.28	.841
47. Hearing other perspectives and viewpoints	4.50	.861
48. Getting help and support from others	4.43	1.103
49. Confronting other group members	3.90	1.398

(continued)

Item	*M*	*SD*
50. Being confronted by other group members	4.03	1.149
51. Attending individual therapy sessions as part of my treatment	4.60	.770
52. Taking prescription medication	3.64	1.598
53. Completing homework assignments	4.04	1.022
54. Staying grounded in my religious and spiritual values	4.62	.983
55. Avoiding drug and alcohol abuse	4.77	.685
56. I am comfortable with the group atmosphere	4.10	1.012
57. I am satisfied with the structure of the group environment	3.94	1.181
58. I am satisfied with the openness and honesty of the group members	4.10	1.094
59. I perceive group members to take a nonjudgmental stance toward each other	3.97	1.224
60. I am satisfied with the fairness of group leaders	4.48	.926
61. I am satisfied with the genuineness of group leaders	4.40	.855

(continued)

Item	*M*	*SD*
62. I perceive group leaders to take a nonjudgmental stance toward group members	4.48	.962
63. I perceive staff members to take a nonjudgmental stance toward group members	4.52	.89
64. I am comfortable participating in group	4.10	1.399
65. I am comfortable helping others in group	4.35	1.082
66. I am comfortable sharing personal issues with group leaders	4.13	1.056
67. I am comfortable receiving feedback from group members	4.19	1.167
68. I am comfortable receiving feedback from group leaders	4.48	.811
69. I am satisfied with the amount of homework	3.41	1.469
70. I am satisfied with the length of sessions	4.03	1.117
71. I am satisfied with the rules about attendance and punctuality	4.26	1.032
72. I am here because I need to be here	3.34	1.738
73. I am motivated for treatment	4.45	1.055

(continued)

Item	*M*	*SD*
74. I remember the content of my group sessions	4.19	.873
75. The treatment is relevant to my personal needs and concerns	3.70	1.409
76. The treatment is NOT helping me change or grow (reverse keyed)	3.57	1.289
77. People who know me can see positive changes in me since I started this treatment	3.79	1.264
78. Overall, I would describe my group treatment experience as:	4.29	.864

Note. N = 31.

Table 2

Importance of Treatment Components Related to Group Content, Reported in Percentages

Item	Very Important	Somewhat Important	Unsure	Somewhat Unimportant	Very Unimportant	Not Applicable
Learning about the stages and processes of change	80.6	9.7	0.0	6.5	0.0	3.2
Accepting responsibility for my offense	77.4	16.1	0.0	3.2	0.0	3.2
Learning about different types of denial and resistance	64.5	25.8	3.2	0.0	3.2	3.2
Understanding my tendency to distort, deny, and make excuses	61.3	16.1	9.7	0.0	6.5	6.5
Understanding the impact of sexual abuse on victims and others	87.1	3.2	3.2	3.2	0.0	3.2
Understanding my offense chains, cycles, and patterns	67.7	22.6	3.2	3.2	0.0	3.2
Understanding my triggers and high risk situations	83.9	6.5	0.0	3.2	0.0	3.2
Learning how cognitive distortions and core beliefs contributed to my offense	74.2	19.4	3.2	3.2	0.0	0.0
Learning what motivated me to offend	67.7	12.9	6.5	3.2	0.0	9.7
Developing a relapse prevention plan	71.0	16.1	0.0	6.5	0.0	6.5
Learning to change or control my deviant arousal	71.0	9.7	3.2	3.2	3.2	9.7

(continued)

Item	Very Important	Somewhat Important	Unsure	Somewhat Unimportant	Very Unimportant	Not Applicable
Understanding the development of my sexual behavior problems	64.5	19.4	3.2	6.5	0.0	6.5
Understanding how early experiences and family life affected me	58.1	19.4	0.0	6.5	0.0	16.1
Understanding my emotional needs and learning to meet them in healthier ways	71.0	22.6	0.0	0.0	0.0	6.5
Understanding healthy emotional and physical intimacy	67.7	29.0	0.0	0.0	0.0	3.2
Learning about healthy sexuality	67.7	22.6	0.0	3.2	0.0	6.5
Learning new relationship and communication skills	71.0	16.1	3.2	0.0	0.0	9.7
Learning how to create a more satisfying life for myself	80.6	9.7	3.2	3.2	0.0	3.2
Identifying ways to become a contributing member of society	80.6	9.7	3.2	0.0	3.2	3.2
Staying grounded in my religious and spiritual values[a]	70.0	10.0	0.0	3.3	3.3	13.3
Taking prescription medication[a]	23.3	3.3	6.7	6.7	6.7	53.3
Avoiding drugs and alcohol[a]	63.3	6.7	0.0	3.3	0.0	26.7
Completing homework assignments[a]	26.7	36.7	6.7	3.3	3.3	23.3
Attending individual therapy sessions as part of my treatment	71.0	16.1	6.5	3.2	0.0	3.2

Note. N =31. [a]n = 30.

Table 3

Importance of Treatment Components Related to Group Process, Reported in Percentages

Item	Very Important	Somewhat Important	Unsure	Somewhat Unimportant	Very Unimportant	Not Applicable
Sharing my experiences with other sexual offenders	38.7	32.3	6.5	6.5	6.5	9.7
Feeling as though I can relate to the other members of my treatment group	38.7	48.4	3.2	0.0	3.2	6.5
Hearing other perspectives and viewpoints	61.3	29.0	3.2	0.0	3.2	3.2
Getting help and support from others	61.3	19.4	3.2	0.0	6.5	9.7
Confronting other group members	45.2	25.8	9.7	3.2	12.9	3.2
Being confronted by other group members	41.9	29.0	9.7	9.7	3.2	6.5

Note. N = 31.

Table 4

Perceptions about Group Leaders and Program Staff Members, Reported in Percentages

Item	Strongly Agree	Somewhat Agree	Unsure	Somewhat Disagree	Strongly Disagree	Not Applicable
I am satisfied with the fairness of group leaders	64.5	29.0	0.0	3.2	3.2	0.0
I am satisfied with the genuineness of group leaders	51.6	38.7	3.2	0.0	3.2	3.2
I perceive group leaders to take a nonjudgmental stance toward group members	67.7	22.6	3.2	3.2	3.2	0.0
I perceive staff members to take a nonjudgmental stance toward group members	67.7	22.6	6.5	0.0	3.2	0.0

Note. N = 31

Table 5

Perceptions of Treatment Components Related to Comfort with the Group Atmosphere and Engagement with Group Members and Leaders, Reported in Percentages

Item	Strongly Agree	Somewhat Agree	Unsure	Somewhat Disagree	Strongly Disagree	Not Applicable
I am comfortable with the group atmosphere[a]	36.7	46.7	3.3	6.7	3.3	3.3
I am satisfied with the structure of the group environment	32.3	51.6	3.2	3.2	9.7	0.0
I am satisfied with the openness and honesty of group members	38.7	45.2	3.2	3.2	6.5	3.2
I perceive group members to take a nonjudgmental stance toward each other	48.4	22.6	6.5	22.6	0.0	0.0
I am comfortable participating in group	58.1	22.6	3.2	3.2	12.9	0.0
I am comfortable helping others in group	61.3	25.8	6.5	0.0	6.5	0.0
I am comfortable sharing personal issues with group leaders	41.9	41.9	9.7	0.0	6.5	0.0
I am comfortable receiving feedback from group members	54.8	25.8	9.7	3.2	6.5	0.0
I am comfortable receiving feedback from group leaders	64.5	22.6	9.7	3.2	0.0	0.0

Note. N = 31. [a]n = 30.

Table 6

Satisfaction with Policies and Procedures, Reported in Percentages

Item	Strongly Agree	Somewhat Agree	Unsure	Somewhat Disagree	Strongly Disagree	Not Applicable
I am satisfied with the amount of homework	25.8	6.5	19.4	9.7	9.7	29.0
I am satisfied with the length of sessions	38.7	35.5	6.5	9.7	3.2	6.5
I am satisfied with the rules about attendance and punctuality	51.6	35.5	3.2	6.5	3.2	0.0

Note. N = 31.

Table 7

Overall Satisfaction, Motivation, and Perceived Positive Changes, Reported in Percentages

Item	Strongly Agree	Somewhat Agree	Unsure	Somewhat Disagree	Strongly Disagree	Not Applicable
I am motivated for treatment	64.5	19.4	0.0	6.5	3.2	6.5
I remember the content of my group sessions	41.9	41.9	9.7	6.5	0.0	0.0
I am here because I need to be here	38.7	16.1	3.2	9.7	25.8	6.5
The treatment is relevant to my personal needs and concerns	29.0	35.5	3.2	6.5	12.9	12.9
The treatment is not helping me change or grow[a]	6.7	16.7	13.3	30.0	26.7	6.7
People who know me can see positive changes in me since I started this treatment	35.5	22.6	25.8	0.0	9.7	6.5

Item	Extremely Positive	Fairly Positive	Neither Positive or Negative	Fairly Negative	Extremely Negative	Not Applicable
Overall, I would describe my group treatment experience as:	45.2	45.2	6.5	0.0	3.2	0.0

Note. N = 31. [a]n = 30.

Table 8

Intercorrelations of Domain 2 Items related to Group Content

Item	26[b]	27[b]	28[b]	29[c]	30[b]	31[b]	32[b]	33[a]	34[d]	35[c]	36[d]	37[c]	38[c]	39[c]	40[b]	41[c]	42[d]	43[b]	44[b]	51[h]	52[h]	53[f]	54[e]	55[g]
26	–	.308	.312	.113	.536**	.462*	.622**	.050	-.126	-.039	.527**	.212	.652**	.332	.490**	.719**	.322	.474**	.376*	.376*	-.008	.469*	.729**	.362
27	.308	–	.079	.422*	.191	.283	.124	-.145	.133	-.137	.032	.064	.150	.128	.294	.260	.429*	.062	-.031	-.022	-2.27	.237	.197	.656**
28	.312	.079	–	.341	.185	.299	.676**	.774**	.262	.554**	.439*	.357	.225	.453*	.144	.248	-.030	.008	.032	.379*	-.121	.032	.073	.108
29	.113	.422*	.341	–	.137	.432*	.141	.378*	.045	.183	-.018	.119	.142	.300	.329	.380	.317	.250	.219	.481**	-.246	.030	.222	.249
30	.536**	.191	.185	.137	–	.707**	.951**	.707**	.140	.375	.433*	.628**	.120	.474*	.609**	.465*	.625**	.256	.403*	.258	.118	-.244	.012	.761**
31	.462*	.283	.299	.432*	.707**	–	.675**	.305	.171	.383*	.719**	.052	.356	.453*	.236	.568**	.184	.326	.245	.252	-.427	.081	.792**	.050
32	.622**	.124	.676**	.141	.951**	.675**	–	.515**	.383*	.605**	.836**	.499**	.637**	.688**	.275	.549**	.171	.370*	.238	.327	-.244	.014	.482*	-.014
33	.050	-.145	.774**	.378*	.707**	.305	.515**	–	.391*	.768**	.290	.465*	.154	.522**	.072	.088	.024	.143	.212	.536**	-.008	.104	-.080	.016
34	-.126	.133	.262	.045	.140	.171	.383*	.391*	–	.686**	.101	.286	-.054	.399*	.181	-.178	-.075	-.109	-.166	.005	.339	-.187	-.100	-.056
35	-.039	-.137	.554**	.183	.375	.383*	.605**	.768**	.686**	–	.504**	.070	.627**	.231	-.005	.013	.116	.127	.504**	.354	.009	.346	.109	-.065
36	.527**	.032	.439*	-.018	.433*	.719**	.836**	.290	.101	.504**	–	.671**	.662**	.473*	.118	.523**	.215	.436*	.383*	.336	-.006	.258	.723**	-.130
37	.212	.064	.357	.119	.628**	.052	.499**	.465*	.286	.070	.671**	–	.665**	.503**	.103	.169	.461*	.525**	.506**	.574**	.333	.588**	.376	-.090
38	.652**	.150	.225	.142	.120	.356	.637**	.154	-.054	.627**	.662**	.665**	–	.675**	.561**	.760**	.674**	.842**	.775**	.656**	.527	.510*	.548**	.455*
39	.332	.128	.453*	.300	.474*	.453*	.688**	.522**	.399*	.231	.473*	.503**	.675**	–	.667**	.552**	.522**	.589**	.462*	.531**	.170	.325	.344	.541*
40	.490**	.294	.144	.329	.609**	.236	.275	.072	.181	-.005	.118	.103	.561**	.667**	–	.664**	.564**	.596**	.465*	.416*	-.044	.472*	.382	.460*
41	.719**	.260	.248	.380	.465*	.568**	.549**	.088	-.178	.013	.523**	.169	.760**	.552**	.664**	–	.575**	.702**	.621**	.561**	-.008	.271	.619**	.464*
42	.322	.429*	-.030	.317	.625**	.184	.171	.024	-.075	.116	.215	.461*	.674**	.522**	.564**	.575**	–	.802**	.725**	.473*	.222	.510*	.317	.652**
43	.474**	.062	.008	.250	.256	.326	.370*	.143	-.109	.127	.436*	.525**	.842**	.589**	.596**	.702**	.802**	–	.930**	.720**	.298	.537**	.490*	.063
44	.376*	-.031	.032	.219	.403*	.245	.238	.212	-.166	.504**	.383*	.506**	.775**	.462*	.465*	.621**	.725**	.930**	–	.791**	.410	.539**	.386	-.135
51	.376*	-.022	.379*	.481**	.258	.252	.327	.536**	.005	.354	.336	.574**	.656**	.531**	.416*	.561**	.473*	.720**	.791**	–	.434	.488*	.183	-.048
52	-.008	-.227	-.121	-.246	.118	-.427	-.244	-.008	.339	.009	-.006	.333	.527	.170	-.044	-.008	.222	.298	.410	.434	–	.304	-.164	-.350
53	.469*	.237	.032	.030	-.244	.081	.014	.104	-.187	.346	.258	.588**	.510**	.325	.472*	.271	.510*	.537**	.539**	.488*	.304	–	.358	.178
54	.729**	.197	.073	.222	.012	.792**	.482*	-.080	-.100	.109	.723**	.376	.548**	.344	.382	.619**	.317	.490*	.386	.183	-.164	.358	–	-.019
55	.362	.656**	.108	.249	.761**	.050	-.014	.016	-.056	-.065	-.130	-.090	.455*	.541*	.460*	.464*	.652**	.063	-.135	-.048	-.350	.178	-.019	–

Note. [a]N = 31. [b]n = 30. [c]n = 29. [d]n = 28. [e]n = 26. [f]n = 23. [g]n = 22. [h]n = 14.
*$p < .05$. **$p < .01$.

Table 9

Intercorrelations of Domain 2 Items Related to Group Process

Item	45[c]	46[b]	47[a]	48[c]	49[a]	50[b]
45	–	.809**	.641**	.716**	.739**	.572**
46	.809**	–	.885**	.703**	.532**	.507**
47	.641**	.885**	–	.664**	.329	.340
48	.716**	.703**	.664**	–	.532**	.233
49	.739**	.532**	.329	.532**	–	.658**
50	.572**	.507**	.340	.233	.658**	–

Note. [a]n = 30. [b]n = 29. [c]n = 28.
*$p < .05$. **$p < .01$.

Table 10

Intercorrelations of Domain 3 Items Related to Perceptions about Group Leaders and Program Staff Members

Item	60	61[a]	62	63
60	–	.688**	.626**	.577**
61	.688**	–	.902**	.762**
62	.626**	.902**	–	.711**
63	.577**	.762**	.711**	–

Note. N = 31. [a]n = 30
*$p < .05$. **$p < .01$.

Table 11

Intercorrelations of Domain 3 Items Related to Comfort with the Group Atmosphere and Engagement with Group Members and Leaders

Item	56[b]	57	58[a]	59	64	65	66	67	68
56	–	.525**	.740**	.384*	.551**	.513**	.153	.285	.071
57	.525**	–	.661**	.598**	.831**	.645**	.621**	.348	.555**
58	.740**	.661**	–	.620**	.680**	.399*	.282	.311	.135
59	.384*	.598**	.620**	–	.508**	.160	.390*	.028	.184
64	.551**	.831**	.680**	.508**	–	.659**	.600**	.397*	.486**
65	.513**	.645**	.399*	.160	.659**	–	.600**	.397*	.486**
66	.153	.621**	.282	.390*	.600**	.600**	–	.277	.703**
67	.285	.348	.311	.028	.397*	.397*	.277	–	.496**
68	.071	.555**	.135	.184	.486**	.486**	.703**	.496**	–

Note. N = 31. [a]n = 30. [b]n = 29.
*$p < .05$. **$p < .01$.

Table 12

Intercorrelations of Domain 3 Items Related to Policies and Procedures

Item	69[c]	70[b]	71[a]
69	–	.730**	.457*
70	.730**	–	.543**
71	.457*	.543**	–

Note. [a]N =31. [b]n =29. [c]n = 22.
*$p < .05$. **$p < .01$.

Table 13

Intercorrelations of Domain 3 Items Related to Overall Satisfaction, Motivation, and Perceived Positive Changes

Item	72[b]	73[b]	74[a]	75[d]	76[c]	77[b]	78 [a†]
72	–	.321	.044	.620	-.097	.169	.355
73	.321	–	.201	.468*	-.184	.766**	.653**
74	.044	.201	–	.139	.248	.303	.144
75	.620**	.468*	.139	–	.214	.388*	.610**
76	-.097	-.184	.248	.214	–	-.256	.130
77	.169	.766**	.303	.388*	-.256	–	.408*
78	.355	.653**	.144	.610**	.130	.408*	–

Note. [†] Response options for this item are reverse keyed, as follows: 1 = Extremely Negative; 2 = Fairly Negative; 3 = Undecided; 4 = Fairly Positive; 5 = Extremely Positive.
[a]N = 31. [b]n =29. [c]n = 28. [d]n = 27.
*$p < .05$. **$p < .01$.

Table 14

Group Member Responses to the Most Helpful and Least Helpful Aspects of Treatment and Suggestions to Improve the Treatment Program

ID	#79: Most Helpful	#80: Least Helpful	#81:Suggestions for Improvement
1	The treatment process has helped me focus on my future and help me change some of my core beliefs.	Having to listen to outragious lies by a couple of group members and the group facilitators not addressing those issues.	Have the group facilitators challenge some of the group members for their lying in group when it is all too obvious. Have the group facilators go into detail about the reasons that a person commits a sexual offense. Have the group facilitators discuss options for recovery.
2	Hearing others' experience and knowing that I'm not alone. Learning about cognitive distortions. Associating with others in my situation.	Answering the same check-in questions week after week.	Eliminate or change the check-in questions.
3	The overall professionalism of the staff. Topics that are relatable and relevant. Frequency of meetings and questions that are asked by the staff.	Length of DAM model could be shorter. Introductions.	Have meeting days consecutive, back to back; beyond that the structure is working.
4	Learning to set and enforce boundaries. Reflecting on my beliefs and cognitive distortions. Learning to "take it in" and stop responding to advice or criticism impulsively or defensively.	The polygraph exams. The quarterly reviews (until recently). Being asked to censor my sexual thoughts and fantasies.	Provide an exit path leading to approved termination or treatment. Use quarterly reviews as treatment tool, not just for evaluation. Stop assuming that all accused or convicted offenders need treatment or are a danger to others or themselves.

(continued)

ID	#79 Most Helpful	#80 Least Helpful	#81 Suggestions for Improvement
5	Being able to relate my story, my side I couldn't share in the courtroom. I take responsibility for getting into this situation, but was set up; I am not in denial. Seeing warning signs and not trusting strangers, as I once had.	I had the option of going to P.O.C. with medication once a month or coming here to take lie detector tests, show my innocence and eventually clear my name through a lawyer. I feel the program overall is a help. I've learned from others. I won't put myself in a position as I was before. In the state of California "hearsay" stands in court.	I've been married nearly 20 years, my family was with me during all the times I was accused of. I just want to be reunited with them and get my life back. The best thing about [facility name] is the ability to discuss what happened -didn't happen- and use the tools you can learn in order to not get in the same fix again. All in all -it's the best program I can think of because I've seen so many who truly need help.
6	N/A	N/A	I'm motivated now. More life skills. Go back to school.
7	N/A	N/A	Communication skills.
8	I didn't commit suicide. I learned patience; I am less judgmental of others. I learned cognitive distortions. I learned about addictions.	The hours interfere with work. Sometimes instructors are slow to remind classmates to be brief; classmates can drag on "check-ins." Sometimes instructors are hesitant to reveal their true opinions.	Have classes on weekends with a lunch break. Keep restrooms better maintained. Remove nails and debris in parking lot.
9	Someone that will listen. Letting you know that you're on the right track. And being there when you need them.	None	When your 18 months are up they're over with and not dragged on.
10	Truthful. Open. Don't lie.	18 months is too long for this program.	Would not change anything.

(continued)

ID	#79 Most Helpful	#80 Least Helpful	#81 Suggestions for Improvement
11	Useful information. Developing self-help skills. Learning how to be punctual.	Having to work around class times to fit my schedule. It's a financial setback having to come here.	Canceling the one on ones. Being able to choose what time fits my schedule. Maybe one hour group sessions.
12	Hearing others' experiences. Individual sessions. Hearing about resources from other group members.	N/A	N/A
13	Participation. Feedback (from leaders and members). Honesty (from myself and group members).	N/A	More homework assignments which can enlighten offenders at home. More challenges from other participants during group sessions as this relieves the offender of his guilt complexes. Every offender should always be honest as this is a major victory in being a success in the sex offender therapeutic program.
14	Staying out of trouble. Staying focused on my life. Getting off parole.	Talking about my crime. Staying focused. Staying out of trouble.	Be in committed relationship. Not have more than one girlfriend. Be honest to the person I am with about my criminal history.
15	Group treatment. Me change or grow. Personal needs and concerns.	Homework assignments. Group sessions.	Attendance and punctuality. Sharing group leaders. Feedback group leaders.
16	Having someone to talk to about the parole. Having a supportive group. Having a reminder to stay in my parole conditions.	How many times I have to attend. The bus ride. Get up in the morning.	Lessen the times I have to go. Lessen the times you have "1 on 1" counseling. Offer snacks, etc. chips, cookies, coffee

(continued)

ID	#79 Most Helpful	#80 Least Helpful	#81 Suggestions for Improvement
17	Education. Discipline (structure as opposed to stricture). Communication.	Disruption. Dealing with others' psychoses. Stigma.	Become a Luddite. Join a monastery. Expire.
18	Cognitive distortions. Rationalizations. Accountability. Seemingly unimportant decisions.	Openness in the group. Non-judgmentalness. Participation of group.	Healthy sexual choices. Empathy of victims. Humanization of victims.
19	Understanding the different terms of sexual abuse. Understanding the reason why I had a sex crime. Understanding the different problem and pain a sex crime can cause someone.	I don't know any offhand.	Drugs. Understanding my personal problem. Understanding the risk of a sex crime.
20	Responsibility. Punctuality.	People who two faced. People who talk bullshit. People who are still in denial.	No changes.
21	Too many guys. Too many questions. Too many visits a mo.	N/A	N/A
22	Touching on topics as a refresher or reminder of how change, growing, learning are the keys to a healthier life. Staying open minded to learning or taking others experiences from the group to use in your own life or to not use in your own life. Education from certain topics cover; New things or points of view I didn't see before from my own points of view.	Some topics covered seemed like stating the obvious or common sense topics, e.g. sex ed, inappropriate sexual behavior, respect for women sexually, healthy types of relationship skills.	Talk about what has gotten us into prison or how we feel about life currently or more real life situations, less classroom education style teaching, it feels like sometimes we are just going through the motions.

(continued)

ID	#79 Most Helpful	#80 Least Helpful	#81 Suggestions for Improvement
23	My time.	N/A	N/A
24	N/A	N/A	Not sure.
25	One on one.	Sitting in a group talking with others who have no clue what happened in my case or I in their's giving advice or opinions.	Do more one on one as individual and less group.
26	Receiving feedback. Being nonjudgmental. Avoiding drugs and alcohol.	Having to attend classes for the 2nd time. Learning how to make a better life for me. Learning my emotional needs to be put in a healthier ways.	Develop a relapse prevention plan. Understanding the impact of sexual abuse on victims. Understanding the triggers and high risk situations.
27	Honesty. Truthful. Positive thinking.	Negative thinking. Dishonest. Untruthful.	Thinking negative thought. Thinking positive thought. High risk situation.
28	Being among others like me. Nonjudgmental environment. Chance to talk openly.	Travel time, 8 am to 5:30, 9.5 hours, for a 90 minute session.	More offices for less travel time. Many of us at Riverside live in SW Riv Co and have to take long bus rides RTA bus co is not dependable.
29	Nothing.	It not teachin me what I'm trying to seeking in life.	Keep trusting in God 4 my ways of life.
30	Triggers. Help reentry. Learning more.	N/A	N/A
31	Group therapy. Behavior. Support-group and individual.	Sex education.	None

Table 15

Significant Correlation Coefficients for Total Satisfaction, Overall Treatment Experience, and Motivation for Treatment

Item 1	Item 2	Pearson *r*	*p* value
Total Satisfaction	Number of group sessions	.717[a]	.003**
Overall Treatment Experience	Importance of hearing the viewpoints of other group members	.759[g]	.000**
Overall Treatment Experience	Importance of relating to other sex offenders	.756[f]	.000**
Overall Treatment Experience	Comfort receiving feedback from group members	.670	.000**
Overall Treatment Experience	Comfort helping others in group	.635	.000**
Overall Treatment Experience	Satisfaction with the group structure	.607	.000**
Overall Treatment Experience	Relevance of treatment to personal needs	.610[d]	.001**
Overall Treatment Experience	Importance of sharing experiences with other sex offenders	.572[e]	.001**
Overall Treatment Experience	Number of convictions	.564	.001**
Overall Treatment Experience	Importance of understanding triggers and high risk situations	.563[g]	.001**
Overall Treatment Experience	Importance of learning about different types of denial and resistance	.542[g]	.002**

(continued)

Item 1	Item 2	Pearson *r*	*p* value
Overall Treatment Experience	Satisfaction with the amount of homework	.539[b]	.010**
Overall Treatment Experience	Importance of getting support from others	.529[e]	.004**
Overall Treatment Experience	Comfort participating in group	.500	.004**
Overall Treatment Experience	Comfort with the group atmosphere	.496[f]	.006**
Overall Treatment Experience	Importance of understanding the development of sexual behavior problems	.476[f]	.009**
Overall Treatment Experience	Comfort receiving feedback from group leaders	.459	.009**
Overall Treatment Experience	Importance of learning to change or control deviant arousal	.473[e]	.011*
Overall Treatment Experience	Length of group sessions	.461[f]	.012*
Overall Treatment Experience	Importance of learning about cognitive distortions and core beliefs	.446	.012*
Overall Treatment Experience	Nonjudgmental stance of group leaders	.427	.017*
Overall Treatment Experience	Openness and honesty of other group members	.411[g]	.024*
Overall Treatment Experience	Importance of being confronted by others	.387[f]	.038*

(continued)

Item 1	Item 2	Pearson *r*	*p* value
Motivation for Treatment[g]	Importance of understanding the development of sexual behavior problems	.785[e]	.000**
Motivation for Treatment	Perception that others have seen positive changes in them	.766[e]	.000**
Motivation for Treatment	Importance of understanding emotional needs and meeting them in healthier ways	.707[e]	.000**
Motivation for Treatment	Importance of relating to other members of the treatment group	.701[f]	.000**
Motivation for Treatment	Overall positive experience	.653[f]	.000**
Motivation for Treatment	Importance of individual therapy	.649[e]	.000**
Motivation for Treatment	Importance of understanding the effects of early experiences and family life	.648[c]	.000**
Motivation for Treatment	Non-contact sexual offense convictions	-.635[f]	.000**
Motivation for Treatment	Importance of hearing other perspectives and viewpoints	.611[f]	.000**
Motivation for Treatment	Importance of understanding triggers and high risk situations	.617[e]	.001**
Motivation for Treatment	Importance of learning about cognitive distortions and core beliefs	.601[f]	.001**
Motivation for Treatment	Importance of learning about different types of denial and resistance	.589[e]	.001**
Motivation for Treatment	Importance of learning to change or control deviant arousal	.548[c]	.004**

(continued)

Item 1	Item 2	Pearson *r*	*p* value
Motivation for Treatment	Importance of sharing experiences with other sex offenders	.543[d]	.003**
Motivation for Treatment	Importance of developing a relapse prevention plan	.525[d]	.005**
Motivation for Treatment	Importance of learning how to create a more satisfying life	.511[f]	.005**
Motivation for Treatment	Total number of sexual offense convictions	-.489[f]	.007**
Motivation for Treatment	Importance of identifying ways to become a contributing member of society	.480[f]	.008**
Motivation for Treatment	Comfort with the group atmosphere	.466[d]	.014*
Motivation for Treatment	Relevance of treatment to personal needs	.468[c]	.016*
Motivation for Treatment	Importance of getting help and support from others	.452[e]	.016*
Motivation for Treatment	Comfort receiving feedback from group members	.440[f]	.017*
Motivation for Treatment	Satisfaction with session length	.434[d]	.024*
Motivation for Treatment	Importance of homework	.459[b]	.032*
Motivation for Treatment	Importance of being confronted by other group members	.399[f]	.032*
Motivation for Treatment	Importance of learning new relationship and communication skills	.401[e]	.034*
Motivation for Treatment	Comfort helping others in group	.381[f]	.041*

Note. N = 31. [a]n =15. [b]n = 22. [c]n = 26. [d]n = 27. [e]n = 28. [f]n = 29. [g]n = 30.
*$p < .05$. **$p < .01$.

Table 16

Demographic Characteristics of Respondents Who Received an Incentive Versus Those Who Did Not Receive an Incentive

	No Incentive (n = 15)		Incentive (n = 16)	
Item	*M*	*SD*	*M*	*SD*
Age	48.14	14.03	42.06	13.80
Number of Sexual Offense Convictions	1.53	0.64	1.75	1.39
Age at First Sexual Offense Conviction	28.79	11.64	29.38	12.85
Total Hands-On Sexual Offense Convictions	1.00	1.00	0.69	0.60
Total Non-Contact Sexual Offense Convictions	0.73	0.88	1.38	2.06
Number of Months in Current Treatment Program	13.64	10.40	7.72	6.60
Number of Group Sessions	83.14	60.64	61.00	52.35
Number of Individual Sessions	9.23	6.37	5.30	5.29
Number of Months in Prior Community-Based Treatment	5.80	5.72	9.29	5.62
Number of Months in Prior Prison-Based Treatment	1.00	-	9.33	4.62

(continued)

Ethnicity	No Incentive	Incentive
African-American	28.6	18.8
Asian-Pacific Islander	0.0	0.0
Caucasian	42.9	43.8
Hispanic/Latino	21.4	18.8
Multiracial	7.1	0.0
Native American/American Indian	0.0	18.8
Marital Status	**No Incentive**	**Incentive**
Single, not in a committed relationship	28.6	60.0
Single, in a committed relationship	14.3	6.7
Currently married	14.3	6.7
Never married	0.0	6.7
Separated	7.1	13.3
Divorced	35.7	6.7

(continued)

Sexual Orientation	No Incentive	Incentive
Bisexual	0.0	0.0
Hetersexual	93.3	87.5
Gay	6.7	12.5

Education	No Incentive	Incentive
Less than High School Diploma	21.4	25.8
High School Diploma or GED	12.9	12.9
Some College	35.7	12.5
Associate's Degree	0.0	0.0
Bachelor's Degree	14.3	12.5
Master's Degree	0.0	0.0
Doctorate or Professional Degree	0.0	0.0

(continued)

Offense Jurisdiction	No Incentive	Incentive
Federal	26.7	0.0
State	73.3	100.0
Current Mental Health Treatment	**No Incentive**	**Incentive**
Yes	46.7	0.0
No	53.3	100.0
Prior Mental Health Treatment	**No Incentive**	**Incentive**
Yes	46.7	25.0
No	53.3	75.0

(continued)

Current Substance Abuse Treatment	No Incentive	Incentive
Yes	0	0
No	100	100

Prior Substance Abuse Treatment	No Incentive	Incentive
Yes	13.3	18.8
No	86.7	81.3

APPENDIX A

Literature Spreadsheet

Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. Criminal Justice and Behavior, 17(1), 19-52.	The objective is to outline the principles of risk, need, responsivity, and professional override using a case illustration.	N/A	N/A	Literature review; theoretical	The two aspects of the risk principle are prediction and matching. Statistical methods of prediction are more accurate than clinical predictions; future research should focus on refining risk assessment instruments and exploring the upper limits of predictive accuracy. Matching refers to increasing predictive accuracy through consideration of personal, interpersonal, and circumstantial variables. The risk principle states that higher levels of service should be reserved for higher risk cases. The need principle proposes that the targets of service should be matched to the criminogenic needs of the offender. Criminogenic needs are determined by identifying dynamic risk factors, such as antisocial attitudes, problems in school and home functioning, and drug abuse. Future research should focus on the development of psychometric assessment measures to determine criminogenic needs. Lastly, the responsivity principle focuses on the offender's responsivity to different treatment styles and modes of intervention.

(continued)

Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention? *Criminal Justice and Behavior, 38*(7), 735-755. doi:10.1177/0093854811406356	Seeks to compare and contrast the good lives model and the risk-need-responsivity model in sex offender rehabilitation and crime prevention.	N/A	N/A	Literature review	Reviews the basic premises of the risk-need-responsivity model and the good lives model, and determines that the primary difference between the two models is the orientation. In other words, the risk-need-responsivity model focuses on avoidance goals, criminogenic needs, and deficits, while the good lives model focuses on approach goals, primary goods, and strengths. The study cited previous research that surveyed sex offender treatment programs and determined that the good lives model was more widely preferred. However, the authors suggest that the risk-need-responsivity model does not ignore the strengths and human suffering of offenders, and they maintain that the primary goal of treatment should be the reduction of criminal victimization.
Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, NJ: Prentice-Hall.	Presents a theory of human motivation based on a social cognitive perspective.	N/A	N/A	Book; theoretical	Cognitive, vicarious, self-reflective, and self-regulatory processes play a prominent role in psychosocial functioning. Cognitive, behavioral, and environmental factors influence human motivation.

(continued)

Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Barrett, M., Wilson, R. J., & Long, C. (2003). Measuring motivation to change in sexual offenders from institutional intake to community treatment. *Sexual Abuse: A Journal of Research and Treatment, 15*(4), 269-283. doi: 10.1177/107906320301500404	Seeks to better understand the dynamic nature of motivation in community versus institutional treatment environments.	101 federally sentenced male sex offenders on conditional release in Toronto, Canada; drawn from 2 community-based treatment programs: a structured program at psychiatric hospital and a relapse prevention and maintenance program; all participants were previously involved in institutional treatment	Rapid Risk Assessment for Sex Offender Recidivism (RRASOR) Psychopathy Checklist-Revised (PCL-R) General Statistical Information on Recidivism Scale (GSIR) Level of Service Inventory-Revised (LSI-R) Goal Attainment Scaling protocol (GAS)	Correlational	Motivation is a dynamic variable that fluctuates over the course of treatment. Motivation increased significantly from institutional assessment to institutional posttreatment. These results suggest that institutional treatment impacts motivation, but may be biased due to the desire of offenders to achieve conditional release. Motivation decreased upon release to community, which could be due to new groups and treatment providers. Although motivation at institutional posttreatment was not maintained in the community, motivation remained higher than at institutional assessment. Some motivational levels increase following community treatment, but levels at institutional posttreatment were not recovered. These results suggest that environmental variables impact motivation. Of note, paraphilic offenders had lower motivation, and were considered high recidivism risk based on prior studies.

(continued)

Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Barbaree, H. (1997). Evaluating treatment efficacy with sexual offenders: The insensitivity of recidivism studies to treatment effects. *Sexual Abuse: A Journal of Research and Treatment, 9*(2), 111-128. doi: 10.1177/107906329700900204	Are Type II errors resulting from insensitive statistical analyses and poorly developed studies responsible for prior findings that institutional treatment does not reduce recidivism?	N/A	N/A	Meta-analytic	Institutional treatment reduces recidivism. Prior studies that have concluded that institutional treatment is unsuccessful have had small sample sizes, making them incapable of detecting a treatment effect unless it is very large. Increasing the N size to at least 150-200 participants in future studies is recommended.
Barbaree, H. E., Langton, C. M., Blanchard, R., & Cantor, J. M. (2009). Aging versus stable enduring traits as explanatory constructs in sex offender recidivism: Partitioning actuarial prediction into conceptually meaningful components. *Criminal Justice and Behavior, 36*(5), 443-465. doi: 10.1177/0093854809332283	Does a sex offender's age at release affect their likelihood for re-offending?	476 offenders in a prison treatment program in Ontario, Canada	Violence Risk Appraisal Guide Sex Offender Risk Appraisal Guide Rapid Risk Assessment of Sexual Offense Recidivism Static-99 Minnesota Sex Offender Screening Test	Correlational	Most actuarial items in assessment instruments were correlated with the age of offenders at the time of their release. Items that reflected aspects of antisocial behavior were negatively correlated with age at release; items that reflected sexual deviance were positively correlated. Overall, younger age at the time of release plus presence of antisocial traits predicts higher likelihood to recidivate. When the effect of age was removed, antisocial traits were less predictive of recidivism, while sexual deviance was more predictive.

(continued)

Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Beech, A. R., & Hamilton-Giachritsis, C. E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment, 17*(2), 127-140. doi: 10.1177/107906320501700204	How does the therapeutic climate relate to group treatment outcome?	88 men convicted of serious sexual offenses in a prison in the United Kingdom.	Group Environment Scale (GES) Victim Empathy Distortion Scale Cognitive Distortions Scale Emotional Identification with Children	Correlational	No relationship was found between treatment length and outcome. No relationship was found between mix of sexual offenders within groups (i.e., offenders with child versus adult victims) and outcome. Leaders viewed groups more positively than members. Leader Support related to Cohesion and Expressiveness; Leader Control related to Anger and Aggression. Cohesion and Expressiveness account for 40% of variance in treatment effectiveness and reduction in pro-offending attitudes.
Bolen, R., & Scannapieco, M. (1999). Prevalence of child sexual abuse: A corrective meta-analysis. *Social Service Review, 73*, 281-313.	What are the prevalence rates for child sexual abuse?	22 reviews dating 1980 to 1998 that used random sampling and represented a North American adult population	N/A	Meta-analytic	Thirteen percent of all male children in the United States are sexually abused, while 30 to 40% of female children are sexually abused.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Cicchetti, D. V. (1994). Guidelines, criteria, and rules of thumb for evaluating normed and standardized assessment instruments in psychology. *Psychological Assessment, 6*, 284-290. doi:10.1037/1040-3590.6.4.284	Outlines guidelines for normed and standardized assessment instruments.	N/A	N/A	Literature review	Assessments should be standardized based on age, gender, education, occupation, and geographic region. If standardized appropriately, norms can be determined for the interpretation of assessments by developing standard scores. Test reliability should be calculated, including internal consistency reliability, test-retest reliability, and interexaminer reliability. A coefficient alpha under .70 is unacceptable; between .70 and .79 is fair; between .80 and .89 is good; and above .90 is excellent. Also consider content validity, face validity, discriminant validity, clinical validity, concurrent validity, factorial validity, and criterion validity.
Doren, D. M. (2004). *Bibliography of published works relative to risk assessment for sexual offenders.* Retrieved from: http://www.atsa.com/pdfs/riskAssessmentBiblio.pdf	The objective was to compile a list of research related to sex offender risk assessment.	N/A	N/A	Literature review	Risk assessment measures include the Rapid Risk Assessment of Sexual Offense Recidivism, Static-99 and Static-2002, Minnesota Sex Offender Screening Test, Minnesota Sex Offender Screening Test-Revised, Sex Offender Risk Appraisal Guide, Violence Risk Appraisal Guide, Sex Offender Needs Assessment Rating, Vermont Assessment of Sex Offender Risk, Sexual Violence Risk-20 and Risk for Sexual Violence Protocol.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Duwe, G., & Goldman, R. A. (2009). The impact of prison-based treatment on sex offender recidivism: Evidence from Minnesota. *Sexual Abuse: A Journal of Research and Treatment, 21*(3), 279-307. doi: 10.1177/1079063209338490	Is prison-based treatment effective?	Treated sex offenders (N=1020) Untreated sex offenders (N=1020)	N/A	Quasi-experimental	Treated offenders had lower recidivism rates (sexual, violent, and general). The best outcomes were seen in offenders who had completed treatment or successfully participated until their release. Treated offenders had 15% decreased risk for any offense as compared to untreated offenders.
Frost, A., Ware, J., & Boer, D. P. (2009). An integrated groupwork methodology for working with sex offenders. *Journal of Sexual Aggression, 15*(1), 21-38. doi: 10.1080/13552600802593535	What are factors of successful group therapy for sex offenders?	N/A	N/A	Literature review	Group must provide an environment conducive to openness, directness, and honesty to promote self-disclosure. Group must provide environment conducive to addressing interpersonal relationships. Therapeutic environment must be based on trust, acceptance, and inclusion, countering feelings of shame, alienation, helplessness, isolation. Successful factors include group cohesiveness, universality, instilation of hope, reality testing, dynamic interpersonal learning, altruism, emotional catharsis, and orientation to the here-and-now. Successful therapist factors include flexibility, interpersonal warmth and empathy, encouragement, genuineness, and a "humanistic approach versus authoritarian expert-driven rigidity."

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Garrett, T., Oliver, C., Wilcox, D. T., & Middleton, D. (2003). Who cares? The views of sexual offenders about the group treatment they receive. *Sexual Abuse: A Journal of Research and Treatment, 15*(4), 323-338. doi: 1079-0632/03/10000323/0	How do sex offenders view their treatment? The objective is to inform future treatment programs.	42 sex offenders at the end of their outpatient treatment group at Reaside Clinic (N=13) and West Midlands Probation Service (N=29)	Investigator-designed questionnaire with items related to general experiences of the group and views about the content of the group.	Descriptive	Offenders had an overall positive experience of their group therapy, and they reported an ability to recall issues addressed and reported that group enhanced their understanding of their offense. Offenders suggested more time be spent on discussing motivation to offend and victim issues. Most experienced their therapists as supportive, but more research is needed about group leaders' attitudes toward offenders.
Hanson, R. K. (2000). Will they do it again? Predicting sex-offense recidivism. *Current Directions in Psychological Science, 9*(3), 106-109. doi: 10.1111/1467-8721.00071	The objective is to briefly review the literature on the prediction of sexual recidivism.	N/A	N/A	Literature review	No single factor is sufficiently diagnostic in the prediction of sex-offense recidivism. It is valuable to understand both static and dynamic factors as they relate to assessment, prediction, and treatment.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Hanson, R. K. (2006). Stability and change: Dynamic risk factors for sexual offenders. In W.L. Marshall, Y. Fernandez & L. Marshall (Eds.), *Sexual Offender Treatment: Controversial Issues.* (pp. 17-31). Hoboken, NY: Wiley.	The objective was to review the literature related to dynamic risk factors.	N/A	N/A	Book chapter; literature review	Static risk factors are unchangeable and include age, prior offenses, and early childhood experiences. Dynamic risk factors are changeable and can be broken down into stable and acute factors. Stable risk factors (i.e., criminogenic needs and causal psychological risk factors) include factors such as intimacy deficits and sexual self-regulation; they are the most appropriate treatment targets. Acute factors (i.e., triggering events and contextual risk factors) include factors such as subjective stress and intoxication. Dynamic risk factors that are highly associated with sexual recidivism include deviant sexual interests and antisocial personality characteristics.
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), 87-96. doi: 10.1037/h0087220	Are there differences in rates of recidivism among treated and untreated sex offenders that suggest treatment effectiveness?	Treated (N=403) and untreated (N=321) sex offenders released between 1980 and 1992; Canadian	Static-2002 (used to control for pre-existing differences)	Quasi-experimental	Treatment was no more effective than no treatment. Suggests that future studies control for cohort effects (i.e., follow-up time, year of release, and static risk factors).

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Hanson, R. K., & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*(2), 348-362. doi: 10.1037/0022-006X.66.2.348	What are the factors that predict recidivism among sex offenders?	87 documents representing 61 studies (30 United States, 16 Canada, 10 Untied Kingdom, 2 Australia, 2 Denmark, 1 Norway); data from 28,972 sexual offenders	N/A	Meta-analytic	Approximately 13.4 % of convicted offenders will sexually recidivate within 4-5 years of being released from prison. The following factors predict sexual recidivism: demographic variables, including young age, single marital status, employment instability, and low social class; criminal lifestyle variables, including antisocial personality disorder and number of prior offenses; sexual criminal history variables, including victims who were strangers, males, or extra familial, earlier age at first offense, and diverse sexual crimes; sexual deviancy variables, including sexual interest in children, particularly boys, other deviant sexual interest, and high MF scale on the MMPI-2; failure to complete treatment; and negative relationship with mother. The most highly predictive factors were criminal lifestyle and antisocial orientation, sexual deviance, and acute psychological maladjustment. Denial, low treatment motivation, being sexual abused as a child, general psychological problems, and alcohol abuse were not predictors.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report on the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 169-194. doi: 10.1023/A:1014624315814	Is sex offender treatment effective in reducing recidivism rates?	43 studies; combined N=9,454 All studies compared recidivism rates of treated sex offenders with a comparison group	N/A	Meta-analytic	Treated offenders had lower rates of recidivism than offenders who had no psychological treatment. On average, sex offenders who had completed treatment had a 12.3% sex offense recidivism rate; sex offenders who had not completed treatment had a 16.8% recidivism rate. Treatments before 1980 had little effect in reducing recidivism; outcome studies that have included treatment from before 1980 have found little efficacy in psychological treatment.
Hanson, R. K., & Harris, A. J. R. (2000). Where should we intervene?: Dynamic predictors of sexual offense recidivism. *Criminal Justice and Behavior, 27*(6), 6-35. doi: 10.1177/0093854800027001002	What dynamic risk factors are most often associated with sexual recidivism and should, therefore, be a focus of intervention?	208 recidivists and 201 non-recidivists	Interviews with community supervision officers; file reviews	Causal-comparative	Static dynamic factors include age, low intelligence, criminal lifestyle, diverse victims, difficult early family background, treatment failures, poor reentry planning, antisocial personality, chaotic lifestyle, substance abuse, lack of cooperation with supervision, entitlement to express sexual drive, viewing oneself as low risk, use of justification, disengagement in treatment, intimacy difficulties, emotional identification with children, and poor social support. Acute factors include anger and decreased mood prior to the offense.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Hanson, R. K., & Morton-Bourgon, K. E. (2004). *Predictors of sexual recidivism: An updated meta-analysis 2004-02.* Retrieved from www.publicsafety.gc.ca/res/cor/rep/_fl/**2004-02**-pred-se-eng.pdf.	What variables can be used to predict sexual recidivism?	153 documents that included a sample of adult and adolescent sex offenders. Retrospective studies and studies that used broad definitions of failures were excluded.	N/A	Meta-analytic	Factors related to recidivism included non-contact offenses, deviant sexual interests, antisocial traits, antisocial lifestyle, lack of cooperation with supervision, intimacy deficits, and emotionally identifying with children. Factors not related to recidivism included social skills deficits, childhood environment, child sexual abuse, denial, and motivation.
Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*(6), 1154-1163. doi: 10.1037/0022-006X.73.6.1154	What characterological variables best predict sexual recidivism?	29,450 sexual offenders from 82 recidivism studies (35 USA, 26 Canada, 12 UK, 2 Austria, 2 Sweden, 2 Australia, 1 France, 1 the Netherlands, 1 Denmark)	N/A	Meta-analytic	Offenders were more likely to recidivate for a nonsexual offense than a sexual offense. Antisocial orientation (i.e., antisocial personality, and history of rule violation) were most predictive of general and violent recidivism. Sexual deviancy (i.e., emotional identification with children), conflicts in intimate relationships, and antisocial orientation were major predictors for sexual recidivism. "The prototypic sexual recidivist is not upset or lonely; instead, he leads an unstable, antisocial lifestyle and ruminates on sexually deviant themes."

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Hanson, R. K., Steffy, P. A., & Gauthier, R. (1993). Long-term recidivism of child molesters. *Journal of Consulting and Clinical Psychology, 61*(4), 646-652. doi: 10.1037/0022.006X.61.4.646	What are the long-term sexual recidivism rates of male child molesters?	106 child molesters treated in southern Ontario between 1965 and 1973 Victim type: 28% extrafamilial boys 42% extrafamilial girls 18% incest with girls 10% boys and girls 1% unknown	RCPM records were used to identify individuals in the sample who had sexually re-offended. As part of the treatment program, each participant completed the MMPI-2, Eysenck Personality Inventory, Lykken Anxiety Scales, Fenz Anxiety Scales, & Internal-External (I-E) Locus of Control Scale	Descriptive; archival	A total of 42% of the sample recidivated. The follow up period was either 20 years or 28 years. For the first 6 years, 5.2% recidivated per year, then 1.8% per year thereafter; 23% of recidivists were convicted more than 10 years after release. There was little relationship between personality inventories and recidivism. The study concluded that between 30% and 40% will sexually recidivate within 20 years of release.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Harris, A. J. (2006). Risk assessment and sex offender community supervision: A context-specific framework. *Federal Probation, 70*(2), 36-43. Retrieved from http://content.ebscohost.com.lib.pepperdine.edu/pdf18_21/pdf/2006/FEP/01Sep06/24036749.pdf?T=P&P=AN&K=24036749&S=R&D=a9h&EbscoContent=dGJyMNLr40SeprU4v%2BvlOLCmr0qep7NSs624S6%2BWxWXS&ContentCustomer=dGJyMPGuslCuqLFQuePfgeyx44Dt6fIA	Reviews the current state of sex offender risk assessment knowledge and practice. Outlines a framework for aligning risk assessment with the goals and challenges of community supervision.	N/A	N/A	Literature review; theoretical	Dimensions of community supervision include primary orientation, risk emphasis, risk factors, primary method, and frequency of assessment. The primary orientation distinguishes between a nomothetic approach and an ideographic approach. Communicating risk can be accomplished using a prediction-oriented style and a management-oriented style, which can be associated with actuarial methods and clinical methods, respectively. Risk factors are divided into stable and dynamic factors. In terms of the primary method of risk assessment, the author suggests blending actuarial and clinical methods. The frequency of assessment differs between the assessment of static factors, which can be assessed once, and dynamic factors, which can be gauged throughout treatment.
Isaac, S. & Michael, W. B. (1997). *Handbook in research and evaluation: For education and the behavioral sciences* (3rd ed.). San Diego, CA: Educational and Industrial Testing Services.	Identifies basic standards and procedures for research in the behavioral sciences.	N/A	N/A	Book; literature review	In a descriptive and exploratory study, a sample size of 30 is sufficient to provide feedback.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Israel, G. D. (1992). Determining sample size. *University of Florida, Institute of Food and Agricultural Sciences Extension.* Retrieved from http://edis.ifas.ufl.edu/pdffiles/PD/PD00600.pdf	Identifies several factors that influence appropriate sample size.	N/A	N/A	Literature review	To determine the sample size, three criteria should be specified, including level of precision, confidence level, and degree of variability. Published tables exist which outline the appropriate sample size based on the size of the population. Considerations should also be made as to the data analyses performed. Any sample size can suffice in the use of descriptive statistics.
Jennings, J. L., & Sawyer, S. (2003). Principles and techniques for maximizing the effectiveness of group therapy with sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 15*(4), 251-267. doi: 10.1177/107906320301500403	What techniques increase the effectiveness of group therapy for sex offenders?	N/A	N/A	Literature review	Group therapy is the treatment of choice for sex offenders. General techniques that increase effectiveness include drawing attention to interaction between members, emphasizing shared emotional experiences, consistently using "group" language, redirecting one-to-one communications to address the whole group, and demonstrating active engagement through nonverbal communication. Techniques specific to male groups include tempering immediate confrontation, confrontation with acceptance and without humiliation, reframing bad behavior as skill-deficits, reframing hyper-masculine displays as fear-control and esteem-protection, and encouraging confrontation by peers.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Kroner, D. G., Mills, J. F., Reitzel, L. R., Dow, E., Aufderheide, D. H., & Railey, M. G. (2007). Directions for violence and sexual risk assessment in correctional psychology. *Criminal Justice and Behavior, 34*(7), 906-918. doi: 10.1177/0093854807301559	Outlines directions for future research related to risk assessment.	N/A	N/A	Literature review	The most commonly used risk assessment measures are the Static-99, RRASOR, MnSOST-R, and SVR-20. Although many risk assessment measures evaluate static factors to predict the likelihood that one will offend again, there has been a strong movement toward including both static and dynamic factors in risk assessment, and is therefore, a priority for future risk assessment research.
Laws, R. D. (1989). *Relapse prevention with sex offenders*. New York, NY: Guilford Press.	Reviews the literature related to the application of relapse prevention techniques to sex offender rehabilitation.	N/A	N/A	Book; literature review	Outlines the modification of relapse prevention in work with sex offenders. The primary problem areas in working with sexual offenders are high risk situations, the sequence of relapse, immediate gratification, and the abstinence violation effect. Best practices in the assessment of risk factors include use of clinical interviews, record analysis, client autobiographies, situational competency tests, self-efficacy ratings, and relapse fantasy analysis to identify coping mechanisms. Skills-building interventions for work with sex offenders include relapse rehearsal, cognitive restructuring, and strategies for coping with urges.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Laws, R. D. (2003). The rise and fall of relapse prevention. *Australian Psychologist, 38*(1), 22-30. doi:10.1080/00050060310001706987	Reviews the history and development of sex offender treatment and the use of the relapse prevention model.	N/A	N/A	Literature review	Relapse prevention literature emerged in the 1960's and was eventually identified as a mainstream cognitive-behavioral treatment. In the 1990's the model was modified for use with sex offenders, and focused primarily on identifying high risk situations and developing adaptive coping responses to maintain abstinence. However, there is not evidentiary support for the effectiveness of the model with sex offenders; thus, revisions have been identified. The self-regulation model of sexual offending was identified, the offense chain model was modified for more fluidity, and harm reduction and public health approaches have emerged.
Levenson, J. S., & Macgowan, M. J. (2004). Engagement, denial, and treatment progress among sex offenders in group therapy. *Sexual Abuse: A Journal of Research and Treatment, 16*(1), 49-63. doi: 10.1177/107906320401600104	What is the nature of the relationship between engagement, denial, and treatment progress in group treatment for sex offenders?	Nonrandom sample of 61 males from an outpatient center in South Florida Most between 36-49 years old	Sex Offender Treatment Rating Scale Group Engagement Measure Facets of Sex Offender Denial	Correlational	Treatment progress was correlated with higher levels of engagement and lower levels of denial. Engagement and denial were negatively associated with each other. Engagement and denial explained variance in treatment progress, suggesting that they interact, in that denial causes an inability or unwillingness to engage and/or engagement allows offenders to let go of denial. Overall, less denial and more engagement increase treatment progress.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
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*(1), 35-56. doi: 10.1177/1079063208326072	How do offenders perceive treatment components?	Nonrandom sample (N=338) of court mandated male sex offenders from three long-term outpatient treatment programs in Florida and Minnesota.	Author-developed satisfaction survey regarding perceptions of treatment content and process, satisfaction with treatment components, specific aspects of the program, demographics, & a checklist of items to which they would like the program to pay more attention. Group Engagement Measure	Descriptive	Clients perceived cognitive-behavioral techniques to be helpful, particularly focused on accountability and victim empathy. Additional content rated as helpful included thinking errors, relapse prevention concepts, exploring motivation to offend, and deviant arousal control. Learning how to meet needs in adaptive ways and creating more satisfying lives for themselves were viewed as important. Communication and relationship skills were rated less important, and identified as a topic that needed more time in therapy. The experience of sharing with others in group therapy was valued for the support and peer confrontation aspects. Most found therapists non-judgmental and supportive, felt that they were treated with respect, and thought the program policies and procedures were reasonable. Cost of treatment was a concern, as many participants were underemployed. GEM scores suggest that members were relatively engaged; engagement and satisfaction were correlated.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Levenson, J. S., Prescott, D. S., & D'Amora, D. A. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology, 54*(3), 307-326. doi: 10.1177/0306624X08328752	What are offenders' perceptions regarding overall experience of therapy, importance of treatment components, satisfaction with services, and engagement?	Nonrandom sample of adult male sex offenders (N=88) in an outpatient treatment facility in Connecticut.	Author-developed survey related to content importance; group process; satisfaction with content, group therapists, policies and procedures, and overall satisfaction. Group Engagement Measure	Descriptive	Clients perceived treatment components focusing on thinking errors, triggers, and offense patterns as having the most utility. Additional factors identified as having utility included development of deviant behavior, motivation to offend, how to meet needs in more adaptive ways, and creating more rewarding lives for themselves; these factors support the Good Lives model. Accountability and victim empathy were perceived as most important in preventing recidivism. Perceived importance of components and satisfaction with treatment were correlated. Most clients were well-engaged; engagement and satisfaction were correlated.
Levenson, J. S., & Prescott, D. S. (2009). Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse: A Journal of Research and Treatment, 21*(1), 6-20. doi: 10.1177/1079063208325205	What are the aspects of treatment viewed by offenders to be the most helpful in preventing reoffense?	Civilly committed adult male sex offenders in a long-term, secure inpatient facility in Wisconsin (N=44)	A modification of a prior survey (Garrett, 2003) that rates content, process, therapists, rules, and completion requirements.	Descriptive	Clients felt the program was too long, and expectations for completion were unclear. The most important components of treatment were relating to others in a meaningful way, learning social skills and conflict resolution, accountability and victim impact, thinking errors, offense patterns, triggers and risk factors, grooming, deviant arousal management, meeting needs in healthy ways, and creating more satisfying lives for themselves.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Mann, R. E. (2000). Managing resistance and rebellion in relapse prevention intervention. In D. R. Laws, S. M. Hudson & T. Ward (Eds.), *Remaking relapse prevention with sex offenders* (pp. 187-200). Thousand Oaks, CA: Sage.	In what ways can mandated treatment fail to engage sex offenders? What strategies can clinicians use to overcome resistance and engage sex offenders in treatment?	N/A	N/A	Book chapter; literature review	For relapse prevention treatment to be successful, the sex offender must have the goal to avoid relapsing and buy into the assumption of the model that lapses are inevitable and that self-management is the only way to control them. If the offender does not share in these criteria, treatment is likely to be unsuccessful, and the offender is likely to be resistant to treatment. To avoid resistance, the goals of treatment can be reframed from the avoidance goal of not reoffending to the approach goal of becoming someone who lives a satisfying life and is respectful of others. Goals should be intrinsically important to the client, and should not be imposed on him. Encouraging a learning orientation rather than an achievement orientation may decrease the likelihood that the client will give up easily. Balance instilling confidence in offenders and managing overconfidence by instilling realistic expectations. Use motivational interviewing with resistant clients.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Marshall, W. L., Ward, T., Mann, R. E., Moulden, H., Fernandez, Y. M., Serran, G., & Marshall, L. E. (2005). Working positively with sexual offenders: Maximizing the effectiveness of treatment. *Journal of Interpersonal Violence, 20*(9), 1096-1114. doi: 10.1177/0886260505278514	What are specific strength-based techniques for maximizing the effects of sex offender treatment?	N/A	N/A	Literature review	The two basic models of sex offender treatment focus on risk management (Risk Needs Responsivity) and increasing skills to enhance offender's adaptability and well-being (Good Lives). Correctional facilities have historically focused on risk management, but could benefit from a shift toward more strength-based approaches. The Good Lives Model poses that humans naturally seek primary goods, including goods of the body (i.e., sex, food, warmth, water, sleep), goods of the self (i.e., autonomy, relatedness, competence), and goods of the social life (i.e., social support, family life, meaningful work, recreational activities). A conception of a good life is to be collaboratively determined for the individual offender (i.e., the offender weights specific primary goods), and a general plan is adapted, taking into account his or her specific capabilities. Features of the Good Lives approach include instilment of hope, enhancement of self-esteem, emphasis on approach goals, collaboration, and a non-confrontational, yet challenging therapist.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment, 17*(2), 109-116. doi: 10.1007/s11194-005-4598-6	What therapist characteristics are related to changes in treatment among sex offenders?	N/A	N/A	Literature review	Treatment success is related to empathy, warmth, directiveness, flexibility, as opposed to rigidly manualized treatment, and provision of rewards for progress, including verbal encouragement, and arrange for rewards outside of treatment to promote generalization.
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 and Treatment, 17*(1), 79-107. doi: 10.1007/s11194-005-1212-x	Does treatment decrease risk for reoffending?	N=704; treatment condition (N=259), volunteer control condition (N=225), non-volunteer control condition (N=220)	SOTEP's motivational questionnaire Phallometric assessment of deviant sexual interests Multiphasic Sex Inventory (MSI) Clinician ratings of participant performance, posttreatment	Randomized controlled trial	Treatment was no more effective than no treatment in reducing sexual recidivism. The results may be reflective of the researcher's willingness to keep unmotivated and unengaged individuals in the treatment group to avoid a high attrition rate. Recommendations to increase the effectiveness of treatment included increasing attention to motivation and more individualized treatment, as opposed to manualized treatment.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Mercado, C. C., & Ogloff, J. R. P. (2007). Risk and the preventive detention of sex offenders in Australia and the United States. *International Journal of Law and Psychiatry, 30*(1), 49-59. doi: 10.1016/j.ijlp.2006.02.001	The purpose is to review the current research knowledge related to the accuracy of risk assessment tools in light of statutory schemes that allow sex offenders to be detained beyond the expiration of their prison sentence based on these assessments results.	N/A	N/A	Literature review	Overall, existing assessment tools have sound support and it is recommended that courts continue to use these measures to inform sentencing decisions. The expertise of the psychiatrists and psychologists who administer tests should be verified before using such results to inform the courts. Additional research is needed to improve the external validity of existing assessments and take into account diverse contexts.
Moster, A., Wnuk, D. W., & Jeglic, E. L. (2008). Cognitive behavioral therapy interventions with sex offenders. *Journal of Correctional Health Care, 14*(2), 109-121. doi: 10.1177/1078345807313874	The objective was to review the literature related to treatment of sex offenders with particular emphasis on cognitive behavioral interventions.	N/A	N/A	Literature review	Sex offender treatment most commonly utilizes cognitive behavioral interventions. Cognitive distortion interventions explain the role of deviant thoughts in sexual offending, and focus on the modification of inappropriate thoughts. Emotion management interventions help clients identify emotions that put them at risk for offending. Interpersonal skills interventions address intimacy, attachment deficits, and self-esteem. Empathy deficit interventions focus on victim issues and remorse. Deviant sexual interest interventions include sensitization; masturbatory satiation and verbal satiation. Relapse prevention and self-management are also a focus.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
National Center for Missing and Exploited Children (2010). *Map of registered sex offenders in the United States*. Retrieved from http://www.missingkids.com/en_US/documents/sex-offender-map.pdf	How many registered sex offenders reside in the United States?	N/A	N/A	Descriptive	In 2010, there were 716,750 registered sex offenders residing in the United States.
Nunes, K. L., & Cortoni, F. (2008). Dropout from sex-offender treatment and dimensions of risk of sexual recidivism. *Criminal Justice and Behavior, 35*(1), 24-33. doi: 10.1177/0093854807309037	Is dropout from sex offender treatment programs correlated with general criminality and sexual deviance?	Randomly selected Canadian, non-Aboriginal male sex offenders who dropped out or were expelled from treatment (N=52), and who completed a treatment program (N=48)	Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR) Static-99	Correlational	General criminality is associated with higher dropout rates, but sexual deviance is not, even when separating out child molesters. Risk for sexual recidivism is not synonymous with risk for dropout or expulsion from treatment. Sex offenders with high risk for sexual recidivism usually have both sexual deviance and general criminality factors. Offenders with high general criminality might benefit from assignment to a pretreatment motivational intervention.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Petersilia, J. (2003). *When prisoners come home: Parole and prisoner reentry.* New York, New York: Oxford University Press.	In what ways could prison and parole practices be reformed in order to increase successful rehabilitation and decrease recidivism?	N/A	N/A	Book; literature review; theoretical	Elements of effective programs include therapeutic communities for substance abusers, cognitive behavioral treatment for sex offenders, adult education, vocational training, and prison industries. England's Rehabilitation of Offenders Act is a model for the expiration of criminal history for those who do not recidivate after 2.5 years; those who do not recidivate are restored to complete citizenship. More family support is correlated with lower recidivism; thus, visitation should be encouraged.
Pithers, W. D., & Cumming, G. F. (1995). Relapse prevention: A method for enhancing behavioral self-management and external supervision of the sexual aggressor. In B. K. Schwartz & H. R. Cellini (Eds.),*The sex offender: Corrections, treatment and legal practice* (pp. 20.1-20.32). Kingston, NJ: Civic Research Institute.	Reviews the literature related to the relapse prevention model and application of the model.	N/A	N/A	Book chapter; literature review	Relapse prevention focuses on risk factors associated with relapse, including high-risk situations and seemingly unimportant decisions, the difference between a lapse and a relapse, and the self-management and supervisory dimensions of the model. Interventions associated with avoiding a lapse include the identification of offense precursors, stimulus control procedures, avoidance strategies, escape strategies, programmed coping responses, coping with urges, and skill building interventions. Strategies to prevent a lapse from becoming a relapse include cognitive restructuring, contracting, and maintenance manuals.

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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*(6), 635-659.	What are some of the sources of the variability of sexual recidivism rates? Is recidivism a function of (a) changes in the domain of criminal offenses that are considered at outcome, (b) changes in the dispositional definition of reoffense (charge, conviction, or imprisonment), and/or (c) changes in the length of exposure time?	265 male sexual offenders committed to the a treatment center for sexually dangerous persons who were released between 1959 and 1985	Official data sources were used to gather information about criminal records including the Massachusetts Board of Probation, Massachusetts Parole Board, Massachusetts Department of Public Safety, Bureau of Identification (State Police), Department of Correction Research Department, Massachusetts Treatment Center Authorized Absence Program, and Federal Bureau of Investigation.	Descriptive; archival	Regarding changes in the domain of criminal offense, 39% of rapists recidivated with new sexual offenses and 74% with any new offense; for child molesters, 52% recidivated with a new sexual offense and 75% with any new offense. In terms of disposition of criminal offense, of rapists who were known to have committed a new sexual offense, 39% were charged, 24% were convicted, and 19% were imprisoned; for child molesters, charges, convictions, and imprisonment were 52%, 41%, and 37%, respectively. In terms of exposure time, 9% of rapists recidivated for sexual charges within the first year, 2-3% per year through fifth year, and then 1% per year until the twenty-fifth year; total new cases within 25 years was 39%. For child molesters, 6% recidivated for sexual charges within the first year, 4% for the next two years, and two to three for the following two years; total new cases within 25 years was 52%. Child molesters outpaced rapists after year five.

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Schaffer, M., Jeglic, E. L., Moster, A., & Wnuk, D. (2010). Cognitive-behavioral therapy in the treatment and management of sex offenders. Journal of Cognitive Psychotherapy: An International Quarterly, 24(2), 92-103. doi: 10.1891/0889-8391.24.2.92	The objective is to review the literature about the Risk Need Responsivity model, the Good Lives model, and cognitive behavioral treatment interventions for sex offenders.	N/A	N/A	Literature review	The goal of the Risk Need Responsivity model is to ameliorate dynamic risk factors by tailoring treatment to client's risk level (i.e., increasing treatment intensity for higher risk offenders) and addressing skill deficits and dynamic risk factors related to offending behavior, while considering the offender's learning style, motivation, and culture. The major criticism is the focus on criminogenic needs to the exclusion of the development of prosocial and fulfilling lives. The Good Lives model helps clients identify goals and values to help motivate and enable behavior change toward a more prosocial and satisfying life. Treatment is focused on creating a more fulfilling lifestyle, which is posited to reduce recidivism. Research demonstrates that use of this approach leads to more motivation, participation, and successful changes. Both models use cognitive behavioral techniques to address cognitive distortions and schemas, emotional dysregulation, interpersonal skills deficits, deviant sexual behavior, and empathy deficits, but GLM makes client values a more central aspect of treatment.

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Sperry, L. (2004). Ethical dilemmas in the assessment of clinical outcomes. *Psychiatric Annals, 34*(2), 107-113.	Seeks to identify why otherwise ethical clinicians may engage in unethical practices related to clinical outcomes, differentiates between the three levels of clinical-outcome assessments, and discusses ethical dilemmas in the use and misuse of outcome assessments.	N/A	N/A	Literature review	Managed behavioral healthcare presents ethical dilemmas related to organizational demands. Outcome assessments are often required, and the patient satisfaction survey method of assessment is the most common, despite research that indicates patient satisfaction is not the most accurate measure of clinical outcome. Organizational dynamics, including financial obligations, expediency and efficiency, and personal versus organizational values, coupled with the focus on outcome assessment, pressure clinicians to engage in ethically questionable behavior.
Stalans, L. J., Hacker, R., & Talbot, M. E. (2010). Comparing nonviolent, other-violent, and domestic batterer sex offenders: Predictive accuracy of risk assessment on sexual recidivism. *Criminal Justice and Behavior, 37*(5), 613-628. doi: 10.1177/0093854810363794	Are there differences in recidivism rates for nonviolent, other-violent, and domestic batterer sex offenders?	846 sex offenders from 4 counties in Illinois	Illinois State Police Criminal Records and FBI reports RRASOR SACJ-Min Static-99 Static-2002	Correlational; archival	Sex offenders who were also domestic batterers had a higher rate of recidivism than nonviolent sex offenders. Sex offenders with nonsexual violent crimes had more extensive criminal history. All measures predicted recidivism among nonviolent offenders, but the Static-2002 was the only instrument that predicted recidivism among all three offender subtypes. Violent offenders who used substances before their crimes had higher risk; nonviolent offenders who did not use substances before their crime had higher risk.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Taxman, F. S., & Thanner, M. (2006). Risk, need, and responsivity (RNR): It all depends. Crime and Delinquency, 52, 28-. doi: 10.1177/0011128705281754	Outlines the development of the Risk Need Responsivity model and seeks to determine if the model (specifically, a "seamless treatment" condition) is useful in the treatment and level of participation of offenders with a drug-related instant offense.	Treated offenders with a drug-related offense (N=143) and a control group (N=51) from two sites.	Drug and alcohol tests	Quasi-experimental	RNR was developed out of research from the 1960's and 1970's by Lee Sechrest, Ted Palmer, and others. The development of risk assessment tools began in the 1920's and 1930's and focused on stable factors such as offense history, intelligence, and disciplinary history in prison. For the next 50 years, assessments relied on data found in criminal records. The Wisconsin tool was then developed and used for classification purposes, moving beyond static risk factors and realizing that dynamic factors are more amenable to change. This then led to the development of classification tools for the purpose of identifying the type and intensity of treatment appropriate for each offender in order to be most responsive to the offenders' needs that were identified by the dynamic risk factor assessment. The seamless treatment successfully increased participation of drug offenders. The seamless treatment resulted in a significant decrease in alcohol use in one site only. No other significant differences were found among treatment and control groups.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. *Aggression and Violent Behavior, 7*, 513-528. doi:10.1016/S1359-1789(01)00076-3	Defines the notion and feature of good lives, and argues that it is necessary to construct conceptualizations of good lives and utilize the conceptualizations to facilitate behavior change.	N/A	N/A	Literature review; theoretical	Offenders need to make their own choices and determinations regarding what constitutes a good life. However, there are necessary features of a good life, and all good lives are made up of primary goods. There are three classes of primary goods, which represent the minimal necessary conditions for human well-being, and include, the basic facts of the body (i.e., physiological needs), the self (i.e., establishment of the necessary psychological capabilities to function in the world), and the social life (i.e., social arrangements that help facilitate the attainment of primary goods). The goal of treatment is to gain the skills and necessary conditions to fulfill individualized primary human goods, and to counteract the influence of obstacles that prevent offenders from attaining their goals.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Ward, T., & Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. Aggression and Violent Behavior, 11, 77-94. doi: 10.1016/j.avb.2005.06.001	The objective was to develop a comprehensive theory of sex offender treatment, The Good Lives Model-Comprehensive (GLM-C), by pulling from the Integrated Theory of Sexual Offending (ITSO) and the Good Lives Model-Original (GLM-O).	N/A	N/A	Literature review; theoretical	The Good Lives Model focuses on offender context, personal agency, and therapeutic relationship. Three levels of the GLM-C include principles and values (i.e., there is a natural predisposition to seek out primary human goods); etiological assumptions (i.e., biological, ecological, and psychological); and clinical practice. Four pathways to sexual offending: *avoidant-passive* (i.e., desire to avoid, but lack adequate coping skills), *avoidant-active* (i.e., desire to avoid, but ineffective strategies are used), *approach-automatic* (i.e., desire to offend, plus impulsive behavior), *approach-explicit* (i.e., desire to offend and use of careful planning to execute offense). Offending is a result of failures in seeking primary goods: inappropriate means, lack of scope, incoherence or conflict, and lack of capacity. Risk-management and GLM-C are compatible in that dynamic risk factors are red flags that indicate difficulty in the ways in which primary human goods are sought; the offender's degree of risk indicates the severity of social and psychological problems; a Good Lives plan contains strategies for dealing with stressors, similar to a relapse prevention plan.

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Ward, T. & Hudson, S. M. (1996). Relapse prevention: A critical analysis. *Sexual Abuse: A Journal of Research and Treatment, 8*(3), 177-200. doi:10.1007/BF02256640	Critically analyzes the original relapse prevention model and the application of relapse prevention to the treatment of sexual offenders.	N/A	N/A	Literature review	Marlatt's original relapse prevention model was based on Bandura's social learning theory and applied to the treatment of addictions. Relapse prevention procedures aimed to enhance self-management skills to maintain the behavior change induced by therapy. Pithers originally applied the relapse prevention model to the rehabilitation of sex offenders. Changes in the definition of a lapse and a relapse were necessary, and the result moved the identification of a lapse farther back on the behavioral change, to account for the legal definition of a victim. Thus, a lapse is defined as a deviant sexual fantasy, rather than an act of sexual offending, which is defined as a full relapse. Additionally, Pithers puts more emphasis on skills deficits than decision-making, which is a major criticism of the model. Additional criticism includes the definition of negative affect as a high risk situation, the application of the abstinence violation effect, and that the model does not adequately address those offenders who display rigid cognitive distortions that contribute to relapse. Further elaboration on the theory and empirical research are suggested.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Ward, T., & Stewart, C. (2003). Criminogenic needs and human needs: A theoretical model. Psychology, Crime & Law, 9(2), 125-143. doi: 10.1080/1068316031000116247	Attempts to broaden the notion of "need" to encompass personal goods, as opposed to a primary focus on criminogenic needs.	N/A	N/A	Literature review; theoretical	Criminogenic needs, including pro-offending attitudes and values, aspects of antisocial personality, poor problem solving, substance abuse, hostility and anger, and criminal associates, are a subset of factors that predict recidivism. The authors criticize the sole focus on criminogenic needs in offender rehabilitation because the presence of a "need" indicates a lack or deficiency of some kind. Therefore, it would be assumed that the focus of treatment should be on the primary human goods that offenders lack, which contribute to their offending behavior. The authors suggest that needs are more broadly concerned with the attainment of personal goods that sustain and enhance an individual's life.
Willis, G. M., & Grace, R. C. (2009). Assessment of community reintegration planning for sex offenders: Poor planning predicts recidivism. *Criminal Justice and Behavior, 36*(5), 494-512. doi: 10.1177/0093854809332874	Does reintegration planning prevent recidivism of child molesters?	141 male child molesters who completed a treatment program in a New Zealand prison	Automated Sexual Recidivism Scale	Correlational	Poorer reentry planning was predictive of sexual recidivism. Those who re-offended had particularly poor planning for employment and social support. Planning for accommodation (housing), employment, and social support yielded the best reintegration outcomes.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Wilson, R. J., & Yates, P. M. (2009). Effective interventions and the Good Lives Model: Maximizing treatment gains for sexual offenders. Aggression and Violent Behavior, 14, 157-161. doi: 10.1016/j.avb.2009.01.007	The objective was to outline the Risk Needs Responsivity model and the Good Lives model and discuss the integration of the two models to maximize treatment gain.	N/A	N/A	Literature review; theoretical	The Risk Needs Responsivity (RNR) model is based on three principles. The *risk principle* states that the intensity of interventions match the level of risk posed by the offender. The *need principle* states that treatment should target those areas most related to offending (i.e., criminogenic needs). The *responsivity principle* states that treatment providers must consider the offender's characteristics in creating treatment plans and implementing interventions. RNR reduces the rates of general and sexual recidivism. The Good Lives model (GLM) posits that offenders are drawn toward fundamental human goods, but use inappropriate strategies to attain those goods. Treatment focuses on identifying important goals and developing the skills to attain those goals in non-offending ways. A focus on approach goals leads to increased engagement and a stronger therapeutic alliance. Adding GLM principles to RNR will maximize outcome by focusing on risk reduction and also ensuring consumer buy-in by attending to the overall well-being and prosocial functioning of treatment participants.

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Author/Year	Research Questions/Objectives	Sample	Instruments	Research Approach/Design	Major Findings
Wong, S. C. P., Olver, M. E., & Stockdale, K. C. (2009). The utility of dynamic and static factors in risk assessment, prediction, and treatment. In J. T. Andrade (Ed.), *Handbook of Violence Risk Assessment and Treatment: New Approaches for Mental Health Professionals* (pp. 83-120). New York, NY: Springer.	The objective is to differentiate between static and dynamic risk factors and discuss their roles in risk assessment, prediction, and treatment.	N/A	N/A	Book chapter; literature review	Static factors are unchangeable and are important factors in risk assessment. Dynamic risk factors are changeable, and are an important focus of treatment. Treatment should target dynamic factors in order to yield the most positive outcome. There is a trend toward including dynamic risk factors in risk assessments.