THE ROLE OF THE THERAPEUTIC ALLIANCE IN PSYCHOTHERAPY WITH SEXUAL OFFENDERS

by

Daniel B. Rothman

University of Manitoba

A dissertation submitted to the University of Manitoba in partial fulfillment of the requirements for the degree of Doctor of Philosophy

in the

Department of Psychology.

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirement of the degree

Doctor of Phyilosophy

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Abstract

The present study investigated which components of the therapeutic alliance were predictive of positive therapeutic outcomes in psychotherapy with a population of male sexual offenders. Measured elements of the alliance included: therapist empathy, unconditionality, positive regard, and congruence; the client-therapist bond; and client-therapist collaboration on the tasks and goals of treatment. Outcome indices included: global functioning; attainment of specific treatment goals; healthy intimacy development; and reduction in cognitive distortions. Participants were 44 men participating in either community- or institutionally-based treatment. Hierarchical regression analyses, guided by an exploratory factor analysis, indicated that the quality of the therapeutic alliance was significantly predictive of indices of treatment outcome, producing medium to large effect sizes. In particular, therapist empathy was significantly associated with most outcome indices, accounting for up to 28% of the variability in outcome. The findings were robust, and generally unaffected by ancillary variables such as risk level and treatment duration. Quantitative results were largely consistent with qualitative data, which indicated that participants attributed treatment success to factors associated with therapeutic style, instillation of hope, social connectedness, and healthy skill development. Results are consistent with the general psychotherapy literature and suggestive of a fundamental role for the therapeutic alliance in the treatment of sexual offender populations. Implications are discussed with regard to the treatment of sexual offender populations.

The Role of the Therapeutic Alliance in Psychotherapy with Sexual Offenders

The field of psychotherapy research has faced a number of challenges over its lifetime. Because it is now generally accepted that psychotherapy is efficacious, it is often forgotten that from the 1950s through to the mid-1980s a fierce debate ensued concerning whether or not psychotherapy was effective at all. This first challenge began in 1952 with the publication of a review of 24 studies which contended that the success rate of psychotherapy was no greater than the rate of spontaneous remission in the treatment of neuroses (Eysenck, 1952). The strongest proponents of this position were Hans Eysenck (1952) and S. Rachman (1971, 1977), both advocates of behavior therapy (as distinct from psychotherapy) (Wampold, 2001).

On the other side of the debate were the defenders of traditional psychotherapy, among them Saul Rosenzweig (1954), Lester Luborsky (1954), and Allen Bergin (Bergin & Lambert, 1978), who contended that Eysenck's and Rachman's claims concerning the ineffectiveness of psychotherapy were empirically flawed and that the evidence supported the efficacy of psychotherapy. Then, in 1977 Smith and Glass produced the first meta-analytic study (a study of studies in which the effect sizes of treatment, placebo and control groups in different studies are statistically combined and compared) of psychotherapy outcomes, finding that psychotherapy was remarkably beneficial and that the arguments of its critics were empirically indefensible. Subsequent analyses have supported these findings (e.g., Elkin et al, 1989; Lambert & Bergin, 1994; Lipsey & Wilson, 1993; Shapiro & Shapiro, 1982; Wampold et al., 1997). Today, the efficacy of psychotherapy in general has been firmly established and is no longer the subject of debate. Notably, the estimate of the effect size (a measure of the strength of the

relationship between two variables) produced in the early meta-analyses, distributed around .80, is a relatively large one, and has turned out to be particularly robust (Wampold, 2001).

Hundreds of studies have demonstrated that psychotherapy works better than nothing. What is not so clear, however, is whether psychotherapy works for reasons specified by theory. The emergence of managed health care and recent advances in biological psychiatry present new challenges to the field of psychotherapy. These events have created pressure for a more accurate and precise assessment of psychotherapeutic effectiveness. Many (e.g., Barlow, 1994) believe that the effectiveness of specific psychological treatments must be empirically validated to justify their use with clients and their reimbursement by insurance companies and government agencies that are demanding more accountability. Unfortunately, instead of developing a more unified model, psychotherapy is experiencing a period of conceptual-theoretical turmoil (Kopta et al, 1999). The major source of this unrest can be traced to two competing meta-models of psychotherapy: the medical model and the common factors model.

A Medical Model of Psychotherapy

As reviewed by Wampold (2001), the origins of psychotherapy can be said to lie in a medical model. Sigmund Freud (1913), in his practice as a physician, became involved in the treatment of individuals with hysteria. He believed that (a) hysteric symptoms are caused by the repression of some (real or imagined) traumatic event in the unconscious, (b) the specific nature of the symptom is related to the specific nature of the event, and (c) the symptom could be alleviated by insight into the connection between the event and the symptom. Freud experimented with and developed a number of techniques to retrieve

repressed memories including hypnosis, dream analysis and free association. Thus, from the beginnings of psychoanalysis, the basic components of the medical model were emerging: (1) a disorder (hysteria), (2) a theoretically based explanation of the disorder (repressed traumatic events), (3) a mechanism of change (insight into the unconscious), and specific therapeutic techniques applied to ameliorate the symptom (free association).

The advent of behaviorism also contributed to the emergence of the medical model of psychotherapy. Behavioral psychology developed a logical and efficient explanation of behavior based on objective observations of externally observable behavior. Pavlov's (1927) work on classical conditioning detailed, without making use of complicated mental constructs, how animals acquired a conditioned response, how the conditioned response could be extinguished, and how neurosis could be induced experimentally (Wampold, 2001). Watson and Rayner's (1920) "Little Albert" study further established that a fear response could be conditioned. It was not until years later that behavior therapy gained momentum when Joseph Wolpe (1952), who, like Freud, was a medical doctor, became dissatisfied with psychoanalysis as a method to treat his patients. Inspired by the work of Pavlov, Watson and Rayner, Wolpe studied how eating, an incompatible response to fear, could be used to reduce previously conditioned phobic reactions in cats. After studying physiologist Edmund Jacobson's (1938) work on progressive relaxation, Wolpe realized that the incompatibility of relaxation and anxiety could be used to treat anxious patients. He developed a technique as a remedy for anxiety that was called systematic desensitization, a technique that subsequently helped to popularize behavior therapy.

Although the behavioral system certainly does not share the medical, psychoanalytic "illness" conceptualization of *psychopathology* (i.e., behaviorists view

psychological problems as resulting from environmental contingencies whereas psychoanalysts view them as originating within the individual), and the explanations of anxiety proposed by the psychoanalytic and behavioral models differ considerably, structurally the two approaches are quite similar. Systematic desensitization is used to treat an identified disorder (phobic anxiety), is based on an explanation of the disorder (classical conditioning), incorporates the mechanism of change within the explanation (desensitization), and specifies the therapeutic technique necessary to effect the change (systematic desensitization). Thus, although the psychoanalytic model is dependent on psychological constructs whereas the behavioral paradigm avoids such intervening explanations, both are systems that explain maladaptive behavior and offer therapeutic procedures for reducing stress and promoting more adaptive functioning (Wampold, 2001). Both systems conform to a medical model regarding the process of treatment.

Contemporary Status of the Medical Model of Psychotherapy

It is evident that the roots of the psychotherapy are firmly planted in the medical model. It is also apparent that the psychotherapy research community continues to adhere to this meta-theory of psychotherapy. Two recent developments in psychotherapy research, psychotherapy treatment manuals and empirically supported treatments, have helped to secure the authority of the medical model.

Psychotherapy Treatment Manuals

The first treatment manual is usually accredited to Beck, Rush, Shaw, and Emery (1979), who specified a cognitive-behavioral treatment for depression. A treatment manual contains "a definitive description of the principles and techniques of [the] psychotherapy,...[and] a clear statement of the operations the therapist is supposed to

perform (Kiesler, 1994, p. 145). The purpose of a manual is to standardize the treatment, thereby reducing variability in how the procedure is carried out, and to ensure that clinicians correctly perform the specific techniques that are characteristic of the treatment's theoretical approach. Treatment manuals today have almost become required for the funding and publication of outcome research in psychotherapy (Wampold, 2001). It is evident that the treatment manual fits perfectly into the medical model of psychotherapy. The basic components of the manual – defining a disorder, providing a theoretical explanation for the disorder, providing a mechanism of change, and specifying the therapeutic technique necessary to produce change – are identical to the components of the medical model itself (Wampold, 2001).

Empirically Supported Treatments

The other major recent development in psychotherapy research is the identification of empirically supported treatments (ESTs). The emphasis in the United States in the 1990s on managed health care increased momentum to empirically validate the different psychotherapeutic approaches. This impetus has resulted in the establishment of the American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures (American Psychological Association Taskforce, 1995). Its mission has been to identify a set of criteria that characterize effective treatments and to determine which of the more than 400 therapies in existence satisfy these criteria (see Chambless & Hollon, 1998). Interestingly, another connection to the medical model is indicated by the Task Force's adoption of criteria from those used by the US Food and Drug Administration. These criteria stipulated that a treatment could be designated as empirically validated (the term was later changed to "supported") for a particular disorder

provided that at least two studies demonstrated the superiority of the treatment to control groups (groups that attempted to control for general effects) and that the treatments were administered to a well-defined population of clients (where the clients' disorder or symptoms were specified) using a treatment manual (American Psychological Association Taskforce, 1995). Notably, the list of ESTs to date is overwhelmingly dominated by behavioral treatments, serving to connect the EST movement with the medical model. As well, the identification of a disorder (often utilizing the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision - a medical text), an emphasis on treatment manuals, and the requirement of specificity (a given technique must be shown to ameliorate a specified disorder or symptom) all firmly imbed the EST movement in the medical model of psychotherapy.

Empirical Support for the Medical Model

Despite the predominance of the medical model in psychotherapy research, researchers have repeatedly failed to find convincing evidence that different psychotherapies are differentially effective. General meta-analyses continually report no differences among different types of therapies (e.g., Smith & Glass, 1977; Smith et al., 1980; Wampold et al., 1997). Occasionally, when differences are found, they disappear after methodological confounds are taken into account (Grissom, 1996; Robinson et al., 1990; Smith et al, 1980). One of the foremost of these confounds tends to be experimenter allegiance. Allegiance refers to the degree to which the therapist delivering the treatment believes that the treatment is efficacious. For example, according to these research findings, a therapist who identifies herself as behavioral in orientation would be expected to find that a group of depressed clients to which she delivers behavioral treatment

improves more than another group to which she delivers a non-behavioral form of therapy. The effect of experimenter allegiance cannot be underestimated. As observed by Luborsky et al. (1999) and Wampold (2001), in comparative psychotherapy studies where allegiance has been statistically modeled, treatment effects that had previously indicated the superiority of one treatment over another disappeared (e.g., Berman et al., 1985; Robinson et al., 1990). Although cost prohibitive and complicated to coordinate, large, multi-site, multi-experimenter design strategies (e.g., the National Institute of Mental Health Treatment for Depression Collaborative Research Program; Elkin et al., 1989) are perhaps the best individual study design strategies to control for various threats to validity such as experimenter allegiance. Although these designs are certainly not immune from criticism (e.g., Jacobson & Hollon, 1996), the conclusions that can be drawn from them set them above studies with fewer participants and less adequate designs. And significantly, the results of these studies tend to be consistent with the results of the meta-analyses investigating the same issues (Wampold, 2001).

A number of meta-analytic studies have also examined the question of whether particular psychotherapies are more efficacious for particular disorders including depression, agoraphobia, panic, generalized anxiety, social phobia, OCD, and PTSD (e.g., Abromowitz, 1996, 1997; Dobson, 1989; Chambless & Gillis, 1993; Clum et al., 1993; Mattick et al., 1990; Sherman, 1998; Taylor, 1996; van Balkom et al., 1994). With only three exceptions, these analyses have uniformly reported equivalence among the psychotherapies compared. In one of those exceptions Mattick et al., (1990) concluded that exposure treatments were superior to nonexposure treatments for panic disorder. This finding was not replicated in two other meta-analyses, however (Chambless & Gillis,

1993; Clum et al., 1993). In another exception, Abramowitz (1996) found that for OCD and general anxiety symptoms, therapist-controlled exposure was superior to self-controlled exposure. However, Abromowitz noted that this finding provides evidence for general psychotherapeutic effects, and he surmised that the therapist's presence likely adds nonspecific effects to treatment in that coaching and support from a caring individual may put the client more at ease during exposure. In the third exception, Dobson (1989) found meta-analytic evidence for the superiority of cognitive therapy over other treatments for depression. However, when Robinson et al. (1990) controlled for the allegiance of the investigators in each of the component studies, this effect disappeared.

Certainly, individual comparative studies (e.g., Crits-Christoph, 1997) have demonstrated the superiority of one particular therapeutic approach over another. However, as discussed by Wampold et al. (1997), the probability of Type-I error alone would lead one to expect individual studies to find significant differences in the efficacy of different psychotherapies. In fact, Wampold et al. (1997) demonstrated that the number of studies showing a significant difference for a specific treatment was exactly what would be anticipated from sampling error. Although it is certainly possible that specific treatments may be more effective than others for particular disorders, the existing empirical evidence does not strongly support this notion.

A vital component of the medical model concerns specificity: the importance ascribed to matching a particular technique with a particular disorder or symptom. Component studies are designed to test the efficacy of a given component or components of a treatment by dismantling or adding to a set of techniques in order to determine exactly which components represent the active ingredients of a therapy (e.g., Jacobson et

al., 1996). Ahn and Wampold (2001) recently conducted a meta-analysis of component studies of psychotherapeutic treatments. It was found that the effect size for the difference between a therapy "package" with and without the critical components was not significantly different from zero, indicating that the theoretically purported critical components are not responsible for therapeutic benefits. Moreover, the effect sizes were homogeneous, which suggests that there were no important variables moderating effect sizes. Gaffan et al. (1995), in another meta-analysis, found evidence related to the components of cognitive–behavioral therapy (CBT) for depression. The authors' results suggested that altering the protocol of CBT does not diminish the benefits of this treatment. In their meta-analysis, Wampold et al. (1997) concluded that the uppermost effect size due to specific psychotherapeutic treatments (before any adjustments for allegiance effects) was .20. This value indicates that, at most, specific psychotherapy ingredients likely account for 1-8% of the variance in outcome. Certainly, these results cast doubt on the specificity of psychological treatments, and therefore on the medical model as well.

According to the medical model of psychotherapy, adherence to a treatment manual is imperative because the specific ingredients contained in the manual are supposedly remedial for the disorder being treated. Consequently, treatments delivered using manuals should be more beneficial to clients than treatments provided without a manual. However, the empirical literature indicates that the use of treatment manuals does not seem to be of any particular benefit to clients. Shadish et al. (2000), in their meta-analysis of 90 studies that examined treatment efficacy, found evidence that strongly suggests that the use of a manual does not increase the benefits of psychotherapy. A

number of other studies (e.g., Goldfried et al., 1997; Shaw et al., 1999) support this finding. Further, research by Strupp and his colleagues (Henry, Schacht, et al., 1993; Henry, Strupp, et al., 1993) has indicated that adherence to a therapy protocol could actually be detrimental to the client, especially if the relationship between therapist and client is poor.

Hollin (1994, 1995, 1999, 2002), in his examination of the offender treatment literature, concluded that particularly successful treatment programs were notable for containing a high degree of structure and a high degree of treatment integrity. Treatment integrity was defined as the delivery of treatment as intended in theory and design (Hollin, 1995), where “what is actually delivered…is evaluated against a treatment plan that specifies what is intended" (Lipsey, 1988). It involves attending to both organizational resistance (i.e., the obstacles that impede the progress that might be made with a properly implemented rehabilitation program) and ensuring that the treatment providers possess a high level of requisite skills (Hollin, 1994). Unsurprisingly, high-impact treatment programs were delivered by highly trained practitioners, carefully considered their treatment methods and goals, structured their program around those methods and goals, and were supported, managed, and evaluated by their host organizations to ensure high treatment integrity (Hollin, 2002).

However, in examining the implications of adherence to specific treatment manuals in treatment programs for offenders, Hollin (2002) concluded that manual-based treatment programs can impede treatment effectiveness because they (1) eliminate individualized treatment and case formulation, (2) tend to rely on research findings generated from unrepresentative samples, and (3) frequently adhere to a single theoretical

model at the expense of advancing knowledge. Hollin (2002) further asserted that adherence to specific treatment manuals may be particularly ineffective in bringing about change that generalizes beyond the treatment setting. Instead, Hollin (2002) argued that treatment programs should maintain a high degree of structure and remain rooted in applicable and relevant theory, yet should also seek to deliver individually-tailored services based on individualized case formulation and analysis of the offender's specific needs.

Adherence to treatment protocols is absolutely required in a medical model of psychotherapy, and underlies the basis of its two most prominent phenomena – treatment manuals and empirically supported treatments. Nevertheless, there is no compelling evidence that adherence to a particular psychotherapeutic manual or system is important. It can therefore be powerfully argued that psychotherapy equivalence is a reality and that the active-ingredients model borrowed from medicine is not a useful analogy. Why, then, does the efficacy of the medical model continue to be debated? Bergin and Garfield (1994) commented on this:

> With some exceptions…there is massive evidence that psychotherapeutic techniques do not have specific effects; yet there is tremendous resistance to accepting this finding as a legitimate one. Numerous interpretations of the data have been given in order to preserve the idea that technical factors have substantial, unique, and special effects. The reasons for this are not difficult to surmise. Such pronouncements essentially appear to be rationalizations that attempt to preserve the role of special theories, the status of leaders of such

> approaches, the technical training programs for therapists, the professional legitimacy of psychotherapy, and the rewards that come to those having supposedly curative powers (p. 822).

If specific ingredients are not remedial in and of themselves, then an alternative hypothesis, that the commonalities of treatment are responsible for its benefits, must be considered.

Common Factors in Psychotherapy

The weight of empirical evidence strongly supports the notions that psychotherapy works and that different psychotherapies produce equivalent outcomes. Psychotherapy equivalence also suggests that common beneficial processes among the different treatments are mostly or completely responsible for the similar outcomes. This theoretical dilemma has been labeled the "Dodo Bird Effect" (Rosenzweig, 1936) after the dodo bird in *Alice of Wonderland* who proclaimed "Everybody has won and all must have prizes." Rosenzweig recognized as early as the 1930s that a number of different psychoanalytic therapies were claiming similar high levels of success, and he surmised:

> The proud proponent, having achieved success in the cases he mentions, implies, even when he does not say it, that his ideology is thus proved true, all others false....[However] it is soon realized that besides the intentionally utilized methods and their consciously held theoretical foundations, there are inevitably certain unrecognized factors in any therapeutic situation – factors that may be even more important than those being purposely employed (Rosenzweig, 1936, p. 412).

Rosenzweig was arguing against the notion of specificity in psychotherapy and suggesting that the efficacy of psychotherapy may be due to aspects of the therapy that are not central to the theoretical approach.

Since Rosenzweig proposed that common elements of therapy were responsible for its benefits, attempts have been made to identify the aspects of therapy common to all psychotherapies (e.g., Castonguay, 1993; Goldfried, 1980; Lambert & Bergin, 1994; Luborsky et al., 1975). Attempting to bring coherence to the many theoretical discussions of common factors, Grencavage and Norcross (1990) reviewed the literature that discussed commonalities among most therapies and divided these commonalities into five areas: (1) client characteristics (e.g., hope or faith, actively seeking help), (2) therapist qualities (e.g., cultivating hope, warmth), (3) change processes (e.g., an opportunity for catharsis, provision of rationale), (4) treatment structures (e.g., the use of techniques, a focus on the "inner world"), and (5) relationship elements (e.g., development of a therapeutic relationship, engagement). These common therapeutic elements largely overlap with those proposed by others (e.g., Castonguay, 1993; Lambert & Bergin, 1994). This common factors model proposes that there is a set of factors shared by all forms of psychotherapy and that these common factors are responsible for psychotherapeutic benefits rather than the ingredients specific to the particular theoretical approaches. However, a common factors model of psychotherapy is a rather diffuse model in that it specifies only that (a) there are a set of elements common to all psychotherapies and that (b) these factors are therapeutic (Wampold, 2001). Alternatives to the medical model are necessary to explain the workings of psychotherapy, and these models need be more comprehensive than what is offered through a common factors perspective.

A number of writers (e.g., Bohart & Tallman, 1999; Brody, 1980; Frank & Frank, 1991; Yalom, 1995) have proposed comprehensive models of psychotherapy that encompass those elements found to be common to all psychotherapies. These models tend to emphasize the process of psychotherapy, attending to how the characteristics of the therapist, the client, and the interactions between the two influence the outcome of psychotherapy. Wampold (2001) has termed these paradigms *contextual models*, because they emphasize the contextual elements of the psychotherapy endeavour.

A Contextual Model of Psychotherapy

According to Frank and Frank (1991), people who present for psychotherapy are demoralized and have a variety of problems, typically depression and anxiety, and seek psychotherapy for the demoralization that results from their symptoms, rather than for symptom relief. Frank proposes that "psychotherapy achieves its effects largely by directly treating demoralization and only indirectly treating overt symptoms of covert psychopathology" (Parloff, 1986, p. 522; quoted in Wampold, 2001).

Ilardi and Craighead (1994), on the basis of a literature review, contended that cognitive therapy produced rapid change in depression as a result of the remoralization of the client. Interestingly, these authors argued that clients who are sufficiently remoralized in the early stages of therapy are able to successfully apply the cognitive techniques taught in therapy and consequently complete their recovery. Indeed, although some writers consider processes common to different forms of psychotherapy to be both necessary and sufficient (e.g., Frank & Frank, 1991; Patterson, 1984), others (e.g., Crits-Christoph, 1997; Garfield, 1991) view them as playing a substantial role in patient improvement but often in conjunction with unique ingredients. Few studies have empirically examined this

question. Carroll et al. (1994) examined whether the therapeutic alliance (a common factor) impacts differentially on outcome (with cocaine-dependent clients) in technique-reliant "active" psychotherapies (cognitive-behavioral therapy) and therapies that are not technique specific (clinical management). Although the magnitude of difference was small, the authors found evidence to suggest an interaction between common factors and unique ingredients in psychotherapies. Interestingly, the results also suggested a stronger relationship between common factors of psychotherapy (e.g. alliance) and outcome than between specific ingredients and outcome. The hypothesized interaction between common and specific ingredients should certainly continue to be investigated.

Frank and Frank (1991) described the elements shared by all psychotherapeutic approaches. The first element is that psychotherapy involves an emotionally charged, confiding relationship with another person (the therapist). The second element is that the context of the relationship is a healing setting where the client presents to a professional who the client believes can provide help and who is entrusted to work in his or her behalf. The third element is that there exists a rationale, or conceptual framework, or myth that provides a reasonable explanation for the client's symptoms and stipulates a procedure or ritual for resolving them. Frank and Frank (1991) assert that the particular rationale must be accepted by both the client and therapist, but need not be "true." It is vital, however, that the rationale for the treatment be consistent with the worldview, schemas, attitudes and values of the client or that the therapist assists the client in accepting the rationale. That is, the client must believe in the treatment or be lead to believe in it (Wampold, 2001).

As observed by Wampold (2001), six components common to the procedures or rituals used by all psychotherapists are identified by Frank and Frank (1991). First, the therapist contends with the client's sense of alienation by developing a relationship that is maintained after the client discloses feelings of demoralization. Second, the therapist sustains the client's expectation of being helped by linking hope for improvement to the process of therapy. Third, the therapist provides new learning experiences for the client. Fourth, the client's emotions are stimulated as a result of the therapy. Fifth, the therapist enhances the client's sense of mastery or self-efficacy. Sixth, the therapist provides opportunities to practice newly acquired skills. Notably, many of these contextual components overlap with those proposed by Yalom (1995), who presented a number of factors found to be curative in group psychotherapy. These include instillation of hope, imparting of information, interpersonal learning, catharsis, and group cohesiveness.

Wampold (2001) notes the status of techniques in this contextual model of psychotherapy. He observes that specific ingredients are essential to any effective psychotherapy, whether it fits into a medical or contextual model of treatment. However, contrary to the medical model which posits specific ingredients as being directly responsible for the benefits of therapy, in the contextual model specific ingredients are necessary to build a coherent treatment that therapists believe in and that provides a convincing rationale to clients. As expressed by Frank and Frank:

> My position is not that technique is irrelevant to outcome. Rather, I maintain that...the success of all techniques depends on the patient's sense of alliance with an actual or symbolic healer. This position implies that ideally therapists should select for each patient the therapy that accords, or can be brought to accord, with

> the patient's personal characteristics and view of the problem. Also implied is that therapists should seek to learn as many approaches as they find congenial and convincing. Creating a good therapeutic match may involve both educating the patient about the therapist's conceptual scheme and, if necessary, modifying the scheme to take into account the concepts the patient brings to therapy (Frank & Frank, 1991, p. xv).

Indeed, these statements are very much in accord with the research findings discussed above that suggest that therapist allegiance accounts for most or all of the beneficial effects often attributed to specific therapeutic techniques. The statements also emphasize one component of the contextual model that has received the greatest amount of empirical support: the therapeutic relationship.

The Therapeutic Relationship

The conclusion that psychotherapies are generally effective and the inability of researchers to find a consistent difference in the effectiveness of psychotherapy across orientations has led researchers to look for common factors across therapies that can explain therapeutic outcomes. In the past two decades, psychotherapy researchers and practitioners have proposed that the therapeutic relationship is an essential element of the therapeutic process (Norcross, 2005). The principal reason the alliance has grown in significance is the consistent finding that the quality of the alliance is related to subsequent psychotherapeutic outcome Of the common factors associated with most psychotherapies, the therapeutic relationship has emerged as a consistent and robust predictor of positive outcome across psychotherapies of different types and with diverse clinical samples (Horvath & Luborsky, 1993). As a consequence of this, many

contemporary theories of psychotherapy now emphasize the importance of the alliance to the extent that it has been labeled "the quintessential integrative variable" of therapy (Wolfe & Goldfried, 1988, p. 449).

The terms *therapeutic alliance, working alliance, therapeutic bond,* and *helping alliance* have been used to refer to specific aspects of the therapeutic relationship or as synonyms for the relationship as a whole. Because the use of these terms has not been consistent, the terms therapeutic relationship and alliance are used interchangeably here to refer to the construct of the relationship between client and therapist that facilitates healing.

The Alliance in Psychoanalysis

The influence of the client-therapist relationship on the outcome of psychotherapy is one of the oldest themes in psychotherapeutic thought. In 1913 Freud explored the difference between the neurotic aspects of the client's attachment to the therapist (transference) and the healthy, affectionate, trusting feelings that the client has toward the therapist. Freud (1958) felt that the positive, reality-based component of the therapeutic relationship allowed for a therapeutic collaboration between therapist and client against the common enemy, the client's neuroses (Horvath & Luborsky, 1993). Interest in the impact of the therapeutic relationship was maintained through the years by a number of psychoanalytic writers (e.g., Gitleson, 1962; Horwitz, 1974; Sterba, 1932; Zetel, 1956).

The Rogerian View of the Alliance

A different formulation of the alliance was later developed by Carl Rogers and his associates (e.g., Barrett-Lennard, 1962; Rogers, 1957). This client-centered conceptualization of the therapeutic relationship was based on the idea that it is the

therapist's ability to be empathic and congruent (genuine), and to assume an attitude of unconditional positive regard (warmth, acceptance) toward the client that is both necessary and sufficient for the client's improvement.

Empathy was defined by Rogers (1980) as "the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view" (p. 142). In their definition of congruence, Klein et al. (2002) indicate that "congruence involves both a self-awareness on the part of the therapist, and a willingness to share this awareness in the moment" (p. 196). Indeed, Rogers (1957) described the congruent therapist as someone who is "freely and deeply himself, with his actual experience accurately represented by his awareness of himself" (p. 97) and who is "accurately himself in this hour in this hour of this relationship" (p. 97). Congruence has come to be synonymous with genuineness. Farber and Lane (2002) note that early in his career, Rogers viewed positive regard and unconditional acceptance as separate concepts, but later combined these attributes into one of his basic conditions, unconditional positive regard. As defined by Rogers (1957), "To the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience as being a part of that client, he is experiencing unconditional positive regard" (p. 101). In reference to the difficulty defining this particular concept, Orlinsky et al. (1994) used the term "therapist affirmation" to describe the general constellation of attitudes encompassed by this concept (Farber & Lane, 2002). In all, these qualities of empathy, congruence, and unconditional positive regard were termed the *therapist offered conditions* or the *core conditions* of psychotherapy. From the Rogerian perspective the therapeutic relationship,

as facilitated by the therapist offered conditions, is perceived as being directly and specifically curative.

The Alliance as a Pantheoretical Concept

Bordin (1976) proposed a broader definition of the therapeutic alliance, defining it as the "active relational element in all change-inducing relationships" (Horvath, 1994, p. 110). His pantheoretical conceptualization, perhaps most similar to Freud's (1958), emphasizes the client's positive collaboration with the therapist against the common foe of the client's pain and self-defeating behavior. Horvath (1994) describes Bordin's model in detail. According to this model, the alliance has three components: *tasks, goals* and *bonds. Tasks* refer to the in-counseling behaviors and thoughts that form the substance of the counseling process. In a well-functioning relationship, both client and therapist must perceive these tasks as relevant and beneficial, and each must accept responsibility to perform these acts. A strong alliance is also characterized by the client and therapist mutually supporting and valuing the *goals* (outcomes) that are the target of therapy. The concept of *bonds* refers to the personal attachments between client and therapist that include issues such as mutual trust, acceptance, and confidence. Not surprisingly, Horvath and Greenberg (1986) found that empathy correlated more highly with the bond component of this conceptualization of the alliance than with the task and goal components. The task-bond-goal alliance model has informed much of the recent research on the therapeutic relationship, and a measure of the alliance developed from this model (The Working Alliance Inventory; WAI; Horvath & Greenberg, 1986) is a popular measure in the alliance literature.

Empirical Support for the Therapeutic Alliance

A number of individual, well-designed studies (e.g., Burns & Nolen-Hoeksema, 1992; Connors et al., 1997; Gallop et al., 1994; Gaston et al., 1991; Gerstley et al., 1989; Gaudino & Miller, 2006; Krupnick et al., 1996; Prigatano et al., 1994) have indicated that the therapeutic relationship is strongly and significantly predictive of therapeutic outcome in a wide range of therapies (including behavioral, cognitive, cognitive-behavioral, psychodynamic, client-centered, and medical management) for a variety of problems (e.g., depression, bipolar disorder, substance dependence, eating disorders, anxiety, and antisocial personality disorder).

Two meta-analyses (Horvath & Symonds, 1991; Martin et al., 2000) support these findings. Moreover, these meta-analyses suggest that the relation of the alliance to outcome does not appear to be influenced by moderator variables such as the type of outcome measure used in the study, type of alliance measure, source of outcome rating, time of alliance assessment, source of alliance rating, length of treatment, or the form of treatment provided. And as suggested by the empathy studies reviewed above, and consistent with the Rogerian conception of the alliance, it is the client's perception of the alliance that is most strongly related to outcome. Estimates of the effect size of the therapeutic alliance from meta-analyses and research reviews have ranged from medium ones representing between 5 and 7 % of the variance in outcome (Horvath & Symonds, 1991; Martin et al., 2000) to large ones representing 30% of outcome variance (Lambert, 1992). Certainly, it is evident that the therapeutic relationship, a vital component of the contextual model of psychotherapy, accounts for somewhat more of the variability in outcomes than does the total of specific ingredients.

Over the past three decades, a number of investigations have specifically examined the effects of Rogers' therapist offered conditions. Many of these findings are supportive of the original hypothesis: Therapists who provided high levels of the therapist offered conditions were more successful in helping their clients than those who provided less of those conditions (e.g., Barrett-Lennard, 1985; Gurman, 1977; Rogers et al., 1967). Other reviews of past research results have noted that the relation between the therapist offered conditions and therapeutic outcome was not consistent across different types of treatment, types of measurement, or source of ratings (Mitchell et al., 1977; Orlinsky & Howard, 1986). Overall, however, investigations have found that the Rogerian therapist-offered conditions (Rogers, 1957) of empathy, warmth, and genuineness are all moderately to highly associated with treatment outcome (see reviews by Bohart et al., 2002; Farber & Lane, 2002; and Klein et al., 2002). Studies have also indicated that the Rogerian conditions appear to be intercorrelated, and that the conditions also correlate highly with a measure of the overall strength of the therapeutic alliance (Blatt et al., 1996; Salvio et al., 1992). These results suggest that clients' perceptions do not readily distinguish between Rogers' therapist-offered conditions and other relationship factors (Bohart et al., 2002).

In a recent meta-analytic study of process-outcome psychotherapy research, Bohart et al. (2002) found that empathy alone accounted for 10% of the variance in outcome (a medium effect size of .32). This indicates that empathy accounts for more outcome variance than do specific interventions, which have been estimated to account for only 1% of outcome variance, after allegiance effects are accounted for (Wampold et al., 1997). Interestingly, the majority of findings indicate that it is the client's perception of

the therapist as an empathic person, rather than actual therapist behavior, that best predicts outcome (Barrett-Lennard, 1981; Gurman, 1977).

Research has also examined to what extent client-therapist goal consensus and collaboration are related to treatment outcomes. A recent literature review determined that, of those studies examined, goal consensus was positively related to treatment outcomes 68% of the time, and collaborative client-therapist involvement was positively related to treatment outcome 89% of the time (Tryon & Winograd, 2002).

The Therapeutic Alliance in the Treatment of Sexual Offenders

A wealth of research evidence demonstrates the importance of the therapeutic alliance to psychotherapy outcome in the general psychotherapy literature, and empirical interest in the alliance has greatly increased over the past two decades. Nevertheless, this same interest has not been expressed in work with sexual offenders. Literature reviews (e.g., Marshall & Anderson, 1996; Marshall et al., 1999) and meta-analytic studies (e.g., Hanson, 2000; Hanson et al., 2002; Lösel & Schmuker, 2005) indicate that sexual offender treatment is effective in reducing subsequent recidivism. These studies also suggest, however, that reoffense rates are higher than are desirable. Yet most treatment programs for sexual offenders persistently adhere to the precepts of the medical model of psychotherapy, holding that highly specified procedures alone will maximize treatment outcome (Marshall, Fernandez, et al., 2002). Treatment manuals represent the standard approach to sexual offender treatment (Green, 1995; Marshall, 2005). While it is true that treatment programs for sexual offenders have evolved over the last 30 years in complexity and scope (Marshall et al., 1998; Marshall et al., 1999), these programs have tended to

ignore and even resist acknowledging the importance of therapeutic process and contextual variables in treatment outcome.

The literature on therapeutic process issues in the field of sexual offender treatment is negligible. Notwithstanding a few theoretical papers (Blanchard, 1995; Houston, Wrench, & Hosking, 1995; Kear-Colwell & Pollack, 1997; Marshall, 1996; Marshall, Fernandez, et al., 2002) and four empirical studies (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005; Marshall, Serran, Moulden, et al., 2002; Marshall et al., 2003), a dearth of research exists in this important area. Indeed, as identified by Marshall, Fernandez, et al. (2002), there exists an ongoing debate about the relative values of either an aggressive, confrontational approach (e.g., Salter, 1988; Wyre, 1989) versus a more supportive therapeutic stance toward these clients (Garland & Dougher, 1991).

The extant research in the field speaks to this issue. Kear-Colwell and Pollock (1997) reported finding that an unempathic, confrontational therapist style tended to lead self-confident and assertive offenders to become resistant and argumentative. These offenders were often considered uncooperative and removed from treatment. Confident clients who remained in treatment tended to adopt a manipulative strategy, agreeing with the therapist on all issues. Those clients who lacked self-confidence were inclined to yield to therapist demands, which had the additional effect of eroding their self-esteem. Beech and Fordham (1997) carried out a between-group comparison study on sex offender group therapy treatment using a variety of within-group treatment measures (increases in self-esteem, empathy, lessening of cognitive distortions, assertiveness, identification of offence cycle, development of relapse prevention strategies). They found that the group with the highest rated cohesiveness, independence, organization, and leader support

showed the most improvement. The least improvement was demonstrated in the group with the lowest ratings on these measures. The authors concluded that more effective therapists are supportive, model effective interpersonal interactions, set a clear treatment structure, and are not aggressively confrontational. A more recent replication of aspects of this study produced similar findings (Beech & Hamilton-Giachritsis, 2005). Similarly, in a study of therapy with delinquent adolescents, therapist features (including empathy) accounted for 60% of variance on outcome measures (Alexander et al, 1976). Nicholaichuk and his associates (Nicholaichuk et al., 1998; Wong et al., 2002) analyzed retrospective data on a group of treated sexual offenders and found evidence suggesting that stronger therapeutic alliances were associated with positive therapeutic outcomes and a reduction in general criminal recidivism.

Recently, Marshall and his colleagues (Marshall, Serran, et al., 2002; Marshall et al., 2003) identified a number of therapist features that are reliably associated with positive outcomes in sexual offender treatment, including improved relationships, increased accountability, and decreases in denial of offence planning, victim blaming, and minimization of offence severity. These qualities consisted of empathy, warmth, rewardingness, and directiveness. Confrontational approaches were negatively associated with treatment outcomes. In all, the limited research literature suggests that confrontational approaches fail to produce therapeutic improvements and that certain process variables (therapist-offered empathy and warmth and a supportively directive and rewarding therapist attitude) are significantly related to outcome with this population. Notably, each of these therapist features is completely in accordance with a contextual

model of psychotherapy and, in particular, each has been identified as a component of the therapeutic alliance (i.e., empathy, warmth, unconditional positive regard, collaboration).

Hypotheses

In this exploratory study, one of the first to specifically examine the therapeutic alliance and its relationship to treatment outcome with sexual offenders, it was hypothesized that the therapeutic alliance would be positively related to therapeutic outcomes in psychotherapy with a population of sexual offenders. The term "outcome" is specifically used here to refer to indices of change that are associated with or often used to measure therapeutic progress, and that have been empirically or theoretically linked to sexual recidivism. In this regard, the relationship between ratings of the therapeutic alliance and ratings of both global and specific measures of therapeutic outcome would be investigated.

Given the preponderance of data indicating that the Rogerian core relationship conditions of empathy, warmth, genuineness, and positive regard (Rogers, 1957) are consistently related to treatment outcome, and the finding that clients do not readily distinguish between Rogers' therapist-offered conditions and other relationship factors (Bohart et al., 2002), it was predicted that the Rogerian core conditions would be fundamental to both the therapeutic relationship and to treatment outcome with sexual offender populations. It was therefore further hypothesized that the core Rogerian relationship conditions would contribute greater amounts of unique outcome variance than the collaborative aspects (i.e., collaboration on treatment goals and tasks; Bordin, 1976) of the client-therapist working alliance.

Methodological Issues in Measuring the Therapeutic Alliance

The impact of the alliance has been demonstrated in treatments ranging from 4 to over 50 sessions. Duration of treatment, however, does not appear to influence the relation between the quality of the alliance and therapy outcome (Horvath & Symonds, 1991). In the present study, participants were involved in treatment for a wide range of durations. Based on the research evidence cited above, this was not expected to impede the detection of an association between alliance and outcome.

A number of authors have suggested that the therapeutic alliance is most predictive of outcome when it is measured early in therapy (e.g., DeRubeis & Feeley, 1990; Plotnicov, 1990). The only meta-analysis to examine this issue found that treatment effect sizes for measures of the alliance at early and late stages of therapy were nearly identical (Horvath & Symonds, 1991). This suggests that the timing of the alliance measures in the current study would not be critical to detecting a relationship between the therapeutic relationship and measures of outcome.

Investigations of ethnicity in the counseling literature have mostly focused on client preferences (Erdur et al., 2000). In their meta-analysis, Coleman et al. (1995) found that ethnic minority clients tend to prefer ethnically similar therapists. In the only psychotherapy outcome study to look at both alliance and therapist/client ethnicity, Erdur et al. (2000) examined the therapeutic alliance and its relationship to treatment outcome in ethnically similar and dissimilar client-therapist pairing. Overall, their results revealed very little evidence that either the therapeutic alliance or client outcome were affected by therapist-client ethnicity combinations. This finding bears directly upon the current study, where ethnic diversity in therapist-client dyads was the norm, rather than the exception.

As well, in a study specifically examining the impact of a sex offender treatment program on minority ethnic offenders, Webster et al. (2004) found that, for the most part, treatment was equally effective for both minority and nonminority offenders.

There is a commonly held assumption among psychotherapy researchers regarding the potential method bias resulting from studies that use measures of process and outcome based on the same source (e.g., Orlinsky & Howard, 1986). These researchers have raised the possibility that ratings of alliance and outcome by the same raters (e.g., the client rates both the alliance and outcome) might be influenced by a "halo effect" (Horvath & Symonds, 1991). For example, a client who perceives the therapeutic process to be positive may also tend to rate its outcome as beneficial. Horvath and Symonds (1991) investigated this possibility and concluded that no significant interaction existed between the source of alliance rating (i.e., therapist, client, or observer) and the source of outcome assessment. Nonetheless, different combinations of source ratings were utilized in the present study and were therefore not expected to obscure interpretation of the data.

Methodological Issues in Assessing Sex Offender Treatment Outcome

One of the primary goals of therapy with sexual offenders is a reduction of harmful behaviors. Indices of recidivism, therefore, probably reflect the efficacy of sex offender treatment more convincingly than any other statistic. Although sex offender treatment has been shown to significantly reduce reoffense rates in treated individuals (Hanson, 2000), recidivism has demonstrated itself to be an extremely elusive outcome variable to detect. Literature reviews (Alexander, 1999; Barbaree, 1997) have indicated that the statistical analysis of recidivism data tends to be quite insensitive to the effects of treatment. Either very large sample sizes or very large treatment effect sizes are necessary

to detect recidivism differences between treated and untreated groups of offenders, and both these components are generally lacking in such investigations.

The recognition of this weakness of recidivism studies places greater importance on non-recidivism studies of treatment efficacy, particularly studies of within-treatment behavior change (Barbaree, 1997). Although deviant sexual preference and pre-offence, static, historical variables related to sexual deviance (e.g., prior sex offences, stranger victims) tend to be the most powerful predictors of subsequent recidivism (Hanson, 2000; Hanson & Bussière, 1998), Hanson (Hanson, 2000; Hanson et al., 1991) argues for evaluating treatment by measuring change in factors known or thought to be related to risk for reoffending. Though research support remains tentative, the following five factors are thought to be dynamic risk factors for sexual offenders: (1) intimacy deficits, (2) negative social environment, (3) attitudes tolerant of sexual offending, (4) emotional/sexual self-regulation, and (5) general self-regulation deficits (Hanson, 2000). In support of this proposition, Marques and her colleagues (Marques, 1995; Marques et al., 1994; Miner et al., 1990) have shown that the acquisition of coping skills designed to prevent relapse was related to the risk of reoffense among released offenders. It was also found that a reduction in denial, minimization, and deviant sexual interest and arousal, together with the development of a sound relapse prevention plan, were related to improved success among released offenders. And Marshall and his colleagues (Marshall, 1989, 1993; Ward et al., 1995) have developed a comprehensive model that integrates both intimacy deficits and attachment style in a theory to explain the etiology and maintenance of sexual offending behavior as well as potential directions for intervention. A focus on these

within-treatment factors appears to be a promising approach for continuing research and supports their use as appropriate outcome targets in the current investigation.

Method

Participants

Participants in the present study were 45 volunteers from a sample of approximately 100 men who have been convicted of sexual crimes and participated in sexual offender treatment in either a moderate intensity program at a federal medium security correctional institution or in a community-based clinic that specializes in the treatment of high risk/high need sexual offenders. Treatment involved either individual therapy alone or a combination of individual and group therapy. Because of the written nature of the measures to be used in the present study, only those participants who were functionally literate were able to participate. Table 1 presents demographic and offence characteristics of the sample.

In reference to the variable *Ethnicity*, participants were assigned to different categories based on self-identification with a particular ethnic group. The "other" category included individuals of Latin American, Laotian, and Guyanese origins. The variable *Risk* was coded according to the guidelines of the Static-99 (Hanson & Thornton, 1999), an actuarial instrument widely used to predict an individual's risk for sexual recidivism based mainly on static, or historical, variables (e.g., whether the victim of the offence was male or female, whether the victim was a stranger or someone known to the offender, etc.). Descriptors are included for different risk levels. The variable *Offence Type* refers to the participant's index offence (i.e., the offence(s) most recently adjudicated), and may include a charge, arrest, conviction, or rule violation, as defined by Hanson and Thornton

(1999). Consistent with current Canadian law, a sexual offence was coded as "Child victim" if the victim of the offence was younger than 14 years of age. Sexual offences involving victims 14 years or older were coded as "Adult victim." If the index offence involved victims who were both younger and older than 14 years of age, the offence was coded as "Mixed."

The participants ranged in age from 20 to 58 years ($M = 36.38$, $SD = 9.68$). Their static level of risk for sexual recidivism, as calculated according to the guidelines of the Static-99 (Hanson & Thornton, 1999), ranged from 0 to 9 ($M = 4.36$, $SD = 2.50$). The length of time participants had been involved in treatment ranged from 1 to 120 months ($M = 25.59$, $SD = 32.09$). Treatment was carried out by seven therapists (5 men and 2 women) at either a community clinic or a federal correctional centre. Years of therapist experience range from 8 years to 18 years, and therapists came from a variety of academic backgrounds representing undergraduate university-level, Masters-level and doctorate-level educations. Therapists also endorsed a number of different theoretical orientations, encompassing cognitive, behavioral, humanistic, spiritual, and integrative approaches. In terms of ethnicity, all seven therapists identified themselves as Caucasian.

Procedure

Therapists requested volunteers for the present study from those clients on their caseloads. In order to maximize participation, the investigator also actively recruited participants by presenting the opportunity to participate to the participants of four different therapy groups offered at the clinic. As another strategy to increase participation, prospective participants were promised (and delivered) feedback about the general findings of the study following its completion.

The general goals of the study were explained to prospective participants by both the investigator and the individual therapists, according to guidelines developed prior to recruitment. This allowed for some measure of standardization in the manner in which the goals of the study were explained. The goals of the study were specifically described as follows: *The purpose of this research is to examine what characteristics of therapy and therapists are most helpful in assisting men who have committed sexual offences in making positive changes in their lives and managing their risk to reoffend.* Formal written permission was obtained from all who agreed to participate. It was made clear to clients verbally (by the investigator) and in written contractual form (signed by both the investigator and the participants) that participation in this research was on a completely voluntary basis and that only the primary investigator of the present study and not the individual therapists would have access to the clients' responses. It was also stipulated that none of the information obtained through the present study would be utilized for assessment or treatment purposes.

File data was gathered on each participant regarding such information as: nature of the sexual offence(s), age of client, ethnicity of client, and duration in treatment. A risk prediction score for sexual recidivism was calculated from file information using the guidelines of the Static-99 (Hanson & Thornton, 1999). In a single period of time lasting approximately one half-hour in duration, clients were asked to complete two self-report questionnaires assessing the quality of the therapeutic alliance, two questionnaires measuring outcome variables, and a questionnaire asking about their treatment experiences (designed to gather qualitative data). Clients completed these questionnaires

individually at times mutually agreed upon by both the participant and the investigator.

Table 1

Demographic and Offence Characteristics of the Sample

Characteristic	n	Percentage
Age		
<30 years	10	22.7
30-39 years	16	36.4
40-59 years	18	40.9
Ethnicity		
Aboriginal	16	36.4
Caucasian	21	47.7
Other	7	15.9
Residence		
Community	34	77.3
Correctional Institution	11	22.7
Risk (Static-99)		
0-1 (low)	6	13.6
2-3 (moderate-low)	11	25.0
4-5 (moderate-high)	13	29.5
>5 (high)	14	31.8
Offence Type		
Child victims	24	54.5
Adult victims	16	36.4
Mixed (both child and adult victims)	4	9.1
Treatment Duration		
<6 months	15	36.4
6-12 months	8	15.9
13-24 months	6	13.6
25-60 months	9	20.5
61-120 months	6	13.6
Treatment Modality		
Individual only	15	34.1
Group only	0	0.0
Both Individual and Group	29	65.9

Although there is no research to indicate that the ordering of these questionnaires would impact upon response tendencies, the order of presentation of these questionnaires was counterbalanced in order to protect from any possible confounds due to the ordering. Therapists were also asked to rate their clients' progress in therapy on two pen-and-paper outcome measures. The presentation order of these measures was also counterbalanced.

Measures

The Relationship Inventory. The Relationship Inventory (RI; Barrett-Lennard, 1962, 1986; see Appendix A) is one of the earliest instruments designed to measure the client's experience of the psychotherapeutic relationship. It is a 64-item self-report form that examines Rogers' (1957) therapist offered conditions, as separated into four subscales: Empathy, Level of Regard, Unconditionality, and Congruence. The RI provides both an overall alliance score and also a score for each of its subscales. The RI has been used in a vast number of studies and has demonstrated itself to be a reliable and valid instrument (Barrett-Lennard, 1962, 1986; Gurman, 1977). Internal consistency has been calculated for each subscale using split-half and alpha coefficient methods, and is as follows: regard .91, empathy .84, unconditionality .74, and congruence .88 (Gurman, 1977). Test-retest reliabilities have been calculated using test-retest intervals ranging from 12 days to 12 months and indicating coefficients ranging from .61 to .95 (Gurman, 1977). It should be noted, however, that the usefulness of test-retest reliability indices of an alliance measure is questionable because the alliance has been shown to fluctuate significantly over the course of therapy (Martin et al., 2000; Safran et al., 2001). Evidence for validity of the RI has been found in a number of studies indicating that its subscales

are especially sensitive to changes in relationship quality, as assessed by alternate instruments (Barrett-Lennard, 1986).

The Working Alliance Inventory. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1986; see Appendix B) is a 36-item self-report instrument designed to assess Bordin's (1976) pantheoretical conceptualization of the alliance. The WAI provides both an overall alliance score and also a score for each of its subscales (Task, Bond, and Goal). The WAI has undergone substantial psychometric validation, and its psychometric properties are reviewed in detail by Horvath (1994). Estimates of internal consistency for the whole instrument (Cronbach's alpha) range from .84 to .93. Test-retest reliability ranges from .68 to .92 for the instrument as a whole and is slightly lower, but in a similar range, for the subscales. The three subscales are also highly correlated, with intercorrelations ranging from the low .60s to the high .80s, depending upomn the populations sampled. Validity has been demonstrated by the WAI's high correlations with a number of other alliance measures.

Although the RI and WAI are conceptually different, a number of research findings lead to an expectation that the two scales will be significantly correlated: (1) Most alliance scales used in research have been shown to be related to outcome (Horvath & Symonds, 1991; Martin et al., 2000), (2) empathy appears to be associated with the bond component of the therapeutic alliance (Horvath & Greenberg, 1986), and (3) Rogers' therapist offered conditions are all highly intercorrelated (Blatt et al., 1996; Salvio et al., 1992). A few doctoral dissertation studies have also tested the relation between the RI and the WAI. One of these studies (Jones, 1988) found that the Task component of the WAI is the most independent of the RI's subscales (correlations ranging from .30 to .49), the Goal

dimension overlaps more with the others is (correlations from .43 to .59), and Bond is the most highly intercorrelated (.60 to .74; as reported in Horvath, 1994).

Research has repeatedly found that it is the client's experience of the therapeutic relationship that has the strongest relation to psychotherapy outcome (Horvath & Luborsky, 1993). Therefore only the client forms of each of the alliance measures were used in the present study.

Global Assessment of Functioning Scale. A comprehensive review of psychotherapy process-outcome literature (Lambert & Hill, 1994) concluded that gross ratings of change produce larger estimates of change than ratings on specific dimensions or symptoms. The Global Assessment of Functioning Scale (GAFS; APA, 1987; see Appendix C) was originally developed as a simplified version of the Health-Sickness Rating Scale (HSRS; Luborsky, 1962), a scale designed to assess a client's overall functioning operationalized in terms of sickness or health. This measure was subsequently revised as the Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976) for the evaluation of overall severity of psychiatric disturbance, and it was a modified version of the GAS, the Global Assessment of Functioning Scale (GAFS), that was included in the revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; APA, 1987) to measure axis V difficulties (overall level of functioning). The GAFS continues to appear in the newest edition of the DSM. The GAFS is a scale ranging from 1-100 that is used to evaluate clients' overall level of functioning. The scale is anchored at each 10-point interval with a clinical description that includes level of occupational and social functioning, as well as subjective distress. In the present study, GAFS ratings were obtained from the clients' primary therapist.

The GAFS has been used in a number of psychotherapy studies as an indicator of general self-regulation as therapeutic outcome and is one of the most widely used assessment tools in clinical practice (Garrison, 2001). The GAFS has also been successfully used in alliance studies (e.g., Castonguay, 1992; Raue et al., 1993). Thus, the scale appears to have adequate sensitivity to detect treatment effects associated with the therapeutic alliance. The GAFS has also been shown to be resistant to rater bias (Hall, 1995). A recent study examined the psychometrics of the GAFS, and interrater reliability was found to be very high (interclass correlation of .92). Findings also supported its convergent and discriminant validity (Hilsenroth et al., 2000).

Assessment of cognitive distortions. The cognitive distortions of sexual offenders are considered to be influential in the etiology and maintenance of deviant sexual behavior and are commonly accepted as valid predictors of treatment potential and success (Bumby, 1996, 2000). Distortions such as denial, minimization, rationalization, justification, and victim blaming are believed to diminish the anxiety, guilt, or shame that accompanies sexually assaultive behaviors (Abel et al., 1989; Hanson, 2000; Langton & Marshall, 2000). Ward et al. (1998) have emphasized the importance of cognitive processes at various points throughout the offense cycle, arguing that cognitive distortions likely occur preceding, during and following the offensive behaviors.

Bumby's (1996) RAPE and MOLEST Scales (see Appendix D) are designed to assess, respectively, the cognitive distortions of rapists and child molesters. Results of validation efforts indicate that both scales demonstrate strong internal consistency (α = .97 for both scales) and test-retest reliability (r = .86 and .84, respectively) as well as good construct, convergent, and discriminant validity (Bumby, 1996). Both measures also

exhibit freedom from a socially desirable response bias and utility in assessing treatment gains (Bumby, 1996). The RAPE Scale is a 36-item self-report measure which asks the respondent to respond to each item on a 4-point Likert-type scale anchored by "Strongly agree" and "Strongly disagree." The MOLEST scale has an identical format, but contains 38 items. An informal survey of prospective participants indicated that, because of biased attitudes frequently held about dissimilar sex crimes (e.g., a rapist of adults was more likely to hold negative beliefs about a child sex crime versus a sex crime involving an adult victim), clients would be less likely to complete questionnaires if they were asked questions regarding dissimilar crimes. Therefore, client participants were asked to complete the questionnaire that best fit the target population of their sexual offence(s).

Assessment of intimacy deficits. Intimacy deficits have been tentatively linked to an increased risk for sexual offending among those predisposed to offend (Hanson, 2000; Hanson et al., 1991). The concepts of intimacy deficits and emotional loneliness tend to be used interchangeably in the sexual offender literature (e.g., Hudson & Ward, 1997; Ward et al., 1995). The Revised UCLA Loneliness Scale (Russell, Peplau, & Cutrona, 1980) (see Appendix E) is a 20-item, self-report Likert-type scale used as a measure of emotional loneliness. It is a widely used measure of loneliness and is part of an intimacy assessment battery in the Canadian National Sex Offender Program's Assessment Manual (Correctional Service Canada, 2002). The range of possible scores is 20 to 80. Cronbach's alphas ranging from .89 to .94 and a one-year test-retest correlation of .73 have been reported by the authors (Russell & Cutrona, 1988). Reviewers gave high marks to this scale for its discriminative validity and its successful attempts to reduce social desirability in responses (Shaver & Brennan, 1991). Clients completed this questionnaire.

Standardized Goal Attainment Scaling. A method of therapeutic outcome assessment that has received widespread attention and use is Goal Attainment Scaling (GAS; Kiresuk & Sherman, 1968; Lambert & Hill, 1994). As outlined by Lambert and Hill (1994), GAS requires that a number of treatment goals are formulated prior to treatment. For each goal specified, a scale with a graded series of likely outcomes, ranging from the least to the most favorable, is devised. An attempt is made to articulate and specify goals with enough precision to allow an independent observer to determine how well a client is functioning at a given time. Each goal is weighted to give those with high priority in therapy more weight than less important goals. The procedure allows for transformation of the overall attainment of specific goals into a standard score, if desired. A major advantage of GAS is its flexibility in application and the wealth of information it can acquire (Woodward et al., 1978). GAS is a method that can be adapted for any psychotherapy outcome assessment. It has been observed that that convergent validity of GAS has not been conclusively established and that GAS occasionally suffers from poor interrater agreement (Calsyn & Davidson, 1978). This is thought to be because goal attainment is often judged on a relative rather than an absolute basis so that behavior change can be confounded with expectations (Lambert & Hill, 1994). However, reviewers have described specific procedures for goal creation and later evaluation that increase reliability and validity without reducing the advantages of individualized goals (Mintz & Kiesler, 1982; Lewis et al., 1987).

The GAS used in the present study (see Appendix F) was designed by Correctional Service Canada (CSC; 2002) as part of the National Sex Offender Programs Assessment Manual for the standardization of Canadian treatment programs for sexual offenders.

Although this recently designed GAS instrument has no established psychometric properties, it was modeled after a 12-item GAS system for measuring treatment performance of sexual offenders developed by Hogue (1994). Hogue's (1994) validation efforts demonstrated that the system provides a reliable and valid method of measurement. As well, this system is reflective of the approach often taken in assessing treatment outcome with sexual offenders (e.g., Nicholaichuk et al., 1998). The CSC GAS covers 12 areas theoretically connected to sexual recidivism, including ratings of: accountability, empathy, cognitive distortions, understanding of offense cycle, identification of relapse prevention concerns, and treatment participation. These therapeutic goals are all identified in the National Sex Offender Programs Treatment Manual (CSC, 2002) for the standardization of Canadian treatment programs for sexual offenders. This manual was utilized by the therapists in the current study to ensure that these treatment goals are identified and addressed in therapy. Regular (bi-weekly) supervision meetings make certain that the identified goals of treatment are attended to. The primary therapists were asked to complete a GAS form for each of their clients participating in the study. Lambert and Hill's (1994) review of psychotherapy process-outcome research concludes that therapist and expert judge-based data in which judges are aware of the treatment status of clients produce larger effect sizes than self-report data. This finding argues for methodological advantages to the inclusion of a therapist-rated system of outcome assessment (such as the GAS and the GAFS) in the present study.

Clients' Treatment Experiences. Efforts were made to gather qualitative data to supplement the quantitative data collected through the alliance and outcome measures. To this end, client participants were asked to respond, in written form, to four open-ended

questions related to their experience of helpful and unhelpful characteristics of therapy, the therapeutic relationship, and the therapist (see Appendix G). The initial question was intended to solicit general information regarding which aspects of treatment the participants' perceived as beneficial with regard to risk management. Subsequent questions were designed to guide participants to focus on those aspects of their treatment experiences that were specifically under investigation in the current study. This would allow for a comparison of responses across questions, facilitating an examination of how clients' experiences of their overall treatment, therapeutic relationships and therapists interact and contribute to therapy progress. In this way, hypotheses could be tested regarding which aspects of psychotherapeutic treatment clients perceive as contributing to or impeding their treatment gains.

Qualitative research is a cover term for a group of methodologies dedicated to the description and interpretation of social phenomena (for reviews, see Bogdan & Biklen, 1992; Denzin & Lincoln, 1994). Ethnography, ethnomethodology, discourse analysis, narrative analysis, grounded theory, thematic content analysis, phenomenology, frame analysis hermeneutics, and conversation analysis are all approaches used by researchers to examine qualitative differences both within and between collected or generated phenomena. In general, qualitative studies are discovery oriented (Mahrer, 1988). They are less concerned with quantification and instead "explore the meanings, variations and perceptual experiences of phenomena" (Crabtree, & Miller, 1992, p. 6.). Qualitative research has no prepackaged designs (Crabtree & Miller, 1992). Instead, qualitative researchers use a variety of methods, procedures, and analysis "to create unique, question-

specific designs that evolve throughout the research process" (Crabtree & Miller, 1992, p. 5).

Most qualitative inquiries in psychotherapy have examined and found support for the importance of the therapeutic relationship (Maione & Chenail, 1999). Several studies have identified the characteristics of a good therapeutic relationship including respect for the therapeutic hierarchy, therapist empathy, and perceived helpfulness of various techniques (Bischoff & McBride, 1996), the importance of being engaged in the therapy process, understanding what was happening in therapy, and being understood (Howe, 1996) and therapist characteristics including acceptance, empathy, caring, competence, support, and being personable (Kuehl, Newfield, & Joanning, 1990; McCollum & Trepper, 1995). Qualitative approaches have also recently shown significant promise in sex offender treatment research (e.g., Wakeling et al., 2005; Webster & Beech, 2000; Milsom et al., 2003; Williams, 2004).

Although qualitative approaches are certainly valid data collection methodologies in their own right, they have also been identified as useful in supplementing data gathered through quantitative methods (Morgan, 1988). Indeed, guidelines have been outlined recently proposing good practice research methods for combining quantitative and qualitative approaches to investigations in the area of sexual offender research (see Webster & Marshall, 2004). Some of the strengths of such an approach lie in its ability to bring forward material that might not come out in responses to highly specific and structured instruments (Morgan, 1988), to address response bias and social desirability response issues present in quantitative investigations (Langevin et al., 1998; Webster,

2000); and to effectively examine the multidimensional aetiology of sexual offending behavior (Ward & Hudson, 2000).

A Priori Power Analysis

A computer program (GPOWER; Erdfelder et al., 1996) was used to estimate the statistical power that would be available to detect the hypothesized effects given a specific, predetermined sample size and a multiple regression method of data analysis (see Table 2). This method of power analysis is particularly useful when working with clinical populations of predetermined sample size parameters that may be too small to satisfy conventional levels of alpha and beta, given an estimated effect size (Cohen, 1988; Press et al., 1988). Considering the exploratory nature of the present study, slightly inflated alpha levels were regarded as a rational compromise between the demands for a low alpha-risk and a large power level, given the fixed sample size (Cohen, 1988; Press et al., 1988).

A number of factors were considered in conducting the power analyses. Previous estimates of the effect size associated with the therapeutic alliance (i.e., Horvath & Symonds, 1991; Martin et al., 2000) have indicated r^2 values of .22 and .26. A mean estimate of $r^2 = .24$ was used for the purposes of the current power analysis. Another factor considered in performing the power analyses was the number of independent variables that were to be examined in the main multiple regression equations. Table 2 illustrates how the values of power, alpha, critical F and lambda change in relation to different sample sizes and numbers of multiple regression predictors. With reference to Table 2, if 40 participants were recruited for the study and the maximum number of

independent variables ($n = 9$) were to be used in the multiple regression analyses, the power to detect an association between alliance and indices of therapeutic outcome would

Table 2

Power Levels Associated with Different Sample Sizes and Levels of Predictors

N	Predictors	Power	Alpha	Critical *F* (*df*)	Lambda
40	9	.8128	.1872	1.5169 (9, 30)	12.6280
40	6	.8479	.1521	1.7136 (6, 30)	12.6280
40	3	.8946	.1054	2.2281 (3, 30)	12.6280
50	9	.8609	.1391	1.6319 (9, 40)	15.7850
50	6	.8913	.1087	1.8775 (6, 40)	15.7850
50	3	.9290	.0710	2.5280 (3, 40)	15.7850
60	9	.8970	.1030	1.7461 (9, 50)	18.9420
60	6	.9224	.0776	2.0396 (6, 50)	18.9420
60	3	.9520	.0480	2.8249 (3, 50)	18.9420

Note. Effect size is estimated at $r^2 = .24$. Converted to $f^2 = .3158$.

be .8609 (alpha = .1391, critical $F[9, 40] = 1.6319$, lambda = 15.7850).

The results of these power analyses suggested that even with low numbers of participants (N = 40), power would still remain within acceptable levels to detect statistical effects if they existed, without adjusting the level of alpha and without unduly increasing the probability of committing Type-II error (Cohen, 1988).

Results

Quantitative Analysis

Data was examined for missing values and outliers through the production of frequency tables. Examination of frequencies indicated that values were missing for approximately 1% of the data points and that the missing values appeared to be randomly distributed. Item means were imputed for missing responses prior to calculation of scale scores. One participant did not complete an entire questionnaire (i.e., the WAI), and thus his data was not utilized for analyses. The total sample size was therefore 44 for the purposes of most statistical analyses.

However, for analyses involving the MOLEST and RAPE scales, the *n*'s were 24 and 15, respectively, because participants only completed those measures that were directly applicable to their sexual offending history. That is, participants who had sexually offended only against children ($n = 24$) were asked to complete the MOLEST Scale, while those who offended solely against adults ($n = 16$) were asked to complete the RAPE Scale. Of this particular group, one participant with adult victims did not complete the RAPE Scale and was therefore excluded from analyses that included this cognitive distortion measure. Thus, the final sample for this group included 15 men. Unfortunately, the four individuals whose sexual offences involved both child and adult victims were necessarily excluded from analyses involving the cognitive distortion measures because the small number of individuals in this group was not suitable for meaningful statistical analysis.

Following guidelines suggested by Tabachnick and Fidell (2001), data was examined for univariate outliers and to determine whether univariate assumptions of

normality, linearity, and homoscedasticity were met. Analysis indicated an absence of outliers and an absence of any gross violations of these assumptions that would require data transformations. Basic descriptive and internal consistency statistics for the measures used in the study are presented in Table 3. According to the guidelines of Helms et al. (2006), acceptable internal consistency was observed for all measures except for the UCLA Loneliness Scale, which evidenced poor internal consistency, indicating that participants did not respond in a consistent manner to the items within this scale.

Table 3

Basic Descriptive Statistics and Cronbach's Alpha for the Measures

Variable	*M*	*SD*	α
Relationship Inventory	6.00	34.145	.867
Working Alliance Inventory	159.61	12.872	.620
Goal Attainment Scaling	4.31	11.603	.970
Loneliness Scale	57.00	4.462	.275
Molest Scale	63.93	20.515	.957
Rape Scale	65.25	21.592	.973
Global Assessment of Functioning Scale	63.02	11.433	--

Note. No α statistic was calculated for the Global Assessment of Functioning Scale because the measure is comprised of a single rating.

Factor Analysis

The original GAS measure was comprised of 12 items, each rated by a therapist and measuring a different aspect of a client's progress in therapy (e.g., empathy development, ability to construct a cohesive relapse prevention plan, etc.). A principal components analysis with a direct oblimin rotation was performed on all 12 variables in order to summarize the correlations of variables more efficiently and better understand if and how these variables grouped together (see Table 4). Additionally, in the event a factor

analysis revealed strong item loadings on one or more factors, it could potentially serve to reduce the number of dependent variables in the study, thereby reducing the number of necessary regression analyses. This would help keep alpha from becoming artificially inflated and reduce the probability of Type-I error.

Results of the initial analysis indicated that two factors were extracted. The first factor accounted for approximately 70.5 percent of the variance and the second factor accounted for approximately 9.5 percent of variability. Interestingly, examination of the pattern matrix indicated that only one variable appeared to load well onto the second factor. That variable, GAS item 11, was a measure of a client's participation in group therapy. Examination of response frequencies indicated that the majority of participants had missing scores for that item. Indeed, because most participants were not involved in group therapy at the time of their participation, that particular item was inapplicable to many of the participants. A decision was therefore made to drop this item from analysis. When a second factor analysis was run on the remaining eleven GAS variables (see Table 5), only one factor was extracted, representing over 77% of the variance. The component matrix for this analysis is presented in Table 5.

By way of interpretation, greater factor loadings indicate greater probability that the variable is a pure measure of the factor. According to the guidelines set out by Comrey and Lee (1992), the factor loadings of nearly every one of these items meet the criteria for "excellent" (i.e., in excess of .71). A single, dependent variable called GAS Total was constructed from this one-factor solution by summing the participants' scores for each of the eleven GAS items. This factor is deemed to fairly represent a therapist-rated measure of overall progress in sex offender-specific treatment.

Table 4

Summary of Factor Loadings for Oblimin Two-Factor Solution for 12-item Goal Attainment Scaling

Item	Factor Loading	
	1	2
1. Acceptance of guilt	.829	-.031
2. Show insight into victim issues	.872	.021
3. Shows empathy for own victims	.817	.174
4. Accepts personal responsibility	.902	.069
5. Recognizes cognitive distortions	.904	-.013
6. Minimizes consequences	.879	.135
7. Understands lifestyle dynamics	.628	.464
8. Understands offence cycle	.933	-.026
9. Identifies relapse prevention concepts	.973	-.317
10. Discloses personal information	.491	.527
11. Participation in group treatment	-.008	.948
12. Motivation to change behavior	.799	.070
Factor Correlations		
Factor 1	--	.393
Factor 2	.393	--

Table 5

Summary of Factor Loadings for Oblimin One-Factor Solution for 11-item Goal Attainment Scaling

Item	Factor Loading
	1
1. Acceptance of guilt	.876
2. Show insight into victim issues	.885
3. Shows empathy for their victims	.876
4. Accepts personal responsibility	.939
5. Recognizes cognitive distortions	.915
6. Minimizes consequences	.928
7. Understands lifestyle dynamics	.867
8. Understands offence cycle.	.935
9. Identifies relapse prevention concepts	.851
10. Discloses personal information	.703
11. Motivation to change behavior	.866

Variable Selection

In preparation for the regression analyses, correlations were performed with the key independent and dependent variables in order to guide the selection of variables for inclusion in the study's primary analyses. Appendix H displays this correlation matrix. Results indicated that a number of alliance measures were highly and significantly correlated with each other. On the basis of both statistical and theoretical considerations,

decisions were made to include in primary analyses only those variables that (a) had been shown in the empirical and theoretical literature to be most strongly associated with treatment outcome, (b) shared less than 80% of the variance (i.e., correlations less than .90, as suggested by Cohen et al., 2003) and (c) allowed for the most thorough examination of the study's hypotheses.

Empathy, Regard, and Congruence subscales of the Relationship Inventory (RI) were highly and significantly intercorrelated, raising concerns about multicollinearity. Because the general psychotherapy literature has similarly demonstrated high correlations between these concepts and has further demonstrated that therapist-offered empathy is a particularly powerful predictor of treatment outcome (i.e., as powerful as the therapeutic alliance as a whole; Bohart et al., 2002), the decision was made to retain the Empathy subscale from the Relationship Inventory measure and to exclude the Regard and Congruence subscales from subsequent analyses. The Unconditionality subscale was retained for subsequent analysis because it correlated only moderately with the other scales (suggesting that it measured a distinct element of the alliance), and thus multicollinearity was not of great concern.

Results also indicated that the total score and all three subscales of the Working Alliance Inventory (WAI) were correlated with each other to a moderately high degree. The WAI Task and Goal subscales were most strongly intercorrelated among the WAI subscales, very nearly meeting the criteria for multicollinearity suggested by Cohen et al. (2003). Task and Goal subscales were both correlated with the WAI Bond subscale to a lesser degree. It was also noted that, among the WAI subscales, WAI Task had the lowest correlation with any of the RI subscales. In order to adequately test the research

hypotheses, address multicollinearity issues, and retain only those variables that promised to contribute unique variance to subsequent multiple regression equations, a decision was made to exclude the WAI Goal subscale and to retain the WAI Bond and Task subscales for further analyses.

The correlational analysis indicated that the dependent measures (i.e., the GAFS, GAS, MOLEST Scale, and RAPE Scale) were generally moderately correlated with each other in expected directions, with the exception of the Loneliness Scale, which showed no significant relationships to any of the other dependent variables. As noted above, the UCLA Loneliness Scale evidenced poor internal consistency, which likely accounts, at least in part, for this result. Although correlations between the cognitive distortion measures (i.e., the MOLEST and RAPE Scales) and the other dependent measures did not consistently meet statistical significance, these correlations were notable at the trend level. Given that these relationships were generally in the same direction and of the same magnitude as other dependent variable correlations, the failure to meet statistical significance is likely attributable to the low numbers of participants in these cells.

Also evident in the correlation analysis was that many of the therapeutic alliance measures (i.e., empathy, unconditionality, positive regard, congruence, therapist-client bond, therapist-client agreement on tasks, and therapist-client agreement on goals) were significantly correlated with many of the treatment outcome measures. A frequent exception to this result involved the loneliness measure which showed significant relationships with only two of the independent variables, a finding that is likely attributable to the measure's poor internal consistency, as discussed above. Correlations between the independent measures and the cognitive distortion measures were

consistently notable only at the trend level which, as discussed above, is likely attributable to the low numbers of participants in these cells.

Structural Determinants

Because of some of the limitations of multiple regression analyses (i.e., the addition of variables necessitates the addition of subjects) and a desire to maximize the meaningfulness of the data, efforts were made to focus primary analyses only on those variables indicated by previous research to be most important to the hypotheses under investigation: elements of the alliance and therapeutic outcome. As discussed above, although it is possible that variables such as duration in therapy and client/therapist ethnicity may influence the way in which alliance and outcome measures are related, the existing empirical evidence indicates that such variables do not seem to impact on ratings of the alliance or the alliance's association with therapeutic outcome. Nevertheless, data was collected on a number of structural determinants, ancillary to the major hypotheses of the study. These included: Age; Risk; Client Ethnicity; Client-Therapist Ethnicity Match; Offence Type; Treatment Duration; and Treatment Modality (individual, group, or both). In order to effectively deal with the small sample size and maximize the statistical power of the major analyses, the relationships between these structural determinants and the outcome indices were examined through a series of preliminary, unadjusted multiple regression models. It was decided a priori that only those ancillary variables demonstrating a significant relationship to the outcome indices would be retained for subsequent analyses. This would potentially facilitate a reduction of independent variables in subsequent analyses. This would serve to increase the statistical power of the major analyses.

Table 6

Summary of Multiple Regression Analyses Predicting Treatment-Related Change from Structural Determinants

Control Variable	GAFS	GAS	Loneliness Scale	MOLEST Scale	RAPE Scale
Age	.233	.440**	.466**	-.228	.192*
Risk	-.136	.219	.247	-.082	.262
Ethnicity	.076	-.033	-.258	.252	-.074
Client-Therapist Ethnicity Match	-.049	-.293[a]	-.242	.034	-.512*
Offence Type	-.068	-.072	-.104	.052	.178
Treatment Duration	-.036	.309*	.020	.083	-.160
Treatment Modality	-.161	-.178	-.064	-.276	-.160

Note. Values in the table are standardized beta (β) weights from multiple regression analyses. $N = 44$, except for MS ($N = 23$) and RS ($N = 15$).
[a]p = .051
*$p < .05$ **$p < .01$

Results are presented in Table 6, where the values represent standardized beta weights from the five multiple regression analyses. In summary, the models suggested that three of these variables (i.e., Age, Client-Therapist Ethnicity Match, and Treatment Duration) might be predictive of treatment progress. Based on these analyses, only these three variables were retained as "control variables" for subsequent analyses.

The Therapeutic Alliance and Treatment Outcome

A series of hierarchical (sequential) multiple regression analyses were performed to evaluate the effects of the therapeutic alliance on indices of treatment outcome. Hierarchical regression analysis allows for the determination of the relative contribution of each variable entered into the regression equation. As recommended by Cohen et al. (2003), this stepwise procedure further allows for the removal of the effects of structural variables (i.e., age, client-therapist ethnicity match, treatment duration) prior to examining

the relative contributions of therapeutic alliance variables. Standardized residuals were examined according to the guidelines of Tabachnick and Fidell (2001) to check for multivariate outliers and to determine whether multivariate assumptions of normality, linearity, and homoscedasticity were met. Analysis indicated an absence of outliers and an absence of any gross violations of these assumptions that would require data transformations.

Each hierarchical equation followed the same stepwise procedure, with each examining a different dependent variable (i.e., GAFS, GAS, Loneliness Scale Total, MOLEST Scale Total, and RAPE Scale Total scores). The dependent variable scores were regressed onto structural determinants (age, client-therapist ethnicity match, treatment duration) in Step 1. As discussed above, these determinants served as control variables for the analyses, and were therefore entered simultaneously in this step. Client ratings of therapist-offered empathy (i.e., RI Empathy scores) were included in Step 2. Client ratings of the client-therapist bond (i.e., WAI Bond scores) were entered in Step 3. Client ratings of therapist-offered Unconditionality (i.e., RI Unconditionality) were included in Step 4. Client ratings of client-therapist agreement on therapeutic tasks (i.e., WAI Tasks) were entered in the final step. In accordance with the study's hypotheses, the order of entry of the predictors was based upon previously observed or theorized relationships between these variables and indices of therapeutic change in the psychotherapy literature. As discussed above with respect to the power analysis, no adjustments were made to control for the family-wise error rate. Considering the exploratory nature of the present study and the small sample size, slightly inflated alpha levels were regarded as a rational

compromise between the demands for a low alpha-risk and a large power level (Cohen, 1988; Perneger, 1998; Press et al., 1988; Tutzauer, 2003).

The first analysis examined global functioning (i.e., GAFS scores) as the dependent variable. Table 7 displays the unstandardized regression coefficients (*B*), the standard error of B, the standardized coefficients (β), R^2 and adjusted R^2 (ΔR^2) after entry of the variables at each step. Structural determinants accounted for a negligible amount of the variance in GAFS scores, and this model was not significantly different from zero. None of the variables in this group was significantly related to global functioning. Adding therapist empathy to the model in Step 2 accounted for an additional 18.7% of the variance in global functioning scores, and the model was significantly different from zero, $F(4, 39) = 3.16, p < .05$. Using Cohen's (1988) f^2 statistic and guidelines to calculate effect size, this represents an effect of .201, a medium magnitude effect. None of the other variables entered into this equation significantly improved the predictive ability of this regression model.

The second hierarchical regression analysis examined overall sexual offender treatment progress (i.e., GAS Total) as the dependent variable. Table 8 displays the results of this analysis. Structural determinants accounted for 20.6% of the variance in GAS scores, $F(3, 40) = 4.72, p < .01$. Of the variables in this group, only Age (β=.356, $p < .05$) was significantly related to treatment progress. The addition of therapist empathy at Step 2 accounted for a further 20.4% of the variance in treatment progress, $F(4, 39) = 8.47$, $p < .001$, a medium effect size of $f^2 = .256$. The entire model accounted for 41% of the variance in outcome. None of the other variables entered into this equation significantly improved the predictive ability of this regression model.

Table 7

Hierarchical Regression Analysis Summary for Variables Predicting Global Assessment of Functioning

Predictor	*B*	*SE B*	β	R^2	ΔR^2
Step 1				.051	-.020
Age	.277	.197	.228		
Client-Therapist Ethnicity Match	.613	3.704	.027		
Treatment Duration	-.023	.055	-.066		
Step 2				.245	.167*
Age	.132	.184	.109		
Client-therapist Ethnicity Match	.824	3.347	.036		
Treatment Duration	-.044	.051	-.123		
Therapist Empathy	.353	.112	.462**		
Step 3				.248	.149*
Age	.135	.186	.111		
Client-therapist Ethnicity Match	.758	3.388	.033		
Treatment Duration	-.047	.052	-.131		
Therapist Empathy	.305	.166	.400		
Client-therapist Bond	.087	.224	.084		
Step 4				.273	.155
Age	.171	.188	.141		
Client-therapist Ethnicity Match	1.067	3.386	.047		
Treatment Duration	-.045	.051	-.127		
Therapist Empathy	.373	.176	.488		
Client-therapist Bond	.107	.224	.103		
Therapist Unconditionality	-.201	.178	-.195		

(table continues)

Table 7 (continued)

Predictor	*B*	*SE B*	β	R^2	ΔR^2
Step 5				.297	.160
Age	.175	.187	.144		
Client-therapist Ethnicity Match	1.194	3.378	.052		
Treatment Duration	-.033	.052	-.092		
Therapist Empathy	.322	.181	.422		
Client-therapist Bond	-.066	.272	-.063		
Therapist Unconditionality	-.191	.178	-.185		
Client-therapist Agreement on Tasks	.266	.240	.262		

Note. $N = 44$
$*p < .05$ $**p < .01$

The third hierarchical regression analysis examined intimacy deficits (i.e., LS Total) as the dependent variable. As shown in Table 9, structural determinants accounted for 11.5% of the variance in Loneliness Scale Total scores, $F(3, 40) = 2.86, p < .05$. Of the variables in this group, only Age (β=.344, $p < .05$) was significantly related to intimacy deficits. The addition of therapist empathy at Step 2 accounted for an additional 11.7% of the variance in intimacy scores and the model was significantly different from zero, $F(4, 39) = 4.253$, $p < .01$. This represents an effect size of $f^2 = .302$, a medium effect. Adding client-therapist bond and therapist unconditionality in Steps 3 and 4 did not significantly improve the predictive ability of the model, although the addition of these variables to the equations made the contribution of therapist empathy to the model nonsignificant, suggesting some shared variance between these measures. The addition of client-therapist agreement on treatment tasks in Step 5 added an additional, statistically significant 16.3% of variance, relative to previous steps ($f^2 = .195$, a medium effect size) and the model was statistically significant $F(7, 36) = 4.776, p < .01$.

Table 8

Hierarchical Regression Analysis Summary for Variables Predicting Goal Attainment Scaling

Predictor	*B*	*SE B*	β	R^2	ΔR^2
Step 1				.262	.206**
Age	.437	.175	.356*		
Client-Therapist Ethnicity Match	-3.152	3.298	-.137		
Treatment Duration	.089	.049	.248		
Step 2				.465	.410***
Age	.287	.156	.234		
Client-therapist Ethnicity Match	-2.933	2.844	-.128		
Treatment Duration	.068	.043	.189		
Therapist Empathy	.365	.095	.473***		
Step 3				.470	.401***
Age	.283	.157	.231		
Client-therapist Ethnicity Match	-2.845	2.870	-.124		
Treatment Duration	.072	.044	.200		
Therapist Empathy	.429	.141	.556**		
Client-therapist Bond	-.116	.190	-.111		
Step 4				.482	.398***
Age	.308	.160	.251		
Client-therapist Ethnicity Match	-2.629	2.885	-.114		
Treatment Duration	.073	.044	.202		
Therapist Empathy	.476	.150	.617**		
Client-therapist Bond	-.102	.190	-.097		
Therapist Unconditionality	-.140	.152	-.135		

(table continues)

Table 8 (continued)

Predictor	*B*	*SE B*	β	R^2	ΔR^2
Step 5				.510	.415***
Age	.313	.158	.255		
Client-therapist Ethnicity Match	-2.492	2.847	-.108		
Treatment Duration	.086	.044	.240		
Therapist Empathy	.421	.153	.546**		
Client-therapist Bond	-.290	.229	-.276		
Therapist Unconditionality	-.129	.150	-.124		
Client-therapist Agreement on Tasks	.288	.202	.280		

Note. $N = 44$
** $p < .01$ *** $p < .001$

A fourth hierarchical regression analysis examined attitudes supportive of child sexual abuse (i.e., cognitive distortions) as the dependent variable. Notably, this analysis only looked at those participants whose sexual offences solely involved child victims, and thus the sample size for this analysis was substantially reduced, $n = 23$. Regrettably, this greatly reduced statistical power. As shown in Table 10, structural determinants accounted for a negligible and insignificant amount of the variance in MOLEST Scale total scores, $F(3, 19) = .362$, $p = .78$. None of the variables in this group were significantly related to the dependent variable scores. The addition of therapist empathy at Step 2 improved the predictive validity of the model, contributing an additional 28.1% of variance to MOLEST Scale Total scores. This represented a large effect size of $f^2 = .391$. This model did not meet the conventional level of statistical significance, hovering around the trend level, $F(4, 18) = 2.255$, $p = .103$. Although the regression models in Step 3, 4, and 5 were significantly different from zero, none of the variables entered into these equations subsequent to Step 2 significantly improved the predictive ability of the models.

Table 9

Hierarchical Regression Analysis Summary for Variables Predicting Intimacy Deficits

Predictor	*B*	*SE B*	Β	R^2	ΔR^2
Step 1				.177	.115*
Age	.391	.171	.344*		
Client-Therapist Ethnicity Match	-3.454	3.222	-.162		
Treatment Duration	-.013	.048	-.039		
Step 2				.304	.232**
Age	.500	.165	.440**		
Client-therapist Ethnicity Match	-3.614	3.002	-.170		
Treatment Duration	.025	.045	.007		
Therapist Empathy	-.267	.100	-.374*		
Step 3				.321	.232**
Age	.493	.165	.434**		
Client-therapist Ethnicity Match	-3.466	3.007	-.163		
Treatment Duration	.009	.046	.027		
Therapist Empathy	-.160	.148	-.225		
Client-therapist Bond	-.195	.199	-.200		
Step 4				.327	.218*
Age	.509	.169	.448**		
Client-therapist Ethnicity Match	-3.328	3.044	-.157		
Treatment Duration	-.009	.046	.028		
Therapist Empathy	-.130	.158	-.183		
Client-therapist Bond	-.186	.201	-.191		
Therapist Unconditionality	-.090	.160	-.093		

(table continues)

Table 9 (continued)

Predictor	*B*	*SE B*	Β	R^2	ΔR^2
Step 5				.481	.381**
Age	.498	.150	.438**		
Client-therapist Ethnicity Match	-3.629	2.710	-.171		
Treatment Duration	-.020	.042	-.060		
Therapist Empathy	-.011	.146	-.015		
Client-therapist Bond	.225	.218	.231		
Therapist Unconditionality	-.115	.142	-.119		
Client-therapist Agreement on Tasks	-.630	.192	-.664**		

Note. $N = 44$
$*p < .05$ $**p < .01$

A fifth hierarchical regression analysis examined attitudes supportive of adult sexual assault as the dependent variable. As with the previous analysis, this analysis was subject to considerable loss of statistical power, as it only examined those participants whose sexual offences solely involved adult victims, which reduced the sample size considerably, $n = 15$. As shown in Table 11, the structural determinants accounted for a statistically insignificant amount of the variance in RAPE Scale Total scores, $F(3, 11) = 1.858, p = .195$. None of the variables in this group were significantly related to RAPE Scale Total scores. Steps 2, 3, and 5 did not significantly improve the models predictive accuracy, although the addition of therapist unconditionality in Step 4 did contribute a statistically significant, additional 31% of variance to the RS Total scores (a large effect size of $f^2 = .449$), and this model was significantly different from zero at the trend level, $F(7, 7) = 3.456, p = .055$. This indicates that higher levels of therapist unconditionality were associated with higher levels of cognitive distortions regarding forcible adult sexual contact. Notably, in this model (which included the structural determinants, therapist empathy, client-therapist bond, and therapist unconditionality, and accounted for 51% of

the variability in RS Total scores), therapist empathy was also related to RS Total scores at the trend level, β=-.985, p = .05.

Table 10

Hierarchical Regression Analysis Summary for Variables Predicting Attitudes Supportive of Child Sexual Abuse in a Sample of Men Who Have Sexually Assaulted Children

Predictor	B	$SE\ B$	β	R^2	ΔR^2
Step 1				.054	-.095
Age	-.474	.503	-.233		
Client-Therapist Ethnicity Match	-1.259	9.846	-.032		
Treatment Duration	.018	.184	.024		
Step 2				.334	.186[a]
Age	-.062	.459	-.031		
Client-therapist Ethnicity Match	2.344	8.589	.059		
Treatment Duration	.148	.166	.194		
Therapist Empathy	-.825	.300	-.570*		
Step 3				.342	.149
Age	-.064	.469	-.031		
Client-therapist Ethnicity Match	1.846	8.850	.046		
Treatment Duration	.155	.170	.204		
Therapist Empathy	-.714	.391	-.493		
Client-therapist Bond	-.276	.599	-.121		
Step 4				.450	.244
Age	-.254	.455	-.125		
Client-therapist Ethnicity Match	-1.793	8.585	-.045		
Treatment Duration	.121	.161	.159		
Therapist Empathy	-.892	.382	-.615*		
Client-therapist Bond	-.598	.593	-.263		
Therapist Unconditionality	.680	.383	.432		

(table continues)

Table 10 (continued)

Predictor	*B*	*SE B*	β	R^2	ΔR^2
Step 5				.510	.281
Age	-.382	.454	-.187		
Client-therapist Ethnicity Match	-2.259	8.382	-.057		
Treatment Duration	.027	.172	.035		
Therapist Empathy	-.565	.445	.390		
Client-therapist Bond	.279	.871	.123		
Therapist Unconditionality	.724	.375	.460		
Client-therapist Agreement on Tasks	-1.205	.895	-.600		

Note. $n = 23$
[a]$p = .103$
$*p < .05$

Table 11

Hierarchical Regression Analysis Summary for Variables Predicting Attitudes Supportive of Adult Sexual Assault in a Sample of Men Who Have Sexually Assaulted Adults

Predictor	*B*	*SE B*	β	R^2	ΔR^2
Step 1				.336	.155
Age	.005	.849	.002		
Client-Therapist Ethnicity Match	-23.256	13.850	-.566		
Treatment Duration	-.119	.145	-.253		
Step 2				.485	.278
Age	.706	.887	.331		
Client-therapist Ethnicity Match	-13.179	14.113	-.321		
Treatment Duration	-.052	.140	-.110		
Therapist Empathy	-.668	.394	-.522		
Step 3				.488	.203
Age	.685	.936	.321		
Client-therapist Ethnicity Match	-12.418	15.160	-.302		
Treatment Duration	-.027	.178	-.058		
Therapist Empathy	-.595	.512	-.465		
Client-therapist Bond	-.175	.725	-.108		

(table continues)

Table 11 (continued)

Predictor	*B*	*SE B*	β	R^2	ΔR^2
Step 4				.722	.513[a]
Age	-.200	.808	-.094		
Client-therapist Ethnicity Match	-21.685	12.383	-.527		
Treatment Duration	-.080	.141	-.169		
Therapist Empathy	-.985	.428	-.769[b]		
Client-therapist Bond	.329	.600	.203		
Therapist Unconditionality	1.256	.485	.669*		
Step 5				.740	.481
Age	-.085	.850	-.040		
Client-therapist Ethnicity Match	-21.150	12.808	-.514		
Treatment Duration	-.125	.159	-.264		
Therapist Empathy	-.992	.442	-.774		
Client-therapist Bond	.718	.826	.443		
Therapist Unconditionality	1.152	.521	.614		
Client-therapist Agreement on Tasks	-.431	.607	-.238		

Note. $n = 15$
[a]$p = .055$ [b]$p = .050$
*$p < .05$

In summary, a series of hierarchical regression analyses indicated that higher levels of therapist empathy were associated with better treatment outcomes in measures of global functioning (i.e., GAFS scores), sex offender-specific treatment targets (i.e., GAS ratings), intimacy deficits (UCLA Loneliness Scale) and cognitive distortions (MOLEST and RAPE scales). Greater client-therapist agreement on therapy tasks was associated with higher levels of intimacy development. High levels of therapist unconditionality were associated with higher levels of cognitive distortions in a subsample of rapists. Client age was associated with treatment outcome on measures of sex-offender-specific treatment targets with older clients generally showing better attainment of treatment goals. Age was also associated with intimacy deficits, with older participants exhibiting greater levels of emotional loneliness.

Qualitative Analysis

In the present study, responses to the open-ended questions were subjected to thematic content analysis (Smith, 1992; Weber, 1990). Thematic content analysis is a theory-driven qualitative methodology in which data is categorized into thematic categories through a "process of discovery" (Morgan, 1988). This methodology has sufficient flexibility to allow for the discovery of unexpected themes that might emerge in the coding process.

Data was analyzed through the process of coding, and an *open coding* paradigm (Strauss & Corbin, 1990) was adopted to guide the coding process. This process involves the breaking down, naming, comparing, and categorizing of data (Strauss & Corbin, 1990). As similarities and differences in the codes were conceptualized, a coding scheme reflecting theoretical constructs was refined by clustering codes together to make categories. Conceptual saturation was reached when no new categories were generated from the open codes, and the remaining gaps in the emerging conceptual scheme were filled. The categories were then examined for their relationships to each other. The integration and interrelationships of the categories, especially the core categories, were used to explicate, modify, or generate theory, as appropriate.

Due to the overall low level of literacy evident in the participants' written responses, it was determined that, for the purposes of analysis, responses would be analyzed at the level of statements or phrases (rather than complete sentences) used by the participants to describe their treatment experiences. Following the recommendations of Gorden (1992), it was also determined that categories would be mutually exclusive and

exhaustive (i.e., all the data would be classified) in order to facilitate the categorization and analysis of data.

Two clinicians separately examined each response for constituent themes, and each statement or phrase was assigned a categorical label that reflected its underlying theme or concept. Phrases containing similar themes were grouped together and subjected to further examination to determine if and how they thematically fit together. Statements were subjected to rigorous comparisons and were categorized and re-categorized frequently before they were assigned their final conceptual/thematic label.

In some cases, an individual response reflected one cohesive theme. In other cases (and more frequently), multiple themes were reflected in the responses. The following example illustrates the coding process. In response to the first question (*In your therapy experience, what things have you found the most helpful in supporting you to deal with your issues and manage your risk?*), one participant wrote:

> Having someone to talk to, to let out pent up emotions, to have clarification and identification of feelings and emotions, thereby helping build-up identification of warning signs and behaviours. Overall having someone who understands you.

It was determined that two different themes were expressed in this response. In the statement, "Having someone to talk to, to let out pent up emotions, to have clarification and identification of feelings and emotions, thereby helping build-up identification of warning signs and behaviours," it was determined that the participant was describing how the psychotherapy process allows for the venting, labeling and recognition of emotions, which facilitates the effective management of those emotions and an associated reduction in risk. The conceptual label *Managing Emotions* was therefore applied to this statement.

The statement "Overall having someone who understands you" was determined to describe the significance of an empathic therapist, and was classified under the label *Empathic*.

The open coding process resulted in 32 categories of helpful features of treatment and 14 categories of unhelpful elements of the participants' treatment experiences. Frequencies were calculated for each of the thematic categories (see Appendix I), in order to determine how often each theme was expressed in the participants' responses.

A sample of the initial codings from each of the raters was examined for reliability (i.e., degree of inter-rater concordance), and instances of between-rater discordance were resolved through discussion and consensus. To this end, two clinicians independently coded 72 statements extracted from the responses of a sub-sample of seven participants. This data comprised the responses given by the first seven participants in the sample for each of the questions. Nearly 20% of the total responses were represented by this sub-sample. Text from the first seven respondents was selected because this data became available early in the project's data collection phase, allowing for prompt development and testing of the coding scheme. Intercoder agreement was calculated using Cohen's kappa statistic (Cohen, 1960). Kappa is a measure of the amount of agreement between two coders after statistically adjusting for agreement due to chance. Total agreement between two coders yields a kappa = 1.00. Any disagreement produces a value < 1.00, with lower values indicating larger discrepancies. Kappa takes negative values when there is less agreement than expected by chance alone (Cohen, 1960). Landis & Koch (1977) proposed a set of guidelines and labels to describe the degree of concordance: 0.21-0.40, "Fair"; 0.41-0.60,"Moderate"; 0.61-0.80, "Substantial"; 0.81-1.00 "Almost perfect".

According to these guidelines, intercoder agreement in the current study was "almost perfect," κ ($N = 72$) = .910 ($p < .0001$).

The categories derived from this open coding process were then reevaluated in light of their observed interrelationships. Although the small units of information chosen for analysis (i.e., phrases and statements) were not sufficiently dense to be appropriate for more intensive analytic paradigms such as axial coding (Strauss & Corbin, 1990), data here was nonetheless examined according to how categories or concepts thematically clustered together (Neuman, 2003). This allowed for a further refining of the data in order to better reflect its fundamental nature. Through this process, four superordinate themes emerged. These included: *Therapeutic Style*; *Healthy Skill Development*; *Social Connectedness*; and *Instillation of Hope*. Superordinate categories, along with their constituent thematic categories, frequencies, and sample responses are presented in Appendix I (Tables A1 to A4) and Appendix J.

Discussion

Determining how to provide effective treatment for men who have committed sexual offences is an issue crucial to clinical program design, program delivery, and public safety. The general psychotherapy literature is conclusive in its findings that the quality of the relationship between client and therapist is significantly associated with meaningful clinical change. The present study sought to determine to what extent these findings apply to the treatment of sexual offenders.

The Therapeutic Alliance and Treatment Outcomes with Sexual Offenders

Results support the idea that the quality of the therapeutic alliance influences treatment outcomes for sexual offenders. Stronger therapeutic alliances were associated

with better overall client functioning and better treatment outcomes. The study hypothesized that a positive therapeutic alliance would be associated with indices of treatment outcome that included: general self-regulation; sex offender treatment-specific goal attainment (including attitude change, accountability, victim empathy, and relapse prevention knowledge); healthy intimacy development; and a reduction in cognitive distortions supportive of sexual offending. This hypothesis was largely supported. Therapist empathy, a condition long recognized in the general psychotherapy literature as facilitative of positive therapeutic relationships, was found to be positively associated with measures of global psychological, social, and occupational functioning and sex-offender treatment progress (medium effect sizes), and negatively associated with intimacy deficits (a medium effect size) and cognitive distortions supportive of sexual assault (a large effect size). Greater client-therapist agreement on treatment tasks was associated with lower levels of emotional loneliness. And interestingly, higher levels of therapist unconditionality were related to higher levels of cognitive distortions.

The study examined a number of aspects of the therapeutic relationship that have been theoretically and empirically linked to treatment outcome. These included the therapist-offered relationship conditions of empathy, genuineness/congruence, positive regard/warmth, and unconditionality/acceptance (Rogers, 1957), as well as a pan-theoretical construct of the theoretical alliance that includes therapeutic bond, client-therapist agreement on treatment goals, and client-therapist collaboration on the tasks of treatment (Bordin, 1976).

It was hypothesized that, among these elements of the therapeutic alliance submitted for examination, the therapist-offered relationship conditions would

demonstrate the strongest associations with indices of treatment. This hypothesis was also largely supported. Therapist empathy was significantly associated with global functioning, attainment of treatment goals, and healthy intimacy development (accounting for approximately 18%, 20%, and 12% of unique outcome variance, respectively). And when examining the results at the trend level of statistical significance, therapist empathy further accounted for more than one quarter of outcome variance in cognitive distortions supportive of child sexual abuse, and was significantly associated with prosocial attitudes regarding adult sexual assault. Considering the small sample size of participants for these particular analyses, the trend level results are considered notable. A measure of the quality of client-therapist collaboration on treatment tasks was significantly associated with healthy intimacy development.

Relation of Findings to the General Psychotherapy Outcome Literature

These results are remarkably consistent with the general psychotherapy literature, which has demonstrated that the therapeutic relationship is strongly and significantly associated with therapeutic outcome in a wide range of therapies for a variety of problems. The present findings are particularly concordant with the findings of the Bohart et al. (2002) meta-analysis which demonstrated that therapist-offered empathy alone accounted for 10% of the variability in psychotherapeutic outcome. This suggests that what works in psychotherapy with populations presenting for treatment with conditions such as depression, bipolar disorder, anxiety, substance dependence, and eating disorders is not substantially different from what works with individuals with aggressive sexual behavior problems. Specifically, it supports the contention that therapist empathy is one of the interpersonal variables most strongly related to positive change with sexual offenders.

The process by which empathy leads to good outcomes in psychotherapy has been discussed by a number of writers. Bohart et al. (2002) identified four factors as potential mediators between empathy and outcome. It has been hypothesized from research evidence (e.g., Bachelor, 1988; Myers, 2000) that empathy operates as a positive relationship condition that leads clients to feel understood. This, in turn, causes clients to feel safe in the relationship, makes it easier to self-disclose, and increases client satisfaction and treatment compliance. This hypothesis is supported by the present study's qualitative findings, where participants frequently identified *Providing a Sense of Comfort and Safety* and *Self-Disclosure* as effective elements of treatment. It has also been hypothesized that empathy functions as a corrective emotional experience in which an empathic relationship helps clients learn that they are worthy of respect so that they can freely express feelings and needs in relationships (Bohart & Greenberg, 1997; Zimring, 2000; as cited in Bohart et al., 2002). This hypothesis is supported by the findings of Beech and Hamilton-Giachritsis (2005), who found a significant relationship between group cohesiveness and the extent to which group therapy participants felt free to express their emotions in treatment. Researchers have additionally postulated that empathy facilitates cognitive-affective processing, helping clients think more productively and facilitating emotional reprocessing (Greenberg & Paivio, 1997; Sachse, 1990; as cited in Bohart et al., 2002). And a number of writers have theorized that the capacity for healing primarily rests in the client's self-healing potential (Bergin & Garfield, 1994; Bohart and Tallman, 1999). From this perspective, active client involvement is the most important factor in making therapy work (Orlinsky et al., 1994) by promoting involvement,

supporting clients' information-processing efforts, and helping the therapist choose interventions that match well with the clients' world view (Bohart et al., 2002).

Qualitative findings support the quantitative data. Participants identified a number of elements of *Therapeutic Style* associated with their treatment gains. Many of these reflect traditionally accepted and empirically supported elements of the therapeutic alliance, including: *Providing a Sense of Comfort and Safety*, *Empathic*, *Supportive*, *Accepting*, *Warm*, *Genuine*, *Attentive*, *Patient*, *Trustworthy*, and *Cooperative*. Characteristics in opposition to these (i.e., *Uncaring*, *Unempathic*, *Judgmental*, *Dismissive*, *Confrontational*, *Unsupportive*, *Untrustworthy*, and *Uncooperative*) were described by participants as impeding their treatment progress. Treatment elements that facilitated *Social Connectedness* were also found to be beneficial, signifying relationship needs that extend beyond the client-therapist relationship yet can nonetheless be met through the treatment process. These findings are in accordance with previous qualitative investigations examining the therapeutic alliance in both the general psychotherapy literature (e.g., Kuehl, Newfield, & Joanning, 1990; McCollum & Trepper, 1995) and the sex offender treatment literature (e.g., Wakeling et al., 2005).

It is noted that participants offered similar types and quantities of alliance-related responses to different questions, whether they were asked about their therapists' personal qualities (51% of responses were alliance-related) or their relationships with their therapists (53% were related to the therapeutic alliance). Consistent with the Rogerian conception of the therapeutic relationship as well as numerous studies, clients did not readily distinguish helpful therapist qualities from relational ones. This suggests an inseparability of therapist and alliance factors (as perceived by the client) and supports the

notion that therapists' interpersonal qualities impact on the therapeutic relationship and are responsible, in and of themselves, for a significant portion of treatment outcome with sexual offenders.

One interesting result that digressed from findings in the general psychotherapy literature was that higher levels of therapist unconditionality were associated with higher levels of cognitive distortions supportive of forcible adult sexual contact. Participants who perceived their therapists as unconditionally accepting tended to demonstrate higher levels of these cognitive distortions than men who perceived lower levels of unconditional acceptance from their therapists. Although somewhat unexpected, this result, notable at a trend level of statistical significance, points to the importance of appropriate role modeling by clinicians (Andrews & Bonta, 1998). It is probable that sexual abusers who believe their therapists to be unconditionally accepting of them may subtly perceive this acceptance as also extending to their distorted attitudes about their victims.

Indeed, Andrews (Andrews et al., 1979; Andrews, 1980) found that staff who rated high on interpersonal sensitivity and awareness of social rules interacted better with offenders, were more likely to display prosocial behavior, and were more likely to exhibit disapproval of antisocial behavior. These factors were, in turn, found to be associated with lowered recidivism in the offenders with whom these staff members interacted. The most effective probation officers, as judged by their clients' recidivism rates, were those who demonstrated high levels of empathy and were also prosocial in their attitudes and practices. Conversely, the least effective probation officers (i.e., those whose clients had the highest recidivism rates) were those who had high levels of empathy but were not pro-social in their attitudes and supervision practices (Andrews et al., 1979; Andrews, 1980).

Similarly, Trotter (1996) found a strong negative relationship between community corrections officers' (CCO's) use of prosocial modeling and positive reinforcement and recidivism in their clients. No relationship was found between CCOs' use of empathy and recidivism, although it is noted that empathy in this study was rated by the researchers, rather than the clients. In reference to this group of findings, it has been argued that empathy, in the absence of prosocial attitudes and appropriate challenging of antisocial attitudes, can be interpreted by clients as providing permission for their antisocial behavior (Trotter, 1997). That is, therapist empathy may facilitate change, but the direction of that change may be in a positive (i.e., prosocial) or negative (i.e., antisocial) direction depending on the extent to which treatment providers model appropriate attitudes and behaviors (Trotter, 1997).

This hypothesis is supported by the current findings. The treatment model with the strongest association with prosocial client attitudes (notable at the trend level) was one in which low levels of therapist unconditionality were accompanied by high levels of therapist empathy. That is, therapists who were perceived by their clients as empathic but not unconditionally accepting were more likely to have clients with better treatment outcomes. Qualitative results support this finding, indicating that within the context of positive therapeutic relationships, participants identified challenging therapist behaviors that enhanced their accountability as associated with treatment gains. It is suggested that, perhaps more so in the field of offender rehabilitation than in other treatment contexts, it is important for therapists to challenge unhealthy, antisocial attitudes while maintaining an empathic, warm, and supportive relationship. This notion is consistent with Beech and

Fordham's (1997) and Marshall et al.'s (2003) findings that aggressively confrontational approaches produce poorer treatment outcomes.

Relation of Findings to the Sexual Offender Treatment Literature

Results are consistent with the findings of Marshall and his colleagues (Marshall, Serran, Moulden, et al., 2002; Marshall et al., 2003), who found that therapist empathy, warmth, rewardingness, and directiveness were reliably associated with positive outcomes in sexual offender treatment, and with the findings of Beech and colleagues (Beech & Fordham, 1997; Beech & Hamiltion-Giachritsis, 2005), who identified an association between group leader support, group cohesion, and positive sexual offender treatment outcomes. Results are additionally consistent with findings that that aggressively confrontational approaches are less likely to be successful than warm and supportively challenging ones (Beech & Fordham, 1997; Marshall, Serran, Moulden, et al., 2002).

Other helpful elements of treatment identified by participants comprised those related to the *Instillation of Hope*, including *Positive Reinforcement*, *Reliability and Accessibility of Support*, *Generates Positive Expectations*, and *Facilitates Self-Efficacy*. Certainly, these elements can also be regarded as closely reflecting features of the therapeutic alliance. And concurrent with some increasing recognition of the role of the client-therapist relationship in sex offender treatment, the treatment literature is beginning also to recognize the imperative role of hope in the rehabilitation of offenders. Positive approaches to sexual offender treatment such as hope theory (Snyder et al., 2000) and the good lives model (Ward, 2002) have been recently promoted as frameworks for offender rehabilitation (e.g., Marshall et al., 2005; Moulden & Marshall, 2005; Ward & Marshall, 2004). These approaches emphasize the role of hope and positive expectancies in effective

treatment, arguing that an increased focus on offender strengths and primary human goods provides a more holistic and constructive way of treating sex offenders (Ward & Marshall, 2004). This is a perspective with substantial empirical support. For example, in their review of the general psychotherapy outcome literature, Lambert and Bergin (1994) estimated that positive expectancies may account for as much as 15% of outcome variance in treatment.

Qualitative findings additionally demonstrate the substantial value that participants placed on *Healthy Skill Development* in promoting treatment gains. *Risk Management Strategies*, *Self-Disclosure*, *Problem-Solving*, *Managing Emotions*, and *Developing Coping Skills* were some of the skill sets identified as valuable. In fact, with regards to the first qualitative question that enquired generally about effective elements of treatment, over 66% of participants' responses related to the development of healthy, prosocial skills. By way of comparison, approximately 15% of responses referred to *Social Connectedness*, 13% referenced *Therapeutic Style*, and 9% referred to *Instillation of Hope* as helpful in supporting their process of change. And of those elements of *Therapeutic Style* identified as beneficial, only about 41% of responses (129 of 311) to all qualitative questions appeared to be directly related to therapeutic alliance variables (as identified above). Rather, variables such as *Direct*, *Directive*, *Limit Setting*, *Objective*, and *Properly Paced* largely constituted the remainder of the *Therapeutic Style* factors.

In the context of the quantitative findings indicating a strong relationship between the therapeutic alliance and outcome, this finding suggests that, when not asked to specifically attend to therapist or therapeutic alliance variables, sexual offenders are more likely to identify and value skill development as responsible for positive treatment

outcomes. It may be that therapeutic alliance variables operate in the background in effective treatment, possibly by setting the stage or laying the foundation for positive change and maximizing treatment benefits. In support of this notion, participants in the current study frequently indicated that *Providing a Sense of Comfort and Safety* was a *Therapeutic Style* factor related to treatment progress, and Beech and Hamilton-Giachritsis (2005) found a strong relationship between group cohesiveness and the extent to which group therapy participants felt free to express their emotions in treatment.

Writers (e.g., Beech & Fordham, 1997; Marshall, 2005) have suggested that while the traditional conceptualization of a warm and empathic therapist may be essential to positive therapeutic alliances and enhanced treatment outcomes with sexual offender populations, it is unlikely to be sufficient, in itself. Indeed, sexual offenders frequently present for treatment with especially chaotic developmental histories and insecure attachment and relational paradigms (Marshall, 1993; Ward et al., 1995). It is reasonable, therefore, to conclude that while therapist qualities such as empathy and warmth are likely foundational to the change process with these clients, therapist qualities and behaviors that bring structure, organization, and predictability to treatment are likely additionally important. Indeed, Beech and colleagues (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005) found that warm, supportive, and effective treatment providers were more likely to be conducting cohesive, well-organized groups that emphasized practical tasks and decision-making. And Marshall and colleagues (Marshall, Serran, Moulden, et al., 2002; Marshall et al., 2003) found that in addition to qualities such as empathy and warmth, therapist directiveness and rewardingness were reliably associated with positive outcomes in sexual offender treatment. These results are reflected in the present

investigation, where therapist qualities such as *Direct*, *Directive*, *Limit Setting*, *Objective*, *Properly Paced* (i.e., therapist directiveness) and *Generates Positive Expectations*, *Positive Reinforcement*, and *Facilitates Self-Efficacy* (i.e., therapist rewardingness) encompassed many of the helpful therapist and treatment characteristics identified by participants.

Client-therapist treatment collaboration was significantly associated in the current study with intimacy development. Interestingly, this collaborative aspect of the therapeutic alliance was significantly associated with only a single treatment target (as opposed to therapist empathy, which was associated with most outcome indices). Aside from emphasizing the primary role of therapist empathy in therapeutic change, this also suggests that different interpersonal styles may be differently effective with different treatment targets. It may be, for instance, that healthy intimacy development requires not just a warm, empathic therapist, but also one who effectively structures treatment tasks that lead to skill development. Where treatment targets such as cognitive distortions represent internally held attitudes and beliefs that can be largely (but certainly not entirely) addressed within treatment sessions, intimacy development requires addressing intimacy fears and developing specific relationship skills that allow for greater social competency. This idea is suggested by participants' qualitative responses, which identified *Social Connectedness* as a benefit of treatment.

A Contextual Model for the Treatment of Sexual Offenders

If successful psychotherapy largely involves effective persuasion (Frank & Frank, 1991), than the role of client-therapist collaboration becomes even clearer. As noted above, previous writers have identified a number of components common to all effective

psychotherapies: a therapeutic relationship; linking hope for improvement to the therapeutic process; the provision of new learning experiences; emotional stimulation; enhanced self-efficacy; and the opportunity to practice new skills (Frank & Frank, 1991; Wampold, 2001; Yalom, 1995). Examination of the instrument used to measure the collaborative elements of the alliance is informative in this regard (see Appendix B). Many of these common psychotherapy components are imbedded in the items of the Working Alliance Inventory and in its Task subscale, in particular, where hope for improvement is linked to therapy tasks (e.g., *I feel that the things I do in therapy will help me to accomplish the changes that I want*), new learning experiences are provided, and self-efficacy is enhanced (e.g., *What I am doing in therapy gives me new ways of looking at my problem*). It is worth noting again here that *Healthy Skill Development* was the category of responses in the current study that was most frequently cited as helpful in treatment, which supports the idea that client-therapist collaboration on specific, skill-building treatment tasks is another piece essential to effective psychotherapy.

Clinicians and researchers in the psychotherapy field have long worked under the assumption that effective psychotherapy entails optimally matching specific treatment procedures and techniques to specific clinical problems (Drozd & Goldfried, 1996). These efforts have met with mixed success, and many writers have persuasively argued that there is very little evidence to indicate that specified procedures alone produce positive clinical changes (Ahn & Wampold, 2001; Bergin & Garfield, 1994; Wampold, 1997; Wampold et al., 1997; Wampold, 2001). More recently, with increasing recognition of the powerful role of common factors such as the therapeutic alliance in psychotherapy, researchers have begun to espouse the belief and produce evidence that effective treatment

involves matching therapeutic relationship stances *and* procedures to clients based on clients' clinical problems, personality styles, learning styles, and readiness to change (e.g., Castonguay & Buetler, 2006; Norcross, 2005; Rothman & Ellerby, 2006). Certainly if, as estimated by other writers (e.g., Lambert, 1992; Norcross, 2005; Wampold et al., 1997), treatment techniques and procedures account for less than 8% of outcome variance, the therapeutic alliance accounts for 5-30% of outcome, and client variables are responsible for approximately 25% of variability in outcome, then an approach that successfully matches these variables to each other would maximize treatment effectiveness.

The results of the present examination are in accordance with a contextual model of psychotherapy (Wampold, 2001) that accounts for how the characteristics of therapist, client, procedures, and the interactions between the three influence the outcome of psychotherapy. In a model supported by the current study, techniques and procedures are essential to treatment, but not because they are entirely responsible for therapeutic benefits. Rather, in the context of a warm and empathic therapeutic relationship, specific procedures and techniques are primarily necessary to build a coherent treatment that therapists believe in, that provides a convincing rationale and facilitative structure for clients to learn new skills, and that allows for a productive collaboration. Future investigations would do well to explore how to optimize the treatment responsivity of different offender populations, based on the above principles. Some promise has been shown in identifying responsivity factors based on early attachment paradigms (e.g., Ward et al., 1995), and this is one particular direction worthy of future pursuit.

Limitations and Directions for Future Research

It is, of course, not possible to determine conclusively whether the therapeutic alliance variables were responsible for positive treatment outcomes in the current study. The present investigation is far from immune to a common critique of treatment outcome studies: the question of causality. Does therapist empathy cause therapeutic outcome or is it a correlate of it? Rather than the therapeutic alliance being responsible for treatment benefits, it may be that effective treatment simply causes clients to perceive their therapists as empathic. This question cannot be answered definitively from the data.

However, the high level of consistency between the results of this study and others lends some support to the idea that empathy directly facilitates therapeutic benefits. As reviewed by Bohart et al. (2002), several investigations offer clarification. For example, research by Burns and Nolen-Hoeksema (1992) used structural equation modeling to demonstrate a causal relationship between empathy and outcome. Other researchers (i.e., Anderson, 1999; Miller et al., 1980) had observers who were blind to outcome rate therapists' empathy and other interpersonal skills before therapy, and found significant relationships between observer-rated empathy, interpersonal skills, and outcome. Although none of this evidence can conclusively establish a causal role relationship between therapist empathy and treatment outcome, it does add support to the hypothesis. Further research is needed to clarify this relationship, particularly through the use of control group designs.

It should be noted that the present study utilized a "convenience" sample of participants who, at the time of assessment, were each at varying stages of treatment

involvement. One-time measurements were obtained regarding participants' overall functioning and therapy progress, and thus changes in functioning and treatment progress were not measured repeatedly over time. It is therefore possible that the empathy effect found merely represents an effect related to how long the men had been involved in treatment. Clients with lengthier treatment histories might be expected to demonstrate better progress and perceive their therapists as more empathic. However, the current study investigated the possibility of a moderating effect of treatment duration and found no significant relationship, cross-sectionally, between treatment outcome and the length of involvement in psychotherapy. This provides some evidence that the alliance-outcome relationship was not simply a product of treatment length.

Additionally, the effect sizes found in the current study are highly consistent with those found by other researchers who did, in fact, measure treatment-related changes over time. Beech and Hamilton-Giachritsis (2005) found that group cohesion was significantly related to treatment outcome, $r = .65, p < .05$. And Marshall, Serran, Moulden, et al. (2002) found that therapist empathy and warmth were significantly related to treatment outcome in their study (correlations ranged from .45 to .65 for empathy, and from .32 to .74 for warmth). The associations between the alliance and outcome variables in the current study ranged from $r = .495$ to $r = .850$, with a mean effect of $r = .631$. These correlations are quite close to those detected by Beech and Hamilton-Giachritsis (2005) and Marshall, Serran, Moulden, et al. (2002). The consistency between the effects detected in the present study and those found in previous research that obtained multiple measurements provides additional support for the current study's validity.

Future research that measures the therapeutic alliance and treatment progress at multiple points in time would certainly speak more authoritatively to the issue of causality. Longitudinal, repeated measures designs would also be able to explore other hypotheses, such as whether and how the alliance-outcome relationship changes over time with sexual offenders, and whether and how the alliance and other variables (e.g., pharmacological interventions) interact over time. In order to most effectively control for the possible effects of variables such as previous treatment and treatment duration, future studies would ideally involve populations who are entering into their first treatment experiences, and would obtain measurements at identical treatment intervals for each of the participants. While this type of design is difficult when using community samples, (such as in the present study), it is certainly possible with incarcerated populations. Based on the experience of the current investigation, such longitudinal studies would likely run into problems related to participant retention, and thus particularly large sample sizes would be required.

It could be contended that the findings of the current investigation primarily reflect the progress of a small group of people who are generally well functioning and who do extremely well in treatment. Indeed, if this were true, then the alliance-outcome effects may be an artifact of such a bias. However, examination of the distributions of outcome scores across measures indicates that the scores are normally distributed, arguing against such a hypothesis.

It might also be hypothesized that the alliance-outcome associations actually represent a "halo effect" (Horvath & Symonds, 1991) where, for example, therapist

ratings of client progress (which might be communicated to clients via direct feedback or nonverbal behaviors) influence client ratings of their therapists (i.e., as more or less empathic). However, the results demonstrate very similar effects whether the outcome ratings were completed by clients (e.g., the cognitive distortion measures) or by their therapists (e.g., the GAS), arguing for some measure of methodological convergence in the study. The validity of the findings are further supported by Horvath and Symonds (1991), whose meta-analysis of general psychotherapy studies found no significant interaction between the source of alliance rating (i.e., therapist, client, or observer) and the source of outcome assessment. Nonetheless, future investigations would benefit from utilizing multiple source ratings for each of the outcome indices assessed.

Consistent with previous research (e.g., Bohart et al., 2002; Farber & Lane, 2002; and Klein et al., 2002), the Rogerian facilitative conditions of empathy, warmth, unconditionality, and positive regard were found to be highly intercorrelated, indicating that each of the concepts shared a great deal of variance with the others and that the participants made few distinctions between them. This suggests that these concepts are so closely related to each other that it may not even be conceptually useful to distinguish between them, at least with sexual offender populations. Decisions were made to retain the empathy and unconditionality variables based on statistical and methodological issues detailed above. It is important to note that the relationships between positive regard and genuineness and treatment outcomes with sexual offenders therefore remain unexplored. Considering the high intercorrelations between these relationship variables and the ones ultimately submitted for analysis, it is suspected that significant effects might be detected using these variables. Future studies might consider such analyses.

Despite evidence of good psychometric properties by the UCLA Loneliness Scale's authors and other researchers (Russell & Cutrona, 1988; Shaver & Brennan, 1991), poor internal consistency was found in the present study, indicating that the individual items in the scale did not correlate highly with each other. This suggests that, as interpreted by the current study's participants, the items did not measure a single, unified construct. Poor internal consistency makes it difficult to detect significant associations between independent and dependent variables. Although the present investigation did detect significant associations between therapist empathy, client-therapist collaboration, and intimacy development, it is probable that the strength of these associations was underestimated due to the poor internal consistency of this particular instrument. Future studies might benefit from the use of alternate measures of intimacy deficits that evidence better internal consistency with this population.

Correlations between outcome measures indicated that some, but not all of the measures, were moderately to strongly intercorrelated. This adds additional validity to the current results, as progress in one area of treatment might be expected to be found in other areas, as well. However, the lack of consistent findings in this regard suggests that sexual offenders can progress well in some areas and not as well in others. Certainly, this is consistent with various frustrating experiences often encountered in clinical practice. It is also observed that, despite the moderately and inconsistently correlated outcome measures, therapist empathy remained strongly associated with most of the outcome indices. This supports the conclusion that the therapeutic alliance positively influences a wide range of therapeutic outcomes with sexual offenders.

The current study involved a selective sample of sexual offenders. Most of the participants were sampled from a community clinic that specializes in high risk/high need offenders. Many of the treatment referrals are for individuals who have committed multiple sexual offences, and who have had previously unsuccessful treatment experiences. The other participants were recruited from a moderate intensity sex offender treatment program at a medium security federal correctional institution. Arguably, these populations represent a higher risk, more challenging group of clients than those typically seen for treatment. As shown in Table 1, over 60% of participants were classified on the Static-99 as moderate-high to high risk for recidivism. While this might impact on the generalizability of the current findings, it suggests that the influence of the therapeutic alliance with lower risk, lower need sex offender populations may in fact be somewhat greater than what is represented by the current findings.

The study investigated whether a number of ancillary, structural determinants might influence the relationship between the therapeutic alliance and outcome indices. These included: age, ethnicity, client-therapist ethnicity match, treatment length, actuarial risk level, offense type, and treatment modality. Of these variables, only age demonstrated an association to two of the outcome indices. Specifically, older clients were more likely than younger ones to have attained sexual offender-specific treatment goals. The reasons for this remain unclear, although previous research has indicated that, in general, older sexual offenders likely present with a lower risk for reoffending (Doren, 2006; Hanson, 2002; Hanson & Bussiere, 1998), although this relationship may be mediated by factors such as age-at-release, antisociality, sexual deviance, and actuarial risk rating (Doren, 2006). However, if older offenders are generally less likely to reoffend, than a corollary of

this might be that they tend to do better (as assessed by Global Attainment Scaling) on treatment goals that are empirically and/or theoretically related to risk for recidivism.

Somewhat in opposition to this conclusion, the present study also found that older sexual offenders were more likely than younger ones to demonstrate intimacy deficits. By way of explaining this seemingly discrepant finding, it may be that older offenders presenting for treatment with intimacy deficits have longer and more established histories of maladaptive, intimacy-seeking behavior patterns and therefore encounter greater difficulty developing healthy intimacy. Developmental perspectives on intimacy development in sexual offenders theorize that insecure childhood attachment styles develop into adult intimacy deficits and corresponding low levels of social competence (Hudson & Ward, 1997; Marshall, 1989, 1993). Longer histories of social dysfunction (which, from a developmental perspective, would be a frequent outcome for older individuals with historical, insecure childhood attachments) might therefore be more ingrained and difficult to change than other treatment targets such as accountability, relapse prevention knowledge, and treatment participation (i.e., treatment goals assessed by the GAS in the current study).

The lack of significant findings regarding the other structural variables is significant, in itself. In accordance with much of the psychotherapy outcome literature, the relationship between the therapeutic alliance and treatment outcome with sexual offenders did not appear to be influenced by potential moderator variables such as client ethnicity, client-therapist ethnicity match, treatment modality, or treatment duration. This is grossly consistent with the general psychotherapy literature (e.g., Erdur et al., 2000; Horvath &

Symonds, 1991; Martin et al., 2000), and is partly replicated in a finding by Beech and Hamilton-Giachritsis (2005), who determined that cohesive groups with supportive leaders produced better treatment outcomes, but failed to detect any significant association between treatment duration and outcome.

Notably, the relationship between the alliance and outcome in the current study appeared additionally unaffected by risk level, treatment modality, and offence type. In all, the absence of a moderating influence by these variables provides some evidence for the robust nature of the therapeutic alliance, a variable that appears largely uninfluenced by a number of factors yet strongly related to treatment outcome. Further investigation of the potential influence of such moderating variables is worth consideration, as this finding speaks to issues such as effective and appropriate treatment durations and modalities for offenders and the relationship between risk, offence type, and treatment outcome.

As reviewed above, there are a number of indications that the present results are particularly robust. First, significant effects were detected in spite of sample sizes conventionally considered small for multiple regression analyses. Thus, despite lower than ideal levels of statistical power, significant effects were detected. This suggests that the actual association between the therapeutic alliance and treatment outcomes with sexual offenders may be somewhat greater than indicated in the present results. This conclusion is further supported by the detection of an association between the alliance and intimacy deficits, despite the use of a measure with poor internal consistency. Second, associations between the therapeutic alliance and treatment outcome were evident across most outcome measures, despite generally modest correlations between the outcome measures. This

suggests that the therapeutic alliance influences a wide range of sexual offender treatment outcomes including: general self-regulation; sex offender-specific treatment targets (including accountability, empathy, cognitive distortions, understanding of offense cycle, identification of relapse prevention concerns, and treatment participation); intimacy deficits; and cognitive distortions. Third, the relationship between the alliance and treatment outcome was generally unaffected by ancillary variables.

All of these findings are remarkably consistent with both the extensive psychotherapy outcome literature and the sexual offender treatment literature. While this substantiates the validity of the present findings, it does something else as well. It strongly indicates that what works in psychotherapy for non-forensic populations is precisely what works for sexual offenders. The implications of this are clear. The sexual offender field has long embraced highly manualized, psychoeducational programming as the treatment approach of choice (Green, 1995). These methods, which effectively reduce the influence of the therapist, appear to lack wisdom, considering the persuasive evidence concerning the role of the therapist and therapeutic alliance in producing beneficial outcomes (Marshall & Serran, 2004). The therapeutic relationship is a consistent and robust predictor of positive change across psychotherapies of different types and with diverse clinical populations. Researchers, clinicians, program developers, offenders, and the community would most certainly profit from increased awareness and attention to this in the field of offender rehabilitation.

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Appendix A

Relationship Inventory - Client Form

Instructions

Below are listed various ways that one person might feel or behave in relation to their therapist. Please consider each numbered statement with reference to your present relationship with __________, mentally adding his or her name in the space provided. For example, if the person's name was John, you would read statement #1, as "John respects me as a person".

Mark each statement in the answer column on the right, according to how strongly you feel that it is true, or not true, in this relationship. *Please be sure to mark every one.*

Write in a plus number (+3, +2, or +1) for each "yes" answer, and minus numbers (-1, -2, or –3) to stand for "no" answers. Here is the exact meaning of each answer number:

+3:	*Yes (!), I strongly feel that it is true.*	*-1:*	*(No) I feel that it is probably untrue, or more untrue than true.*
+2:	*Yes, I feel that it is probably true.*	*-2:*	*No, I feel it is not true.*
+1:	*(Yes) I feel that it is probably true, or more true than untrue.*	*-3:*	*No (!), I strongly feel that it is not true.*

This questionnaire is confidential. Your therapist will not see your answers.

		ANSWER
1.	__________ respects me as a person..................................	__________
2.	__________ wants to understand how I see things....................	__________
3.	__________'s interest in me depends on the things I say or do......	__________
4.	__________ is comfortable and at ease in our relationship..........	__________
5.	__________ feels a true liking for me................................	__________
6.	__________ may understand my words but he/she does not see the way I feel..	__________
7.	Whether I am feeling happy or unhappy with myself makes no real difference to the way __________ feels about me....................	__________

8. I feel that __________ puts on a role or front with me............... __________

9. __________ is impatient with me...................................... __________

10. __________ nearly always knows exactly what I mean.............. __________

11. Depending on my behaviour, __________ has a better opinion of me sometimes than he/she has at other times.......................... __________

12. I feel that __________ is real and genuine with me.................. __________

13. I feel appreciated by __________..................................... __________

14. __________ looks at what I do from his/her own point of view..... __________

15. __________'s feeling toward me doesn't depend on how I am feeling toward him/her.. __________

16. It makes __________ uneasy when I ask or talk about certain things... __________

17. __________ is indifferent to me....................................... __________

18. __________ usually senses or realizes what I am feeling........... __________

19. __________ wants me to be a particular kind of person...

20. I feel that what __________ says expresses exactly what he/she is feeling and thinking at that moment.................................... __________

21. __________ finds me rather dull and uninteresting.................. __________

22. __________'s own attitudes toward things I do or say prevent him/her from understanding me....................................... __________

23. I can be (could be) openly critical *or* appreciative of __________ without making him/her feel differently about me.................... __________

24. __________ wants me to think that he/she likes or understands me more than he/she really does... __________

25. __________ cares for me.. __________

26. Sometimes __________ thinks that *I* feel a certain way, because that's the way *he/she* feels.. __________

27. __________ likes certain things about me, and there are other things he/she does not like in me....................................... __________

28. __________ does not avoid anything that's important for our relationship.. __________

29. I feel that __________ disapproves of me............................ __________

30. __________ realizes what I mean even when I have difficulty saying it...

31. __________'s attitude toward me stays the same: he /she is not pleased with me sometimes and critical or disappointed at other times.. __________

32. Sometimes __________ is not at all comfortable but we go on, outwardly ignoring it... __________

33. __________ just tolerates me... __________

34. __________ usually understands the whole of what I mean......... __________

35. If I show that I am angry with __________ he/she becomes hurt or angry with me, too... __________

36. __________ expresses his/her true impressions and feelings with me... __________

37. __________ is friendly and warm with me............................ __________

38. __________ just takes no notice of some things I think or feel...... __________

39. How much __________ likes or dislikes me is not altered by anything that I tell him/her about myself............................. __________

40. At times I sense that __________ is not aware of what he/she is really feeling with me... __________

41. I feel that __________ really values me.............................. __________

42. __________ appreciates exactly how the things I experience feel to me... __________

43. __________ approves of me sometimes, or in some ways, and plainly disapproves of me at other times/in other ways.............. __________

44. __________ is willing to express whatever is actually in his/her mind with me, including personal feelings about him/herself or me __________

45. __________ doesn't like me for myself............................... __________

46. At times __________ thinks that I feel a lot more strongly about a particular thing than I really do....................................... __________

47. Whether I happen to be in good spirits or feeling upset does not make __________ feel any more or less appreciative of me......... __________

48. __________ is openly himself/herself in our relationship.. __________

49. I seem to irritate and bother __________............................. __________

50. __________ does not realize how sensitive I am about some things we discuss... __________

51. Whether the ideas and feelings I express are "good" or "bad" seems to make no difference to __________'s feelings toward me.. __________

52. There are times when I feel that __________'s outward response to me is quite different from the way he/she feels underneath........

53. __________ feels contempt for me.................................... __________

54. __________ understands me.. __________

55. Sometimes I am more worthwhile in __________'s eyes than I am at other times.. __________

56. __________ doesn't hide from himself (herself) anything that he (she) feels with me... __________

57. __________ is truly interested in *me*.................................. __________

58. __________'s response to me is usually so fixed and automatic that I don't really get through to him/her............................. __________

59. I don't think that anything I say or do really changes the way __________ feels toward me...................................... __________

60. What __________ says to me often gives a wrong impression of his/her total thought or feeling at the time.............................. __________

61. __________ feels deep affection for me................................ __________

62. When I am hurt or upset __________ can recognize my feelings exactly, without becoming upset too.................................... __________

63. What *other* people think of me does (or would, if he/she knew) affect the way __________ feels toward me............................ __________

64. I believe that __________ has feelings he/she does not tell me about that are causing difficulty in our relationship.................. __________

Appendix B

Working Alliance Inventory

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her therapist. As you read the sentences, mentally insert the name of your therapist in place of _______________ in the text.

Below each statement, inside there is a seven point scale:

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

If the statement describes the way you ***always*** feel (or think), circle the number 7; if it ***never*** applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is confidential. Your therapist will not see your answers.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.)

1. I feel uncomfortable with __________.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

2. __________ and I agree about the things I will need to do in therapy to help improve my situation.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

3. I am worried about the outcome of these sessions.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

4. What I am doing in therapy gives me new ways of looking at my problem.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

5. __________ and I understand each other.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

6. __________ perceives accurately what my goals are.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

7. I find what I am doing in therapy confusing.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

8. I believe __________ likes me.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

9. I wish __________ and I could clarify the purpose of our sessions.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

10. I disagree with __________ about what I ought to get out of therapy.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

11. I believe the time __________ and I are spending together is not spent efficiently.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

12. __________ does not understand what I am trying to accomplish in therapy.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

13. I am clear on what my responsibilities are in therapy.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

14. The goals of these sessions are important for me.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

15. I find what __________ and I are doing in therapy is unrelated to my concerns.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

16. I feel that the things I do in therapy will help me to accomplish the changes that I want.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

17. I believe __________ is genuinely concerned for my welfare.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

18. I am clear as to what __________ wants me to do in these sessions.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

19. __________ and I respect each other.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

20. I feel that __________ is not totally honest about his/her feelings toward me.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

21. I am confident in __________'s ability to help me.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

22. __________ and I are working towards mutually agreed upon goals.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

23. I feel that __________ appreciates me.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

24. We agree on what is important for me to work on.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

25. As a result of these sessions, I am clearer as to how I might be able to change.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

26. __________ and I trust one another.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

27. __________ and I have different ideas on what my problems are.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

28. My relationship with __________ is very important to me.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

29. I have the feeling that, if I say or do the wrong things, __________ will stop working with me.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

30. __________ and I collaborate on setting goals for my therapy.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

31. I am frustrated by the things I am doing in therapy.

1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very often	7 Always

32. We have established a good understanding of the kinds of changes that would be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very often	Always

33. The things that __________ is asking me to do don't make sense.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very often	Always

34. I don't know what to expect as the result of my therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very often	Always

35. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very often	Always

36. I feel that __________ cares about me, even when I do things that he/she does not approve of.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very often	Always

Appendix C

Global Assessment of Functioning (GAF) Scale

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations. (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72).

Code

91–100 Superior functioning in a wide range of activities. Life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.

81-90 Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71-80 If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).

61-70 Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51-60 Moderate symptoms (e.g., flat effect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41-50 Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).

31-40 Some impairment in reality testing or communication (e.g., speech is at all times illogical, obscure or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking or mood (e.g., depressed man avoids friends, neglects family and is unable to work; child frequently beats up younger children, is defiant at home and is failing at school).

21-30 Behaviour is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).

11-20 Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

1-10 Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.

0 Inadequate information.

Appendix D

RAPE Scale

Instructions

Please read each statement carefully and circle the number that indicates how you feel about it. This is about what YOU truly believe, so DO NOT try to answer in a way that you think others will want you to answer.

This questionnaire is confidential. Your therapist will not see your answers.

1. **Men who commit rape are probably responding to a lot of stress in their lives, and raping helps to reduce that stress.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

2. **Women who get raped probably deserve it.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

3. **Women usually want sex no matter how they can get it.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

4. **Since prostitutes sell their bodies for sexual purposes anyway, it is not as bad if someone forces them into sex.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

5. If a woman does not resist strongly to sexual advances, she is probably willing to have sex.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

6. Women often falsely accuse men of rape.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

7. A lot of women who get raped had "bad reputations" in the first place.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

8. If women did not sleep around so much, they would be less likely to get raped.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

9. If a woman gets drunk at a party, it is really her own fault if someone takes advantage of her sexually.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

10. When women wear tight clothes, short skirts, and no bra or underwear, they are just asking for sex.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

11. A lot of women claim they were raped just because they want attention.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

12. Victims of rape are usually a little bit to blame for what happens.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

13. If a man has had sex with a woman before, then he should be able to have sex with her any time he wants.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

14. Just fantasizing about forcing someone to have sex isn't all that bad since no one is really being hurt.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

15. Women who go to bars a lot are mainly looking to have sex.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

16. A lot of times, when women say "no", they are just playing hard to get and really mean "yes".

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

17. Part of a wife's duty is to satisfy her husband sexually whenever he wants it, whether or not she is in the mood.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

18. Often, a woman reports rape long after the fact because she gets mad at the man she had sex with and is trying to get back at him.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

19. As long as a man does not slap or punch a woman in the process, forcing her to have sex is not bad.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

20. When a woman gets raped more than once, she is probably doing something to cause it.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

21. Women who get raped will eventually forget about it and go on with their lives.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

22. On a date, when a man spends a lot on a woman, the woman ought at least to give the man something in return sexually.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

23. I believe that, if a woman lets a man kiss her and touch her sexually, she should be willing to go all the way.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

24. When women act like they are too good for men, most men probably think about raping the women to put them in their place.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

25. I believe society and the courts are too tough on rapists.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

26. Most women are sluts and get what they deserve.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

27. Before the police investigate a woman's claim of rape, it is a good idea to find out what she was wearing, if she had been drinking, and what kind of person she is.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

28. Generally, rape is not planned – a lot of times it just happens.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

29. If a person tells himself that he will never rape again, he probably won't.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

30. A lot of men who rape do so because they are deprived of sex.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

31. The reason a lot of women say "no" to sex is because they don't want to seem loose.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

32. If a woman goes to the home of a man on the first date, she probably wants to have sex with him.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

33. Many women have a secret desire to be forced into having sex.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

34. Most of the men who rape have stronger sexual urges than other men.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

35. I believe that any woman can prevent herself from being raped if she really wants to.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

36. Most of the time, the only reason a man commits rape is because he was sexually assaulted as a child.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

MOLEST Scale

Instructions

Please read each statement carefully and circle the number that indicates how you feel about it. This is about what YOU truly believe, so DO NOT try to answer in a way that you think others will want you to answer.

This questionnaire is confidential. Your therapist will not see your answers.

1. **I believe that sex with children can make the child feel closer to adults.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

2. **Since some victims tell the offender it feels good when the offender touches them, the child probably enjoys it and it probably won't affect the child much.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

3. **Many children who are sexually assaulted do not experience many major problems because of the assaults.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

4. **Sometimes, touching a child sexually is a way to show love and affection.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

5. **Sometimes children don't say "no" to sexual activity because they are curious about sex or enjoy it.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

6. **When kids don't tell that they were involved in sexual activity with an adult, it is probably because they liked it or weren't bothered by it.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

7. **Having sexual thoughts and fantasies about a child isn't all that bad because it is not really hurting the child.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

8. **If a person does not use force to have sexual activity with a child, it will not harm the child as much.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

9. **Some people are not "true" child molesters – they are just out of control and made a mistake.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

10. **Just fondling a child is not as bad as penetrating a child, and will probably not affect the child as much.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

11. **Some sexual relations with children are a lot like adult sexual relationships.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

12. **Sexual activity with children can help the child learn about sex.**

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

13. I think child molesters often get longer sentences than they really should.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

14. Kids who get molested by more than one person probably are doing something to attract adults to them.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

15. Society makes a much bigger deal out of sexual activity with children than it really is.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

16. Sometimes molesters suffer the most, lose the most, or are hurt the most, as a result of a sexual assault on a child more than a child suffers, loses, or is hurt.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

17. It is better to have sex with one's child than to cheat on one's wife.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

18. There is no real manipulation or threat used in a lot of sexual assaults on children.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

19. Some kids like sex with adults because it makes them feel wanted and loved.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

20. Some men sexually assaulted children because they really thought the children would enjoy how it felt.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

21. Some children are willing and eager to have sexual activity with adults.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

22. During sexual assaults on children, some men ask their victims if they liked what they were doing because they wanted to please the child and make them feel good.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

23. Children who have been involved in sexual activity with an adult will eventually get over it and go on with their lives.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

24. Some children can act very seductively.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

25. Trying to stay away from children is probably enough to prevent a molester from molesting again.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

26. A lot of times, sexual assaults on children are not planned… they just happen.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

27. Many men sexually assault children because of stress, and molesting helps to relieve that stress.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

28. A lot of times, kids make up stories about people molesting them because they want to get attention.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

29. If a person tells himself that he will never molest again, then he probably won't.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

30. If a child looks at an adult's genitals, the child is probably interested in sex.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

31. Sometimes, victims initiate sexual activity.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

32. Some people turn to children for sex because they are deprived of sex from adult women.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

33. Some young children are much more adult-like than other children.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

34. Children who come into the bathroom when an adult is getting undressed or going to the bathroom are probably just trying to see an adult's genitals.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

35. Children can give adults more acceptance and love than other adults.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

36. Some men who molest children don't like molesting children.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

37. I think the main thing wrong with sexual activity with children is that it's against the law.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

38. If most child molesters hadn't been sexually abused as a child, then THEY probably never would have molested a child.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

Appendix E

UCLA Loneliness Scale

Instructions

Indicate how often you feel the way described in each of the following statements. Circle one number for each.

This questionnaire is confidential. Your therapist will not see your answers.

1. **I feel in tune with the people around me.**

Never	Rarely	Sometimes	Often
1	2	3	4

2. **I lack companionship.**

Never	Rarely	Sometimes	Often
1	2	3	4

3. **There is no one I can turn to.**

Never	Rarely	Sometimes	Often
1	2	3	4

4. **I do not feel alone.**

Never	Rarely	Sometimes	Often
1	2	3	4

5. **I feel part of a group of friends.**

Never	Rarely	Sometimes	Often
1	2	3	4

6. I have a lot in common with the people around me.

Never	Rarely	Sometimes	Often
1	2	3	4

7. I am no longer close to anyone.

Never	Rarely	Sometimes	Often
1	2	3	4

8. My interests and ideas are not shared by those around me.

Never	Rarely	Sometimes	Often
1	2	3	4

9. I am an outgoing person.

Never	Rarely	Sometimes	Often
1	2	3	4

10. There are people I feel close to.

Never	Rarely	Sometimes	Often
1	2	3	4

11. I feel left out.

Never	Rarely	Sometimes	Often
1	2	3	4

12. My social relationships are superficial.

Never	Rarely	Sometimes	Often
1	2	3	4

13. No one really knows me well.

Never	Rarely	Sometimes	Often
1	2	3	4

14. I feel isolated from others.

Never	Rarely	Sometimes	Often
1	2	3	4

15. I can find companionship when I want.

Never	Rarely	Sometimes	Often
1	2	3	4

16. There are people who really understand me.

Never	Rarely	Sometimes	Often
1	2	3	4

17. I am unhappy being so withdrawn.

Never	Rarely	Sometimes	Often
1	2	3	4

18. People are around but not with me.

Never	Rarely	Sometimes	Often
1	2	3	4

19. There are people I can talk to.

Never	Rarely	Sometimes	Often
1	2	3	4

20. There are people I can turn to.

Never	Rarely	Sometimes	Often
1	**2**	**3**	**4**

Appendix F

Standardized Goal Attainment Scaling

Instructions

Please use the guideline below to rate the behavior and attitudes of the offender during treatment. Remember that a middle score of "0" represents the minimum acceptable attitudes/attitudes. Less than acceptable behavior should be rated – 2 or –1; better than acceptable performance should be rated +1 or + 2.

SCALE	**-2 Very risky or inappropriate attitude or behavior**	**-1 Risky or inappropriate attitude or behavior**	**0 Minimum acceptable attitude or behavior**	**+1 Appropriate attitude or behavior**	**+2 Very appropriate attitude or behavior**
1)Acceptance of guilt **Score:** ____	Insists on his innocence, denies any participation in the offence.	Minimizes his role, attributes blame to the victim, situation and others.	Admits guilt and his role as charged.	Fully admits guilt, exonerates victim of any blame or responsibility.	Admits guilt, recognizes motivation for offence.
2) Show insight into victim issues **Score:** ____	No understanding of victim issues. Sees little/no physical or mental stress impact.	Some understanding but does not fully understand extent of physical/mental harm.	Shows good understanding of victim issues relating to sexual abuse.	Understands full extent of mental and physical harm and related impact on life.	Full understanding including long-term effects on victims, family, spouses, etc.
3)Shows empathy for their victims **Score:** ____	No understanding of the harm to their victim(s), seen as unharmed or enjoying the abuse.	Little understanding, rationalizing their victims coped OK and are not worse for the abuse.	Shows genuine empathy for the victims of the offence.	Shows full empathy and understanding of the mental/physical harm to their victims.	Shows full empathy and understanding, wishes to undo the long-term harm caused.
4) Accepts personal responsibilities **Score:** ____	Accepts little or no responsibility, blames victim, situation and others; does not see action as deviant.	Accepts partial responsibility claiming victim/situation also to blame or blaming victim/situation also to place the blame on the situation.	Accepts full responsibility for the offence and their behavior.	Accepts complete responsibility; sees need to seek help to change behavior.	Accepts full responsibility. Places no blame on victim, fully sees need to change to avoid future offences.

SCALE	-2 Very risky or inappropriate attitude or behavior	-1 Risky or inappropriate attitude or behavior	0 Minimum acceptable attitude or behavior	+1 Appropriate attitude or behavior	+2 Very appropriate attitude or behavior
5) Recognizes cognitive distortions **Score:** ____	Totally fails to understand the role cognitive distortions play in his offending.	Partially recognizes cognitive distortions but only sees them as partially applicable.	Recognizes role of cognitive distortions relating to his sexual offending behavior.	Recognizes personal use of cognitive distortions and avoids/challenges them.	Fully understands role of cognitive distortions and is active in changing use of current/past distortions regarding offending behavior.
6) Minimizes consequences **Score:** ____	Fully minimizes his role and any negative consequences.	Recognizes some effects but minimizes his role or the effect of the offending.	Does not minimize the effects of his offending.	Does not minimize. Thinks about the wide range of impact without minimization.	Does not minimize. Actively accepts all the consequences of his offending.
7) Understands lifestyle dynamics **Score:** ____	Sees no relationship between his lifestyle and his sexual offending.	Has partial understanding of lifestyle and offence but sees little/no need to change.	Understands how his lifestyle relates to his offending.	Recognizes lifestyle dynamics, realizes need to change in future.	Recognizes lifestyle dynamics, actively seeks realistic ways to change.
8) Understands offence cycle **Score:** ____	Denies crime was anything more than a spontaneous act with no precursors and/or cycle.	Unable to identify precursors or cycle. May claim lack of memory or sees this as only partially applicable.	Recognizes offence/deviant cycle and the relationship to his offending.	Identified precursors and/or cycle to his offences, begins thinking how to change the pattern of behavior.	Identified precursors/cycle and actively seeks ways to interrupt cycle to avoid future offences.

SCALE	-2 Very risky or inappropriate attitude or behavior	-1 Risky or inappropriate attitude or behavior	0 Minimum acceptable attitude or behavior	+1 Appropriate attitude or behavior	+2 Very appropriate attitude or behavior
9) Identifies relapse prevention concepts **Score:** ______	No understanding of relapse prevention concepts; unwilling to accept avoidance of high-risk situations.	Shows only partial or superficial understanding and cannot easily identify high-risk situations.	Shows a clear understanding of relapse prevention concepts as applied to sexual offending.	Shows good understanding; able to actively relate concepts to his offence/relapse.	Fully understands relapse prevention and is able to understand proactive avoidance of high-risk situations in the future.
10) Discloses personal information **Score:** ______	Refuses to disclose personal information, even if trivial, even when asked directly.	Reluctantly discloses personal information, which is usually trivial or superficial.	Willing to disclose personal information as necessary.	Willing to share most personal information and details.	Openly shares and discusses information in an open and receptive manner.
11) Participation in group treatment **Score:** ______	Does not participate in the group even when encouraged to do so.	Participates in group only when encouraged or cajoled to do so.	Participates in group as required.	Fully participates in the group and encourages others to do likewise.	Actively participates and encourages others. Seeks understanding beyond the limits of the group.
12) Motivation to change behavior **Score:** ______	Not motivated to change; no perceived genuine interest in changing behavior.	Motivation to change is inconsistent; transient or inappropriate reason to change.	Motivated to change his behavior.	Well motivated to change in consistent and enduring manner for safety of others.	Consistently well-motivated to change and actively encourages others to do likewise.

Appendix G

Qualitative Questions

Please answer the following questions as best and honestly as you can. If you require more space, please continue on the back of the page. Your therapist will not see your answers.

(1) In your therapy experience, what things have you found the most helpful in supporting you to deal with your issues and manage your risk?

(2) In what ways is your *relationship* with your therapist most helpful in supporting you to deal with your issues and manage your risk?

(3) What specific *qualities* of a therapist are *most* helpful in supporting you to deal with your issues and help you to manage your risk?

(4) What specific *qualities* of a therapist are *not* helpful, or make it more difficult for you to deal with your issues and manage your risk?

Appendix H

Correlation Matrix of Study Variables

	1	2	3	4	5	6	7	8	9	10	11	12
1. RI Empathy	--											
2. RI Unconditionality	**.560**	--										
3. RI Regard	**.857**	**.411**	--									
4. RI Congruence	**.877**	**.503**	**.898**	--								
5. WAI Bond	**.748**	**.462**	**.806**	**.835**	--							
6. WAI Task	**.685**	**.378**	**.740**	**.690**	**.779**	--						
7. WAI Goal	**.716**	**.349**	**.747**	**.707**	**.772**	**.890**	--					
8. GAFS	**.469**	.148	**.404**	**.391**	**.374**	**.446**	**.475**	--				
9. GAS	**.581**	.262	**.591**	**.531**	**.392**	**.444**	**.446**	**.395**	--			
10. Loneliness Scale	.030	.170	.100	.136	.157	-.045	-.014	-.095	.186	--		
11. Molest Scale[a]	**-.542**	-.070	**-.457**	**-.440**	-.408	**-.562**	**-.526**	-.118	-.330	.144	--	[c]
12. Rape Scale[b]	-.429	.299	**-.574**	-.547	-.441	-.498	-.449	**-.754**	-.197	-.050	[d]	--

Note. Correlations significant above the 0.05 level (2-tailed) are bolded. N=44 for all correlations other than [a]N=23 and [b]N=15. [c] and [d] Cannot be computed because the variables are non-overlapping.

Appendix I

Representative Qualitative Responses by Question and Category

Table A1

In your therapy experience, what things have you found the most helpful in supporting your process of change?

Therapeutic Style	*n*	**Healthy Skill Development**	*n*	**Social Connectedness**	*n*	**Instillation of Hope**	*n*
Providing a Sense of Comfort and Safety Very flexible and encouraging, I feel safe and able to open up and discuss any problems I might have.	4	**Risk Management Strategies** Helping me see cycles and triggers. Helping me plan a way out of a cycle. Enlightenment. Going from not understanding what happened in my life to seeing and understanding cycles etc.	17	**Peer Support** Well, I jest started the program and I've already found that it help to talk and share with people that have the same concerns and problems you do.	7	**Reliability and Accessibility of Support** ...Plus to call supports if behaviours/symptoms are in remission (maintenance work and support) or acute.	2

(table continues)

Table A1 (continued)

Therapeutic Style	*n*	Healthy Skill Development	*n*	Social Connectedness	*n*	Instillation of Hope	*n*
Properly Paced I find that when me and my therapist take things slow and dealing with the issues at present and past.	**1**	**Enhancing Accountability** Talking about my offence and what happened trying to blame alcohol, revenge.	**5**				
Supportive Emotional support…	**1**	**Managing Emotions** To express myself, and vent any feelings I may have.	**4**				
Accepting …being non-judgement.	**1**	**Developing Coping Skills** Learning how to cope with life in general.	**2**				

(table continues)

Table A1 (continued)

Therapeutic Style	*n*	**Healthy Skill Development**	*n*	**Social Connectedness**	*n*	**Instillation of Hope**	*n*
		Empathy Development It is not healthy to fantasize about young children. If I don't deal with this now I could potentially hurt a child in the future. Put yourself in the child shoes.	**1**				

Table A2

In what ways is your relationship with your therapist most helpful in supporting you to deal with your issues and manage your risk?

Therapeutic Style	*n*	**Healthy Skill Development**	*n*	**Instillation of Hope**	*n*
Directive Being able to steer me in the right direction in examining my thoughts and behaviour and suggests how I can cope more positively.	**9**	**Self-Disclosure** Talking about what happened.	**8**	**Reliability and Accessibility of Support** I know that I've got lots of supports…if I'm in a bind I can phone somebody and get the support I need.	**6**
Trustworthy I find that building trust slowly over a period of time to get to know my therapist is helpful to me.	**8**	**Problem-Solving** That we talk of everyday life and how I can handle the problems at hand.	**7**	**Generates Positive Expectations** … making me feel good about myself and knowing I can become a better person and understanding why I offend.	**3**

(table continues)

Table A2 (continued)

Therapeutic Style	*n*	**Healthy Skill Development**	*n*	**Instillation of Hope**	*n*
Warm I play jokes on him.	**8**	**Managing Emotions** Lets you get things off your chest.	**1**		
Providing a Sense of Comfort and Safety I just feel that the relationship, that I can talk about issues, if I have any fantasies I can bring them up to [my therapist].	**8**	**Therapy Tasks** Putting the learned lessons/plans into action and pro-affirmation action.	**1**		
Accepting Just that they know my issues and are accepting of me as a "person".	**6**	**Enhancing Accountability** When the therapist reiterates the role of self responsibility by putting the "ball back in my end of court", so to speak.	**1**		

(table continues)

Table A2 (continued)

Therapeutic Style	*n*	**Healthy Skill Development**	*n*	**Instillation of Hope**	*n*
Genuine	**5**				
My therapist is open, honest					
Direct	**4**				
Be willing to confront the issues head on rather than dance around them.					
Attentive	**4**				
He/she listens to me and I can say what's on my mind.					
Empathic	**3**				
[My therapist] understands me.					

(table continues)

Table A2 (continued)

Therapeutic Style		**Healthy Skill Development**		**Instillation of Hope**	
	n		*n*		*n*
Patient	**1**				
Patience.					
Limit Setting	**1**				
I some ways when the therapist puts on certain boundaries of what can be discussed or can't not be.					

Table A3

What specific qualities of a therapist are particularly helpful in supporting you to deal with your issues and help you to manage your risk?

Therapeutic Style		Healthy Skill Development		Instillation of Hope		Social Connectedness	
	n		*n*		*n*		*n*
Warm To me the best quality a therapist can have is a caring attitude towards her/his client.	18	**Self-Disclosure** Talking about it opening up, speaking up.	4	**Generates Positive Expectations** By making me see that I am not a bad person just a person who needs help.	5	**Provides Public Education** [My therapist] has gone to conferences to show how he has helped people over the years, to make people understand that there is a treatment for sexual offenders.	3

(table continues)

Table A3 (continued)

Therapeutic Style	*n*	**Healthy Skill Development**	*n*	**Instillation of Hope**	*n*	**Social Connectedness**	*n*
Directive ...set specific goals and specific time lines to help client to further progress.	**11**	**Managing Emotions** Somebody who helps me with my feelings.	**3**	**Facilitates Self-Efficacy** ...allowing me to take the lead and make decisions in my life.	**2**		
Accepting Listening and having non-judgemental attitude.	**11**			**Reliability and Accessibility of Support** That I'm doing good and that if I need someone to talk to he/she will be there for me.	**2**		

(table continues)

Table A3 (continued)

Therapeutic Style		**Healthy Skill Development**		**Instillation of Hope**		**Social Connectedness**	
	n		***n***		***n***		***n***
Attentive Some one that takes the time to listen all you have to say and what is on your mind.	**8**						
Competent Being right on the ball. He's always on the ball when we're talking. He's also smart, too.	**8**						
Empathic Understand what your going through…	**8**						

(table continues)

Table A3 (continued)

Therapeutic Style		Healthy Skill Development		Instillation of Hope		Social Connectedness	
	n		*n*		*n*		*n*
Competent Being right on the ball. He's always on the ball when we're talking. He's also smart, too.	**8**						
Empathic Understand what your going through…	**8**						
Direct They don't back away from an issue, even when I'm not comfortable with it.	**8**						

(table continues)

Table A3 (continued)

Therapeutic Style		**Healthy Skill Development**		**Instillation of Hope**		**Social Connectedness**	
	n		*n*		*n*		*n*
Trust Like I said, trust is a good start.	**5**						
Genuine Being real and not going through the motions.	**3**						
Patient …patience.	**2**						
Cooperative …very cooperative.	**1**						

(table continues)

Table A3 (continued)

Therapeutic Style		**Healthy Skill Development**		**Instillation of Hope**		**Social Connectedness**	
	n		*n*		*n*		*n*
Challenging [My therapist and support team] tell you when you're smoke-screening or lying. They basically tell you and you can correct it. Sometimes it's difficult.	**1**						
Supportive If I need someone to talk to he/she will be there for me.	**1**						
Integrates Family Therapy Gets my family involve…	**1**						

(table continues)

Table A3 (continued)

Therapeutic Style		**Healthy Skill Development**		**Instillation of Hope**		**Social Connectedness**	
	n		*n*		*n*		*n*
Objective Empathy, impartiality, non-judgmental attentive listening, sincerity, objectivity and frankness.	**1**						
Limit Setting Understanding, compassion, firm yet nurturing, non judgemental.							
Properly Paced Plus set specific goals and specific time lines to help client to further progress client's dealing process (at their own rate and speed).	**1**						

Table A4

What specific qualities of a therapist are not helpful, or make it more difficult for you to deal with your issues and manage your risk?

Therapeutic Style	*n*	Healthy Skill Development	*n*
Uncaring Indifference, lack of concern for the individual.	**7**	**Fails to Address Risk Management Strategies** No suggestions to deal with, manage risk.	**7**
Unempathic Seeming to know what you are feeling or going through without even realizing what it is really like.	**7**		
Dismissive Someone that does not listen to what you have to say and what is on your mind.	**5**		

(table continues)

Table A4 (continued)

Therapeutic Style	*n*	**Healthy Skill Development**	*n*
Judgmental	**5**		
Judgment, advocating an agenda.			
Confrontational	**4**		
When we get caught looking at stuff like children and the staff bring it up to us – it's hard for us. We don't want to talk about it.			
Poor Pacing	**4**		
It is not cool when they rush into a topic and rush you out of the door, when you have not say what you wanted to say.			
Indirect	**3**		
Don't always acuse or play games with my mind, lack of co-operation.			
When he can't answer one simple question.			

(table continues)

Table A4 (continued)

Therapeutic Style		**Healthy Skill Development**	
	n		*n*
Untrustworthy	**2**		
Well I feel that if the trust you have with your therapist is gone, well there isn't any point going on.			
Ridged/Strict	**2**		
I find that someone who is strict and ridged and serious is not someone I would work with.			
Uncooperative	**2**		
Don't always acuse or play games with my mind, lack of co-operation.			
Unsupportive	**1**		
Not supporting.			

(table continues)

Table A4 (continued)

Therapeutic Style	*n*	**Healthy Skill Development**	*n*
Poor Communication	**1**		
Getting too technical (ie. Using terms/language you don't understand)			
Naïve/Inexperienced Therapist	**1**		
Lack of life experience.			

Appendix J

Frequencies and Percentages of Qualitative Responses for Each Superordinate Category, Arranged by Question

	Therapeutic Style	Healthy Skill Development	Social Connectedness	Instillation of Hope	*Alliance-related*	Total
Q1	10 (13.3)	50 (66.7)	11 (14.7)	4 (5.3)	7 (9.3)	75
Q2	57 (67.9)	18 (21.4)	0 (0.0)	9 (10.7)	43 (51.2)	84
Q3	89 (82.4)	7 (6.5)	3 (2.8)	9 (8.3)	57 (52.8)	108
Q4	44 (86.3)	7 (13.7)	0 (0.0)	0 (0.0)	22 (50.0)	51
TOTAL	194	81	14	22	129	311

Note. Figures in parentheses represent percent of total responses in each superordinate category.