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GRADUATE COLLEGE

WORKING ALLIANCE AND READINESS TO CHANGE IN INCARCERATED SEX OFFENDERS

A Dissertation

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

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By

DANA LYNN DERRICKSON

Norman, Oklahoma

1999

Working Alliance and Readiness to Change in Incarcerated Sex Offenders

A Dissertation APPROVED FOR

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

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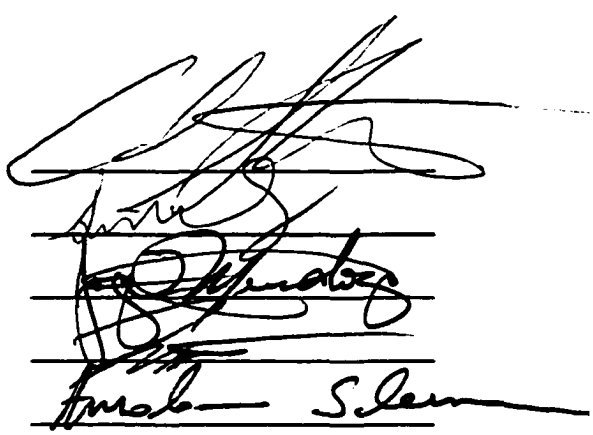

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Abstract

This study measured the effect of treatment alliance on Readiness to Change, utilizing the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) and the University of Rhode Island Change Assessment Inventory (URICA) (McConnaughy, Prochaska & Velicer, 1983). It was hypothesized that a stronger treatment alliance will predict more readiness to change. In addition, the length of treatment and conviction status (child molester versus rapist) were examined as predictors of readiness to change. The participants were recruited from a pool of incarcerated sex offenders in a residential treatment program. It was found that working alliance was a significant predictor of readiness to change, but conviction status and length of treatment did not predict readiness to change or strength of working alliance. Implications of this study are discussed.

Treatment Alliance and Readiness to Change in Incarcerated Sex Offenders

As society as a whole becomes more educated and more aware of sexual abuse, there is a commensurate increase in the public outcry that we "do something" about this social problem. In addition to the public's greater awareness of the occurrence of child sexual abuse, most lay persons appear to believe in the effectiveness of psychological interventions. As a result, treatment professionals are not only called upon to treat the victim of sexual abuse, but also to treat the perpetrator. Because of the increase in court mandated sex offender treatment, the science has yet to determine the most effective practice that would curb the sex offenders' abusive behavior. Sex offender treatment can be an area where providers are left to rely on clinical intuition. Professionals are not exactly sure what may decrease offending behaviors in convicted sex offenders, or what is necessary to initiate the desire to change in these men. This study measured two fundamental prerequisites for successful treatment: the working alliance and readiness to change. These variables combine as an important foundation for maximizing the effect of treatment interventions.

Prevalence

Each year, the statistics regarding child sexual abuse grow more alarming. When Finkelhor (1979b) initially studied a college population, he found that approximately one-fifth of women and one-eleventh of the men surveyed reported unwanted sexual experiences in their childhood. That translates to estimatesof up to 50 million college women, and 22.5 million college men in 1979 who may have suffered some form of childhood sexual abuse. Alarmingly, Finkelhor believes that the results of his study demonstrate an artificially *low* report of actual prevalence. This low report is hypothesized to be the result of victim underreporting and incorrect thinking about what defines sexual abuse. A most disturbing trend noticed in this study is that a family member victimized half of the females who reported abuse. Seventeen percent of the men surveyed reported being sexually victimized, but of this 17%, almost three-fourths (70%) were abused by relatives or persons known to them prior to the offense (Finkelhor, 1979).

In another study, Salter (1988) reviewed the prevalence data of child sexual abuse from 1979 to 1985 and found that estimates of sexual abuse ranged from 8% to 38% for women,

and 3% to 11% for men. The wide range of estimated prevalence among the studies can be accounted for by the respective differences in defining abuse, and in the sampling methods used (Salter, 1988). For example, most of the samples were drawn from a college population. Generally, a college population represents a cross section of society that has a higher socio-economic status than the average. Although sexual abuse occurs at all socio-economic levels, it is more often reported in lower socio-economic strata (Finkelhor, 1979; Salter, 1989; U.S. Department of Justice, 1996). Therefore, when a college population is the sole population sampled, it is likely that the number of incidents of sexual abuse will be lower than if a stratified sample was used that draws from all sections of society (Salter, 1989). Finally, each study that Salter examined utilized different methodology to gather their data, and these differences could contribute to the variety of prevalence statistics reported.

For every victim there is an offender, and the U.S. Department of Justice claimed that on a given day in 1994, there were approximately 234,000 offenders convicted of rape or a serious sexual assault under the custody of the government agencies. Of these men, almost 60% were

monitored in the community. The median age of the victims was less than 13 years (U.S. Department of Justice, 1996).

Although many of these men (for the purpose of this paper, only men will be mentioned and studied) sought treatment in outpatient mental health centers, there are many who only receive treatment while in prison (no numbers of sex offenders receiving treatment in prison were available at this time of this study). Ultimately, successful intervention involves the cessation of offending behaviors. However, current recidivism statistics compiled by the U.S. Department of Justice (1996) suggest that over a three year period an estimated 52% of discharged rapists, and 48% of discharged sexual assaulters were re-arrested for a new crime. Of these men, only 8% of the rapists were re-arrested for another rape even though they were 10.5 times as likely as non-rapists to be arrested for rape. In addition, those offenders who served time for sexual assault/rape are 7.5 times as likely as offenders convicted of other crimes to be arrested for another sexual assault.

Theory of sex offending

Probably the most widely used explanatory theory of sex offending is that proposed by Finkelhor (1984). Finkelhor (1984; Browne & Finkelhor, 1 [illegible] reviewed an

array of theories, and identified three common factors that played a role in offending behavior. The first of these factors involves "emotional congruence." Children are seen as appealing to sex offenders because of the child's perceived innocence, trusting natures, and unconditional acceptance. Men who commit sex crimes are often lonely, isolated, immature, and inept at forming satisfying adult relationships. They find children less threatening, and thus are emotionally drawn to them to meet their adult needs.

A deviant arousal pattern is considered a key part of sex offending, because if a man believes that an action will gratify him, then it is easier to assure himself that the action is acceptable. Arousal to children is not limited to sex offenders though, as there is evidence suggesting that some non-offending men are sexually aroused by children (Briere & Runtz, 1989). They simply do not act on this arousal. Conversely, it must be stressed that most sex offenders are not exclusively aroused by children and that many have engaged in adult sexual relationships (Finkelhor, 1985; Groth, 1978; 1979). The fact remains that before a man will sexually molest a child, he will be sexually aroused by child stimuli. This deviant arousal

allows the offender to further loosen the internal restraints that should typically inhibit his behavior.

The next factor to be considered is the "blockage" that the offender experiences in obtaining emotional gratification in adult relationships. Difficulty in maintaining these relationships could be a situational problem, or represent a long-term pattern of relating to significant others. Most sex offenders are engaged in adult opposite sex relationships during the commission of their crimes, especially in the case of intrafamilial offenders (Groth, 1978). In fact, the women in the offender's life have often been implicitly or explicitly blamed by the offender for the occurrence of abuse against the victim. The offender may insinuate that if the woman had provided better sexual or emotional gratification, then the crime would have not occurred. Personality pathology also is subsumed under the category of "blockage," and is considered a factor that impairs the formation and maintenance of meaningful and satisfying adult relationships.

Finally, Finkelhor stresses that an offender must overcome internal inhibitions. Emotional congruence, deviant arousal and blockage are hypothesized to contribute

to motivation to offend, but to actually carry through with an offense, the man must sweep away the personal inhibitions and the moral admonitions that remain to stay his behavior. To avoid another offense, treatment must bolster internal restraints so that they override the motivation to offend. In essence, the offender must want to inhibit his behavior regardless of desire to offend. So, the motivation to restrain must be greater than the motivation to gratify.

Sex Offender Therapy in Prison

Treatment programs

A variety of treatment programs have been devised to deter the commission of further sex offenses. The most straightforward deterrent is imprisonment. In this way, the offender is precluded from having access to potential victims, and is also clearly sent the message that society finds his behavior reprehensible. However, it is incredibly rare for a sex offender to receive a life sentence, and 60% of convicted sex offenders are maintained in the community (U.S. Department of Justice, 1996). Therefore, offense focused treatment is the intervention that is used to prevent recidivism.

Currently, multi-faceted, cognitive-behavioral group treatment is the treatment of choice, and is utilized in many prison settings in residential sex offender treatment programs, like the Metro State Hospital (California), Atascadero State Hospital (California), the Massachusetts Treatment Center, Western State Hospital (Washington), and the Sex Crime Facility (Wisconsin).

The setting from which this study's sample was drawn is built along this model as well. The treatment approach utilizes heavy disclosure of the particulars of the crime, intense confrontation, and a deep understanding of the "cycle of offense" (Day, Marques, Nelson, & West, 1994; Earls, Marshall, Segal, & Drake, 1983; Marshall & Pithers, 1994; Rice, Quinsey, & Harris, 1991; Salter, 1989; Schwartz, 1992). This cycle conceptualization is similar to a substance abuse model of relapse prevention in that the offender is taught to identify "trigger situations," recognize the internal deprecation that offers an "excuse to offend," and to intervene when the offender begins to relax the inhibitions that the offender uses to "talk himself" into offending. According to this model, sex offending is seen as a behavior that is under the control of the individual. Although the sex offense may bring

temporary gratification and relief from stress, there are severe consequences for the offense like the loss of his family and freedom. This perspective of sex offending is analogous to the substance abuse philosophy in that the alcoholic may relieve some pressures by engaging in drinking, but the consequences of this temporary solution can be very detrimental to the individual (losing a job, losing a marriage).

Most cognitive behavioral treatment approaches, focus on a particular set of target areas for change. These areas of sex offender treatment targets include personal responsibility, social skills, issues with sexuality, cognitive issues, victim empathy, emotional issues, sexual arousal, personality pathology, and relapse prevention (Marques, Day, Nelson, & West, 1994; Marshall, Earls, Segal, & Drake, 1983; Marshall & Pithers, 1994; Salter, 1989; Schwartz, 1992).

A program that exemplifies this approach has been implemented in Washington state by the Northwest Treatment Associates (Salter, 1989). This group provides offense-focused treatment to offenders sentenced in the community. This focused treatment is delivered in a group setting, where each man is required to admit and describe his

offense, and thereby take responsibility for his behavior. "Homework" is assigned that specifically addresses deviant sexual behavior with children and adults, and behavioral tasks are given so the offender can practice desensitizing himself to deviant arousal. Social skills deficits are addressed by means of packaged social skills curricula, and assertiveness training is practiced. In order to reduce the offenders' emotional congruence with sex-offending behaviors, cognitive restructuring is initiated that directly targets the offender's dysfunctional beliefs that maintain his behavior. Finally, the offender is taught to be aware of internal and external situations that predispose him to offend, like job stress or feelings of rejection. The Northwest Treatment Associates' program also includes victim empathy components, which are intended to promote regard for the suffering of others that resulted from the offenders' acts against their victims.

Successful completion of this two year program is measured by a variety of factors: active participation, owning responsibility for offenses, intellectual understanding of offense chain and treatment techniques, emotional understanding of the impact of offenses, attempts to change behavior, willingness to help other group

members, and monitoring of own progress. The offender who completes this program should understand that he will have to remain vigilant to monitor his own behaviors and thoughts in order to prevent further crimes. In other words, after completing the program, the offender should understand that he is not "cured" (Salter, 1989).

Outcome studies

For treatment to be considered "effective," the offender should not offend again. Therefore, recidivism statistics, usually obtained through law enforcement agencies, are gathered to track treatment failures. These statistics consist of official records of re-arrest or re-conviction of a sex offense. Unfortunately, when only law enforcement records are used the ability to gauge the true numbers of offenses committed after an offender's release from prison is limited, because only those offenders who have contact with law enforcement are counted. Thus, the recidivism numbers presented probably represent an artificially low account of sex offender recidivism.

Despite these depressed numbers, outcome statistics following focused intervention are discouraging. Furby, Weinrott and Blackshaw (1989) conducted a meta-analysis of treatment outcome. Their criterion that defined

"successful treatment" was official report of recidivism, or lack thereof. They included a wide variety of programs dating back to the 1950's. As a result, many perspectives were examined which included milieu therapy, person centered and dynamic psychotherapy. In addition to these perspectives, single components of current multi-faceted treatments (aversion therapy, behavior therapy) were reviewed. After analyzing the outcome statistics of these treatments, the authors concluded, "there is no evidence that treatment effectively reduces sex offense recidivism" (p. 25). However, the authors admit that the studies they reviewed suffered from methodological flaws (lack of control groups), analysis problems (overlapping populations resulting in double counting), and obsolete interventions. Therefore, no solid conclusions could be drawn regarding which variables contribute to a successful outcome, even from this exhaustive meta-analysis

Rice, Quinsey, and Harris (1991), members of the Pentanguishene Group of the Mental Health Center in Ontario, Canada, conducted a similar outcome analysis of their own program that relied on post-release arrest and conviction reports. They compared their numbers to other similar programs for sex offenders. These authors not only

concluded that their treatment program was ineffective, but that all treatment programs for sex offenders were ineffective. Upon further examination though, the authors admitted that "the provision of very brief intervention involving no aftercare or clinical follow-up for serious offenders in the present research may be sufficient to explain the differences in outcome between this and other studies (Rice et al., 1991, p. 386). The treatment interventions examined by the Pentanguishene group also were very behaviorally specific and consisted of electrical shock aversion therapy, and biofeedback designed solely to reduce deviant arousal. The literature has consistently raised doubts about the effectiveness of using biofeedback and aversion therapy alone to reduce deviant arousal (Marshall & Eccles, 1993; Quinsey, Chaplin, & Carrigan, 1980; Quinsey & Marshall, 1983). This same literature maintains that any program designed to treat sex offenders must include a variety of interventions that target an array of symptomology and internal processes. Again, no solid conclusions can be drawn from this analysis.

Marques, Day, Nelson, and West (1994) have undertaken a comprehensive, longitudinal study of their sex offender treatment program at the Atascadero State Hospital. They

have obtained 15-year NIMH grant, and have reported their results halfway through the study. This program incorporates the state-of-the-art cognitive behavioral interventions to treat a wide range of extra-familial sex offenders. This study also corrected some of the methodological concerns that have plagued other programs. For example, due to bed availability (only 50 beds on this residential unit are available), there are many offenders who volunteer for this program, but will not be able to participate by the end of their sentence. This creates a comparison group without the usual clinical ethical dilemma of withholding necessary treatment.

To analyze the effectiveness of their program, Marques, Day, Nelson, and West (1994) have obtained access not only to official police records, but to unofficial social service and parole records, and have guaranteed complete confidentiality to released sex offenders who agree to participate in this study. In this way, the researchers are granted access to the "hidden" numbers denied to law enforcement. The researchers used survival analysis techniques that take into account the time that an offender has remained in the community before committing another sex offense. Violent offenses are tabulated

separately from sex offenses, and included in their own separate analysis of recidivism.

These authors (Marques et al., 1994) have been able to tentatively conclude that after seven years, their treatment program has reduced sexual recidivism compared to the volunteer no-treatment group (offenders who requested treatment but were denied due to bed space), and the non-volunteer control group (did not desire treatment). Not only did the offenders treated in this study have a reduction in commission of sex offenses, but they committed fewer non-sexual violent crimes. After 35 months in the community, of those men who completed the program, only 8.2% committed another sex offense compared to 12.5% of the non-volunteer control. An interesting and unexpected finding indicates that those offenders who were accepted for treatment and later quit, had a 37.5% recidivism rate. All of the 59 rapists who dropped out of treatment early committed another sex crime. Out of 240 child molesters who completed treatment, only 7.9% committed another sex crime compared to 28.6% of the drop out group, 10.1% of the no treatment comparison group, and 12.8% of those who did not want treatment at all.

Very recently, Hanson and Bussiere (1998) conducted a meta-analysis to determine the rate of recidivism in sex offenders, and what factors influence recidivism. They reviewed 87 usable studies that included published articles, books, government reports, unpublished program evaluations, and conference presentations from 1943 to 1995. To be included in the meta-analysis, the studies had to follow a sample of sex offenders and report recidivism information pertaining to both sexual and non-sexual offenses. Plus, the study had to include sufficient statistical information to calculate the relationship between a relevant offender characteristic and recidivism. In addition, all of the studies utilized had conducted a matched, longitudinal, follow up analysis. After examining the studies that met this strict inclusion criteria, the authors found that only 13.4% of the offenders sampled (n=23,393) committed another sexual offense. These findings are consistent with the results of Marques et al. (1994) study. Factors that were most predictive of recidivism included a history of sexual deviancy (prior sexual offenses, diverse sexual crimes, boy victims, strangers), and deviant sexual interests (as measured by phallometric procedures), and a criminal lifestyle.

Actually, failure to complete treatment was an only a moderate predictor of sexual offense recidivism (r=.17). Hanson and Bussiere also examined factors that predicted non-sexual recidivism. Again, they found merely small to moderate correlations between premature treatment termination and non-sexual recidivism.

It seems that recent well-controlled outcome studies indicate that sex offender treatment is effective in preventing sexual recidivism among certain types of offenders. However, this review suggests that there is no clear cut "winner" as to treatment of choice. There are many supporters of many approaches to therapy, and while cognitive-behavioral treatment seems effective, it can only be stated that some forms of treatment have been effective in preventing sexual recidivism sometimes with some sex offenders.

Treatment Alliance

A fundamental aspect of treatment, common to all forms of orientations and approaches studied, is a relationship between an offender and a therapist. By definition, therapy implies the existence a working relationship between a client and a treatment professional that is mutually accepting and respectful. A large body of

literature suggests that an accepting and respectful working relationship is necessary for treatment to be successful (Butler & Strupp, 1986; Greenson, 1967; Lacrosse & Barak, 1976; Lacrosse, 1980). In professional terms, this accepting and respectful relationship is called the "treatment alliance," or "working alliance." This relationship is qualitatively different from the traditionally psychoanalytic transference and countertransference relationship because it focuses on the "real" relationship between the client and therapist, not the projected relationship (Waterhouse & Strupp, 1984). Although some researchers make distinctions between the terms treatment alliance and working alliance, these terms will be used interchangeably in this study.

Unfortunately, sex offenders are a population that is difficult to accept and respect. The literature is replete with warnings about allowing the therapist's personal feelings about the crime committed to interfere with the relationship to the offender (Gerber, 1995; Mitchell & Melikian, 1995; Peaslee, 1995). Bordin (1979), defines the working alliance as the "collaboration between the client and the therapist based on their agreement on the goals and tasks of counseling and on the development of an attachment

bond." This definition contains the essential components of the working alliance and can be broken down as follows. First, the treatment process suggests that the therapist and the client are working towards a common "goal." In sex offender treatment, the goal would be the ultimate extinction of offending behaviors. The task component of the alliance would include accomplishing the day to day "tasks" of therapy, like completing homework and disclosing offenses. Finally, the working alliance relies on the development of an attachment "bond" between the client and the therapist. A part of this bond is rapport, but the attachment bond that Bordin speaks of is also constructed by a feeling of mutual respect and trust. Although sex offenders have committed an unusually heinous deed, it has not been demonstrated that they are qualitatively different from any other client who has a problem to solve. Bordin would suggest it is necessary to establish a treatment alliance before any meaningful work between the client and therapist can be done. Unfortunately, considering the nature of the problem that the sex offender seeks to solve, that initial bond may be difficult to form because of therapist disgust or revulsion towards the sex offenders' acts (Mitchell & Melikian, 1995).

There is firm evidence that the working alliance is an integral aspect of therapeutic intervention and common to all therapeutic approaches (Butler & Strupp, 1986; Greenson, 1967; Lacrosse, 1980; Lacrosse & Barak, 1976). In the last ten years, psychoanalytic researchers have lamented the lack of focus on the working alliance in favor of the transference relationship (Marziali & Alexander, 1991). Perry and Birkett (1996) assert that the working alliance in psychoanalysis is the "the conscious attention on the part of the therapist to the patient's subjective experience of therapy." In this way, the alliance serves the purpose of educating the patient as to the purpose of therapy, engages rational (i.e. conscious, or non-transferential) processes in the service of the commitment to change, and highlights the links between the patient and the therapist. The authors go so far as to say that skillful use of the working alliance can break down client resistance and facilitate change.

Kivlighan and Shaughnessy (1995) conducted a study to measure the relationship between treatment alliance and therapy outcome. They distributed the Working Alliance Inventory, Short Version (Tracy & Kokotovic, 1989) after every session, to 21 therapist client dyads in a large

Midwestern university counseling center. They also distributed the Inventory of Interpersonal Problems to the clients at the termination of therapy. Using a hierarchical linear model (HLM) analysis, the results showed that the working alliance grew in a linear progression, and that the linear growth pattern of the alliance predicted success in therapy. That is, that the faster and stronger that the alliance grew, the more likely the client was to report a successful resolution to therapy. This study also discovered that the strength of the working alliance at the beginning of therapy and at the midpoint was not related to client outcome, but rather it was the strength of the alliance at the end of therapy that was related to successful treatment. Thus, the therapist that was able to develop and maintain a strong working alliance generally was more adept at facilitating change in the client.

Tryon and Kane (1993) studied the effect of the working alliance on unilateral client termination. Usually, a therapist would like for the client and herself to decide mutually when the treatment goals are reached and when therapy should end, although this does not always occur. Tryon and Kane distributed the WAI-S to 91

counselor-client dyads after the third session. They found that counselor perceptions of the working alliance after three sessions predicted mutual or unilateral termination, but that client perceptions did not. They concluded that therapists should quickly work to strengthen working alliances that they perceive as weak, in order to avoid the client's unilateral termination.

Stiles, Agnew-Davies, Hardy, Barkhan, and Shapiro (1998) designed and implemented a study to measure the treatment alliance throughout a course of therapy. They were interested in determining if client perception of alliance was more strongly related to treatment outcome than therapist perception. They utilized the Agnew Relationship Measure (ARM) (Agnew-Davis et al., 1998) to measure the treatment alliance. This 28-item instrument contains five scales designed to tap different aspects of the treatment alliance: Confidence, Bond, Partnership, Openness, and Client Initiative. This scale is correlated with other measures of treatment alliance, including the Working Alliance Inventory. The researchers asked the client and therapist to complete the ARM after every session. The length of treatment varied between eight sessions of cognitive behavioral treatment and 16 sessions

of psychodynamic-interpersonal treatment. They found that the quality of the alliance, as measured by the ARM, was significantly correlated with differences in client improvement, accounting for between 40% and 50% of the variance. Instead of the alliance being relatively stable over time and fixed by the third session, the authors discovered that the strength of the alliance fluctuated, but was stronger later in treatment. In addition, they found that when the therapist and client both perceived the alliance to be strong, the outcome was more positive.

Stages of Change: Transtheoretical Model

Based on the above literature, there is evidence to support that a strong treatment alliance is related to successful therapy outcome. However, this factor alone is not considered sufficient to induce change. Frequently, an offender can feel very connected to the treatment professional, and even agree to treatment goals, but continue to maintain maladaptive attitudes and behaviors. In this case, the offender may not be ready to change the offending behavior. He may believe that he does not have a "real" problem, or does not believe that he needs a formal intervention to change the problem. It is very likely that many offenders ordered into treatment by the courts

demonstrate such characteristics. Prochaska and DiClemente have developed and studied a Transtheoretical model that attempts to explain and describe the phenomenon of readiness to change. They hypothesize that any person who wishes to change a maladaptive behavior, or acquire new, more functional behaviors, moves through stages of change (Prochaska & DiClemente, 1992). First, the person must realize there is some problem or difficulty with which he or she struggles. It is theorized that those around the individual recognize a problem before the person in question. This is considered the Pre-contemplation stage. In essence, the individual does not recognize that there is anything in his life for which an intervention is needed. An example of a sex offender operating in the Pre-Contemplation stage could involve a father molesting his daughter. This father may assert that he is "teaching his daughter about sex," and thereby doing her a favor. By definition then, in his mind, there is no problem. His daughter on the other hand may perceive the situation very differently, as does law enforcement.

Next, according to Prochaska and DiClemente, comes the Contemplation phase. Here the individual is aware that something is off balance in his life. Problems that the

person once attributed to outside sources may now be attributed to the individual. Consistent with the above sex offender example, the father in the Contemplation stage notices that his daughter seems frightened of him, and is reluctant to be near him. He loves his child, and her avoidance of him causes the offender distress. When in the Pre-contemplation stage, he may have attributed her behavior to problems at school that were unrelated to him, but in the Contemplation phase, he begins to question whether or not his actions are negatively impacting his daughter.

Following the Contemplation phase is the Preparation stage which "indicates a readiness to change in the near future, and acquisition of valuable lessons from past change attempts and failures" (Prochaska & DiClemente, 1992). The father in this example may decide to curtail his sexual activities with his daughter for a time, and purchase some literature that discusses sexual abuse. From this stage follows the Action stage. This is where the commitment to change is firm, and the individual actively seeks to develop and maintain strategies that will improve his resolve and desire to decrease the objectionable behavior. The offending father in our example may attend a

sex offender treatment group or turn himself in to the authorities. In this stage, the father would strongly believe that he was acting dangerously or irresponsibly, and he would probably believe that he was seriously harming his daughter.

Prochaska and DiClemente hypothesize that the next phase, the Maintenance stage, is where the problem behaviors have been effectively stopped. Here, the individual attempts to continue the achieved change indefinitely. In our example, the formerly offending father may have moved out of the home, or, at the very least, no longer uses his daughter for sex, despite the temptation to do so.

Finally, there is the Termination phase. In this phase, the recovering individual does not have to work as actively to change his behavior or maintain that change, because the change is so firmly entrenched as to be a part of his day-to-day experience. Prochaska and DiClemente allow for potential relapse in this model when the person cycles back through the stages a number of times.

The Transtheoretical Model was initially created to explain the readiness or motivation to change in drug and alcohol addicted patients (Belding, Iguchi, & Lamb, 1996;

Carney & Kivlahan, 1995; DiClemente & Hughes, 1990; Prochaska & DiClemente, 1985;). However, this model has been applied with some success to a wide range of behaviors including smoking cessation, exercise adherence, physician behavior, contraceptive use in HIV+ patients, and promotion of health related prevention behaviors like obtaining mammograms or cholesterol testing (Cohen, Halvorson, & Gosselink, 1994; Cohen, DiClemente & Main, 1995; Crittenden, Lacey, Manfredi, Parsons & Warnecke, 1994; 1995; O'Connor, 1994). Prochaska and DiClemente's model is designed to bridge the theoretical boundaries of orientation and method, which is why they refer to it as a "Transtheoretical Model." These five phases are believed to be uniform across a variety of behaviors and presenting problems, and represent the progressive increase in an individual's motivation for altering dysfunctional behaviors.

The Transtheoretical Model was applied to Pre-contemplation clients involved in a smoking cessation program. DiClemente, Velicer and Rossi (1993) hypothesized that patients identified at the Pre-contemplation stage are the most difficult to treat because they are unwilling to recognize that they have a problem. Thus, it would follow

that if these Pre-contemplation patients were treated as if they were in the Action stage and ready to implement a plan of change, treatment would be unsuccessful. To solve this problem, a professional should intervene differently with persons in differing stages.

DiClemente, Velicer and Rossi (1993) designed the above study to evaluate the effect of counselor support on treatment compliance in Pre-contemplation patients who volunteered for a smoking cessation program. Patients in the support group met with their counselors weekly, and received supportive phone calls as well. From this intervention, the authors found a significant positive difference in treatment adherence and movement through the stages of change. Those participants who had received a supportive phone call in addition to weekly sessions with their counselors moved more quickly through the stages of change and achieved smoking cessation. Once this social support was removed at the end of treatment, however, relapse was more prevalent in those who apparently had come to rely on their counselor.

To combat this phenomenon, another study was designed and implemented that included an "expert computer" feedback system, human counselor support, and a combination

condition to promote smoking cessation (Velicer et al., 1997). The expert computer was designed so that the patient could input data regarding his or her struggles in treatment (days spent thinking about smoking, relapse), and the computer would provide feedback regarding progress. In the counselor only condition, the counselors again would meet with the patients and call them weekly. In the combination condition the participants had the benefit of the immediate feedback from the computer, and the support and encouragement of the counselors' sessions and phone calls. The authors found that although the expert computer system assisted in retaining Pre-contemplation clients, the combination variable had the most success in promoting smoking cessation. It was again demonstrated in the counselor only condition, that when the counselor terminated contact, the patient relapsed faster than when non-human intervention was utilized. The authors hypothesized that this was due to dependence on the counselor's support, and proposed a fading procedure that would gradually phase out counselor contact in order to maximize the "best of both worlds."

Recently, Kear-Colwell and Pollack (1997) suggested that the Transtheoretical model should be tested with sex

offenders. They hypothesize that sex offending could be viewed as a compulsive behavior, or as an escape from situational stressors, similar to the reasons that people abuse drugs. These authors suggest that attempting to enhance motivation would be more effective to positive treatment outcome than a focus on excessive confrontation that is more likely to elicit defensive reactions that stonewall change (Kear-Colwell & Pollack, 1997). Intuitively, such strong confrontation would seem to inhibit a strong working alliance, as it is difficult to form an attachment to someone who is viewed as punitive.

Conclusion

Based on the above review, I submit that there are two common factors that cut across orientations and treatment approaches: treatment alliance and readiness to change. It would seem logical that the stronger the treatment alliance, then the stronger the therapists' persuasive power. The stronger the therapist's persuasive power, the more effective the therapist will be in increasing the client's readiness to change, thus moving the client through the stages of change to successful termination of the problem behavior.

Research Questions

1. Does the working alliance predict an offender's readiness to change?
2. Does conviction status (child offender versus adult rapist) effect an offender's readiness to change?
3. Does length of treatment predict an offender's readiness to change?

Chapter II

Method

Participants

Fifty-nine participants were recruited from a Residential Sex Offender Treatment Program at a medium security prison in a southwestern state. In this study, only those inmates who were actively engaged in treatment were asked to participate. All the inmates in the Residential Sex Offender Treatment Program volunteered for treatment, and passed initial screening measures. Offenders were excluded if they were identified as mentally retarded, or suffered from a mental disorder that is not under control.

This sample had the following demographic characteristics. Sixty men volunteered to participate in this study, and fifty-nine packets were completed. Seventy-three percent of the sample were Caucasian, 8.5% were African American, 6.8% were Native American, and 1.7% were of Hispanic descent. The average age was 39.8 years. The demographic breakdown of the sex offenders in this program was different from that of Oklahoma offenders in general. Of the 20,692 offenders incarcerated in Oklahoma,

54.6% were Caucasian, 34% were African American, 6.9% were Native American, and 4% were Hispanic (Oklahoma Department of Corrections, 1998). It is important to note that 82% of the population of Oklahoma is Caucasian. No demographic breakdown of convicted sex offenders in Oklahoma was available. Nationwide, 69.7% of convicted child molesters were of Caucasian descent. Twenty five percent were African American, 11% Hispanic, and 4.8% were of another race. Convicted rapists had a slightly different demographic. Forty three percent were Caucasian, 53% African American, and 3.6% were of another race (U.S. Department of Justice, 1996).

The majority of the sample was single (83.1%), and if divorced, 59.3% divorced following their offense. Thirty three percent of the sample considered themselves engaged in a professional occupation prior to incarceration, 27.1% were skilled laborers, and 28.8% reported employment as unskilled laborers. Ten percent were unemployed at the time of incarceration. The demographic characteristics of this sample compared to the Oklahoma and national averages are summarized in Table 1.

Offense characteristics

The vast majority of the sample were convicted of an offense against a child (92%), with the remaining sample convicted of adult rape (8%). Sentences ranged from three to 240 years, including life sentences. The mean sentence was 30 years.

Historical Information

Sixty seven percent of this sample reported that they were physically abused as children, and 71% disclosed prior childhood sexual abuse. Sixty six percent of these men admitted that they had a history of substance abuse (35% named alcohol as their drug of choice), but only 10% of these participants reported receiving treatment for substance abuse. Thirty two percent of this sample had received prior psychotherapy, and ten percent of the sample had received inpatient psychiatric treatment. Only 23% of the sample received concurrent individual therapy at this time. Seventy percent of the participants' victims were related to the men. Twenty percent of the offenders were convicted of molesting their biological daughter, 15% were convicted of molesting their stepdaughter, 15% of molesting a related female, and thirty percent were convicted of violating a female stranger. Three percent of the men

sampled were convicted of molesting their biological son, 1% their stepson, and 3% molested an unrelated male.

Residential program phase

This program opened in 1989 under the direction of a doctoral level psychologist. The current Program Director has been in place for about seven years. She holds a Masters of Social Work, and is licensed in the state of Oklahoma. Six masters levels therapists, including the director, implement the residential program. The remaining five therapists hold masters degrees in a psychology related field or community counseling, and one of these therapists is licensed in Oklahoma. These therapists have over 35 years of combined experience in treating sex offenders.

The offenders sampled were all in different phases of treatment. Each phase was designated in three-month intervals, until they reached one year, when they can become "Transitional Residents (TR's)." TR's usually remained on the unit as peer counselors, assisted full time treatment staff in facilitating groups, while they engaged in their own "advanced" treatment groups and individual therapy. Usually a TR moved from the unit after one year following participation in treatment for a total of two

years. Each phase required a particular task to be completed prior to advancing to the next phase. For example, in the first phase, offenders must have written an autobiography that chronicled their deviant behavior. Then they read this autobiography to the group and received feedback. The phase breakdown of this sample is summarized in Table 2.

Assessment Instruments

The Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) is a 36-item instrument that utilizes a seven point descriptively anchored Likert Scale response format. There are three scales that measure a common goal, task and bond of therapy, according to Bordin's (1979) criteria for the treatment alliance, and these three scales are combined to create an overall Working Alliance score. There are two forms of this inventory, a client and a counselor form, but this study only examined the client's WAI score. Although it would have been useful to assess the therapists' perspective of the treatment alliance, group therapy is the mode of treatment here, and the therapists facilitate more than one group, so the therapist would have been required to complete upwards of 20 WAI's. Because of the sheer time required to complete so many

WAI's, therapist compliance would have been difficult if not impossible to achieve.

This scale was developed by theoretical construction, so items were selected on the basis of their adherence to Bordin's (1979) working alliance theory. A large pool of responses were generated (91) based on a content analysis of Bordin's (1976, 1980) descriptions of the bond, goal and task items. Each item was designed to capture a "feeling, sensation, or attitude in the client's field of awareness that may be present or absent depending on the strength of one of the components of Bordin's concept of the working alliance" (Horvath & Greenberg, 1989, p. 225). Following the item generation, seven experts in the field of treatment alliance rated a randomized item pool for construct validity. They were asked to answer two questions: a) Is this item relevant to the working alliance? b) Which of the three dimensions of the working alliance is measured? The relationship of an item to the construct was measured on a five point Likert scale. A one indicated that an item was *not* related to working alliance, and a five indicated that the item was *very relevant* to the working alliance. Items with a mean relevance of .40 or less were eliminated from consideration. The raters also

classified the items as belonging to one of the three categories of bond, goal and task. Finally, only those items with a Percentage of Agreement (PA) score of 70% or above between the raters were included.

Following this analysis, the remaining items were rated by 21 randomly selected psychologists in the community. The rating procedures used here were identical to the ones above. These professionals were given 70 items, and 55 remained following this stage of development. From this pool, the highest rated items were subdivided into the three working alliance dimensions, and then a factor analysis was conducted to divide the items into "meaning clusters" based on similarity of item content. Finally, from this pool, the highest rated items were included in the inventory, resulting in a completed inventory containing three, 12 item scales.

From a pool of 33 items generated by expert rating, 12 items were chosen for inclusion on the Goal subscale. These 12 items had an expert rater agreement of 85.3%. Thirty-five items were produced for the Bond scale, and the included 12 items earned a 94.8% expert rating agreement. The final scale, Task, was created from 23 original items

with an expert rating agreement of 86.2% for the final 12 items.

Admittedly, there is significant overlap among the three scales. The intercorrelations of the three scales are outlined in Table 3. Despite the high correlations, these scales still should be considered discrete components of the working alliance. Tracey and Kokotovic (1989) demonstrated the statistically distinct quality of the WAI subscales when they administered 140 WAI's after a first therapy session in a college-counseling center. A bi-level confirmatory factor analysis identified four separate factors. The first factor was a global alliance factor corresponding to the WAI total score, and the remaining three second level factors corresponded to the Goal, Bond and Task scales, respectively.

Reliability estimates were based on an item homogeneity index (Hoyt, 1941), and they ranged from .85 to .88 on the sub-scales of the client version of the inventory. After the WAI was constructed, two clinical trials were undertaken to measure the utility and validity of the WAI (Horvath & Greenberg, 1989). In the first study, the WAI was administered to 29 counselor client dyads, all of whom were involved in short term (15 sessions

or less) counseling. The counselors adhered to a variety of theoretical orientations, and the clients ranged in age from 19-65. Each client had voluntarily presented for treatment. The working alliance was assessed after the third session.

In addition to completing the WAI, the counselors and clients were asked to complete the Empathy scale of the Relationship Inventory (RI; Barrett-Lennard, 1962), and the clients alone completed the Counselor Rating Form (CRF; LaCrosse & Barak, 1976). The Empathy scale of the RI, and the CRF were included to tap dimensions that should be similar but not identical to the constructs purportedly measured by the WAI. Since working alliance is theorized to be a similar, but broader construct than empathy (tapped by the RI), or social influence (measured by the CRF), moderate correlations were expected.

Treatment outcome was measured by the Client Post Therapy Questionnaire (CPQ; Strupp, Wallach & Wogan, 1964). This instrument referenced three areas of client progress: satisfaction, perceived change, and perceived adjustment. Both client and counselor versions were administered. Results ($r=.42$, $p<.05$) indicated that "statistically reliable relationships exist between early working alliance

measurements and two out of three client-reported outcome indicators (satisfaction and change) (Greenberg & Horvath, 1989, p. 227). No relationship was found between the WAI and the outcome measurement scales though. Correlation coefficients ranged from between .40-.65 for the WAI, the Empathy scale of the RI, and the CRF, indicating that moderate correlations did exist among the various instruments. Therefore, the authors' hypothesis was supported. The WAI measured a broader concept than either the Empathy scale of the RI, or the CRF, indicating that the working alliance as measured by the WAI encompasses a more global concept than empathy or social influence. Two subsequent studies demonstrated similar reliability coefficients, indicating that the WAI is a reliable measure of the working alliance (Horvath & Greenberg, 1989).

The University of Rhode Island Change Assessment Inventory (URICA) (McConnaughy, Prochaska & Velicer, 1983), is a 32-item instrument that utilizes a five point likert scale format. There is a version of the URICA specifically designed for an alcoholic population, and another version, which was constructed to assess the stages of change for "generic" problem behaviors. There are four scales that have demonstrated sufficient discriminate validity: Pre-

contemplation, Contemplation, Action and Maintenance (Carbonari, Wirtz, Neunz, & Stout, 1994). Internal consistency for these scales has been determined to be quite high: Cronbach Alpha levels from .88-.89 (Carbonari, DiClemente, & Zweben, 1994; 1997). Although the authors have only provided alcoholic norms, the URICA has been used to identify readiness to change over a wide variety of problem behaviors including: smoking cessation, exercise adherence, and health maintenance. The four "generic problem" scales were utilized to determine the stages of change. In addition, the authors suggest that a cluster analysis be performed in order to determine specific factors unique to each sample.

The URICA was used to differentiate the stages of change in an outpatient treatment center for alcoholics (DiClemente & Hughes, 1990). Over an 18-month period, 224 adults were treated for "serious" drinking problems that did not require medical detoxification. They were administered various measures that indicated alcohol use and general attitudes regarding recovery in addition to the URICA. A cluster analysis revealed that there were five distinct clusters that corresponded with the four stages of the URICA.

Not only does the URICA provide the first order factors in the form of the previously mentioned stages, one can compute the Readiness to Change score (RTC), a second order factor. The RTC significantly reflects the individual's willingness to change. This score is computed by adding the Contemplation, Action, and Maintenance scales, then subtracting the Pre-Contemplation Scale (Carbonari, DiClemente, & Zweben, 1994; 1997). Carbonari, DiClemente, and Zweben (1997) found that those participants who earn a higher RTC score are farther along in the stages of change than those with lower scores. They examined three distinct profiles drawn from an substance abuse treatment aftercare and outpatient sample. These profiles were: Pre-contemplation, Contemplation and Participation/Preparation. The RTC score accurately and significantly discriminated between the three profiles. In addition, following a cluster analysis of the standard four scales and a computation of the RTC, the RTC was promoted by the authors as "an alternative continuous scoring scheme for accessing one's readiness to change" (Carbonari, DiClemente, & Zweben, 1997).

The RTC was derived by first examining the reliability of the four URICA subscales for two separate sample arms:

alcoholic outpatient and alcoholic aftercare. Cronbach Alpha coefficients ranged from .858 on the Maintenance scale to a low of .740 for the Pre-Contemplation scale, which indicated sufficient reliability to proceed. A confirmatory factor analysis was then undertaken to determine the efficacy of a four primary and one second order factor model of the st ucture of the URICA measure. The significant Chi Square of 1318.86, $p \leq .0001$ (df=346) for an alcoholic outpatient sample, and the Chi square of 1207.57, $p \leq .0001$, (df=346) for an alcoholic aftercare sample both produced a goodness of fit of .97 and .96 and adjusted goodness of fit of .96 and .95 respectively. These significant results indicated the presence of four first order factors and one second order factors, which allowed the analysis to proceed. In order to support the presence of the second order factor, a factor analysis was performed at the subscale level, and this single second order factor was strongly supported in both arms. The results of this analysis indicated a simple weighing scheme of -1, 1, 1, 1, with Pre-contemplation scoring in the opposite direction as one would expect. The correlation of the readiness scale to the factor scores for the outpatient sample was .986, and for the aftercare sample it was 1982.

Thus, the authors concluded that there indeed in a single, second order, continuous readiness to change score (Carbonari, DiClemente, & Zweben, 1997).

This study was interested in determining if readiness to change can be predicted by three different variables (working alliance, length of treatment and type of offense), thus the RTC score was utilized as the indication of the offenders motivation to change the sex offending behavior. As a continuous scoring method, it provides the best single indication of the offender's willingness to change.

Procedure

The researcher recruited participants by posting information about this study on the unit and requesting volunteers. Only those men who were assigned to treatment groups were solicited. If they chose to participate in this study, they were asked to come to the program building at a designated time where the researcher explained the requirements of the study and handed out the materials. This researcher remained available during the men's completion of the testing materials to answer any questions that arose. No treatment staff were present in the room

during testing, and the testing materials did not leave the possession of the researcher.

The confidentiality procedures were conducted as follows. A form was distributed to the men, which, if they agreed to participate, they signed. This consent outlined the nature of the study, asked for their participation, and released the Department of Corrections from any liability.

The men who chose to participate completed a data collection form and two study instruments. The data collection form gathered information including, among other things, age, ethnicity, marital status, crime of incarceration, and stage in the program. The two instruments the men completed were the WAI (Horvath & Greenberg, 1989) and the URICA (McConnaughy, Prochaska & Velicer, 1983). These instruments were counterbalanced to avoid completion bias. It must be stressed that no identifying information (e.g. name or social security number) was requested from these men. Following the completion of the instruments, the men were provided a debriefing form that further explained the purpose of this study. After completing these instruments, the men were asked to seal them in the provided envelopes and return them to the boxes designated for drop off. Every effort

was made to protect the men's confidentiality. Because of the separation of the informed consent and the research packet, it would have impossible for anyone to match the men's names to their completed packets. Since all the men, whether they completed the study or not, returned the envelopes, I was unable to determine who actually completed the study, thereby continuing to protect the men's confidentiality.

Design

The first predictor variable in this study was treatment alliance. It was operationalized according to Bordin's theory of working alliance which was defined it as the "collaboration between the client and the therapist based on their agreement on the goals and tasks of counseling and on the development of an attachment bond." This working alliance was measured by the Working Alliance Inventory (Horvath & Greenberg, 1989).

The second predictor variable is length of time in treatment. Because of mixed results in the literature regarding the effect of length of time in treatment on the working alliance, it was hypothesized that perhaps the longer the offender is in treatment, the stronger the alliance would be.

The final predictor variable was the conviction status of child offender versus rapist. These were two naturally occurring groups within the treatment program, so it seems logical to determine if there are differences between child offenders and adult rapists on readiness to change.

The criterion variable in this study was readiness to change. It is operationalized according to Prochaska and DiClemente's Stages of Change Transtheoretical model, and was be measured using the URICA; McConnaughy, Prochaska & Velicer, 1983), the RTC (Carbonari, DiClemente, & Zweben, 1997).

Chapter III

Results

All dependent variables (WAI total and subscales, conviction status and length of time in treatment) were included in a multiple regression equation predicting Readiness to Change (RTC). This regression analysis revealed that the WAI total predicted a significant amount of the variance for RTC ($F=4.657$, df (6, 52), $p \leq .01$, R-square=.25). The remaining variables, conviction status and length of time in treatment, failed to reach significance for predicting RTC. Results of this analysis are summarized in Table 4.

The subscales of the WAI were examined in the above analysis. The Goal and Task scales were highly correlated ($r=.81$), and so a separate regression analysis was performed using these variables together. The Goal and Task scale together accounted for a significant amount of the RTC variance ($F=7.5$, df (2, 56) $p \leq .001$, R-square=.21). The Bond scale alone did not significantly predict RTC (($F=1.995$, df (1,57), $p \leq .17$). The correlation matrix of the WAI, Goal, Bond, Task scales, RTC and URICA subscales is contained in Table 5.

A one-way analysis of variance (ANOVA) was performed determine if any differences existed between child offenders and adult rapists on RTC. No significant

differences were indicated by this analysis ($F=3.16$, df $(1,57)$, $p \leq .08$). Table 6 summarizes these results.

A GLM multiple analysis of variance was performed to determine if any differences existed between child offenders and adult rapist on the URICA subscales. This analysis indicated that child offenders scored significantly higher than adult rapists did on the Pre-Contemplation scale ($F=5.26$, $(1,57)$ $p \leq .03$), and the Maintenance scale ($F=4.28$, $(1,57)$ $p \leq .04$). Table 7 reports these results.

As previously mentioned, length of time in treatment did not significantly predict RTC scores. Length of time in treatment also did not significantly account for WAI scores ($F=1.89$, $(4,54)$ $p \leq .13$). Table 8 summarizes these results. A GLM MANOVA was performed and indicated no significant differences appeared among the research groups (phases of treatment) on their WAI or RTC scores (Table 9). The descriptive statistics for the WAI and URICA scale scores and totals are summarized in Table 10. The descriptive statistics for length of treatment, RTC and WAI total are presented in Table 11.

Finally, the participants in this study were asked why they decided to participate in the Residential Sex Offender Treatment Program. Most of the offenders who answered this question indicated that they wanted to "change," and not reoffend again. The second most common answer was that

some men are in treatment to increase their chances of parole.

Chapter IV

Discussion

This study attempts to identify the basic factors that predict successful sex offender treatment. It emphasizes the similarities between sex offenders and clients presenting for treatment. As the literature outlines, before any effective treatment is undertaken, the client must have some level of trust for the therapist, be motivated to do the hard work that will lead to change, and be inclined to cooperate with this process. Instead of examining particular techniques, this study examines the precursors to therapeutic techniques, in hopes of identifying and enhancing the conditions that lead to successful treatment.

Research Question One provides the most compelling result of this study, which is the predictive relationship between working alliance and readiness to change. This predictive relationship supports the hypothesis that a strong treatment alliance would facilitate a sex offender's willingness to alter his dangerous behavior. In fact, Kivlignan and Shaughnessy (1995) demonstrate that the faster the alliance becomes strong and remains strong, the more likely the client is to report a positive outcome.

Kear-Colwell and Pollack (1997) hypothesize that a focus on motivation instead of confrontation would facilitate change according to Prochaska and DiClemente's model (1992). It would follow that motivation can be enhanced within a strong, supportive working alliance as opposed to a confrontational, adversarial relationship. Similarly, DiClemente, Velicer and Rossi (1993) demonstrate that counselor support facilitates smoking cessation as measured by movement through the stages of change. Thus, the change process appears to be positively effected by a working relationship between a helping professional and the client.

Although meaningful, this finding takes on greater significance as one considers the philosophy of the program studied. The director of the program states explicitly that there is no effort made to foster a working alliance between the men and their therapist. In fact, this relationship is discouraged in favor of encouraging the men to "bond" with their group. It would seem plausible then, that despite one's best efforts, a working alliance will develop between the client and therapist if both are actively engaged in treatment. Even if no emotional bond is perceived, this study indicates that the target of a mutually identified problem is sufficient to create an

alliance that leads to change. This finding suggests that if two components of the alliance (Goal and Task) lead to a willingness to enter the change process, then the development of all three, including Bond, would be even more productive.

Consistent with the above statement, Bordin (1980) determines that the early alliance (first three sessions) is most determined by general liking between the client and the therapist, mutual trust and overall impression. It is only later in treatment that the Goal and Task components of the alliance take precedence. All of the offenders in the current study are have been participating in treatment for more than a month. As this program is a residential treatment community, the men interact with their primary therapist several times a week, putting them beyond the "early alliance stage." However, it would seem reasonable to develop the Bond component of working alliance in that earliest stage of treatment instead of discarding a potentially useful tool.

On one hand, the uniformly high WAI scores that predict the RTC score could represent a confound endemic to prison studies. In a prison atmosphere, it is impossible to be sure whether the participant believes his confidentiality

will be protected. If he does not trust the promise of confidentiality, he may tend to respond invalidly. Since the participant will be providing feedback about his therapist whom he will see daily, he may believe it to be in his best interest to respond favorably, albeit dishonestly. It could be hypothesized that the participants believe that information about their responses might be expressed to their therapist with negative repercussions. Thus, they could have decided to respond more positively than they would have in a less threatening environment. On the other hand, the scores on the Bond scale are slightly lower than the Goal and Task scores, and account for a very small percentage of the RTC variance. This could indicate that while the offender did not feel personally "close" to the therapist, he did believe that the therapist was invested in changing his behavior.

Luborsky (1994) considers this phenomenon to represent a "Type II" bond where the client develops an alliance based on the investment by the therapist in changing a mutually identified client problem, rather than on developing an emotional connection. The high WAI scores could reflect this Type II alliance, and thereby retain

validity and predictive power in increasing Readiness to Change.

Stiles et al. (1998) support this explanation in their study that examines the relationship between treatment alliance and treatment outcome. Using their ARM, they find that the Confidence scale correlates most strongly with positive treatment outcome. These authors advance that the ARM Confidence scale is very similar to and correlates highly with the WAI Goal scale. Like the WAI Goal scale, the ARM Confidence scale is an indicator of how committed the client believes the therapist is in treating their particular problem. It also assesses the degree to which the client is invested in the therapeutic process. Therefore, it would follow that the Goal and Task scales are the crucial determinants of the offenders' perceptions of the working alliance in this study.

Results of Research Question Two indicate that conviction status was not predictive of readiness to change. Unfortunately, it is difficult to obtain an accurate comparison of adult rape offenders and child molesters because of the discrepancy in the size of the two groups. Further study is needed with more equal group size to adequately determine if there are differences between

these two groups on the formation of a strong working alliance and progression through the stages of change.

Despite the size differential, certain differences are identified between the two groups. Child molesters tend to score highest on the Maintenance scale of the URICA, while the rapists score higher on the Pre-Contemplation scale.

The practical meaning of this finding can be illustrated by the following study. DiClemente, Velicer and Rossi (1993) study Pre-Contemplation clients in a smoking cessation program. They find that these clients are most difficult to treat (i.e., move though the stages of change). These authors also demonstrate that Pre-Contemplation clients would not respond to interventions that are helpful to clients in a later stage. It could be hypothesized that child molesters are more willing to admit that they have a problem, but rapists are reluctant to admit to a problem, and do not actively engage in treatment as a result. If this is the case, then those offenders who are identified in the Pre-Contemplation stage would be best served by different interventions, which would encourage the admission of deviant sexual behavior. Otherwise, they may proceed through treatment, complete this program, and never intend to change their behavior.

The regression analyses performed for Research Question Three suggest that length of time in treatment does not predict the participants' treatment alliance or readiness to change. The conclusions from the literature are mixed regarding how the strength of the alliance over time impacts treatment outcome (Horvath, 1994). Some studies indicate that the alliance is fixed by the third session (Tryon and Kane, 1993), others demonstrate that the alliance fluctuates over time, and the alliance late in treatment is most important (Kivlighan and Shaughnessy, 1995). Tryon and Kane further assert that a weak alliance by the third session predicts unilateral termination. Unfortunately, this study could not collect data on the program failures in order to determine if a weak treatment alliance predicts failure to continue treatment. It is tempting to interpret that the strong working alliance influences the length of time in treatment, and potential successful outcome. At the same time, it could be argued that the fact that these men are participating in treatment presupposes a predisposition or motivation to change, independent of working alliance. Therefore, the results of this study are inconclusive regarding the influence of

length of time in treatment on the treatment alliance or readiness to change.

Unfortunately, this study only had access to treatment "successes," considering that those men who completed these instruments were engaged in therapy. A future avenue of research could involve measuring the working alliance early in treatment, and then measuring the strength of the alliance in those offenders who were dissatisfied with the program, and terminated on their own or were terminated by staff. In this way, the therapist could determine if a weak working alliance contributed to program failure, and perhaps attempt to strengthen the alliance prior to unilateral termination.

It would also be worthwhile to examine other factors that enhance readiness to change other than the working alliance. Perhaps personal factors like marriage, a relatively short sentence, or vocational opportunities influence offenders' engagement in treatment.

I believe that it is imperative that responsible professionals determine the treatment that is most effective with sex offenders. In addition, it is important to remember that while specialized treatment may be necessary, there are some constants that hold true across

all client populations. Because of the nature of their offense, sex offenders are perhaps the most difficult population of all with whom to work (Mitchell & Melikian, 1995). They seem to be a group where a bias may exist even among some therapists. However, the importance of common factors of therapy, including working alliance, has been demonstrated as an important condition for positive outcome. Just like any other client with any other issue, sex offenders who seek to change their behavior deserve the best possible treatment that can be provided. This treatment should rely on empirically supported interventions, which are delivered to them maximum effectiveness. The literature suggests, and this study supports, that the working alliance not only relates to, but actually significantly predicts a sex offender's readiness to change, or to seriously examine his problem behavior with the willingness to entertain ceasing his former actions. Attention should be paid to developing the treatment alliance in all phases of treatment in order to facilitate the very important work being done in sex offender treatment.

Chapter IV

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Table 1

Oklahoma Sex Offender Sample, Demographic Breakdown

	Min	Max	Mean	N	%
Age	22	64	39.8	59	-
Sentence Length (years)	2	240	37	59	-
Education (years)	10	19	13	59	-
Income*	10-19.5	Over 100	30-90	59	-
Caucasian	-	-	-	43	73
African American	-	-	-	5	8.5
Native American	-	-	-	4	6.8
Hispanic	-	-	-	1	1.7
Other	-	-	-	5	8.4

*in thousands

Table 2

Treatment phase

	# of months	N
Phase 1	0 to 3	17
Phase 2	3 to 6	9
Phase 3	6 to 9	10
Phase 4	9 to 12	14
Phase 5	12 to 24	9

Table 3

WAI subscale intercorrelations (Horvath and Greenberg, 1989)

Scale	Bond	Goal	Task
Bond	-	.69	.78
Goal	.84	-	.92
Task	.79	.88	-

Table 4

Multiple Regression Analysis: RTC predicted by WAI, Goal, Bond, Task subscales, Conviction Status and Length of Time in Treatment

	R square	F	Df
WAI	.25	4.66**	(4, 54)
Goal & Task	.21	7.48*	(2, 56)
Bond	.03	1.95	(1, 57)
Conviction	.05	3.16	(1, 57)
Length of Time	.00	.001	(1, 57)
Total	.27	3.228**	(6, 52)

N=59; *p≤.001; **p≤.001

Table 5

Descriptive Statistics for the WAI and URICA

	Min	Max	Mean	Std. Dev.
GOAL	1.77	6.23	4.48	.90
ACTION	2.88	5.00	4.41	.46
BOND	2.23	5.92	4.16	.86
CONTEMPLATION	2.63	5.00	4.49	.41
MAINTENANCE	1.13	5.00	3.62	.79
PRE-CONTEMPL	1.00	3.00	1.40	.49
RTC	4.38	14.00	11.21	1.72
TASK	3.08	5.92	4.76	.71
WAI-TOTAL	2.75	7.31	4.85	.89

Table 6

One-way Analysis of Variance for Research Question 2: Differences between Conviction Status and RTC

	Mean RTC	Std Dev	N
Child Offenders	11.33	1.70	54
Adult Rapists	9.92	1.65	5
Total	11.21	1.72	59

	Sum of Squares	Df	Mean Square	F
Between Groups	9.06	1	9.07	3.165
Within Groups	163.31	57	2.87	
Total	172.39	58		

N=59, *p≤.05

Table 7

Correlation Matrix for WAI Total, Goal, Bond, Task subscales, RTC and URICA subscales

	Goal	Task	Bond	Pre-Con	Cont	Act	Maint	WAI
Goal	1.00							
Task	.81*	1.00						
Bond	.63**	.74**	1.00					
Pre-Con	-.39**	-.42**	-.19	1.00				
Cont	.51**	.50**	.23	-.58**	1.00			
Act	.47**	.49**	.31*	-.78**	.69**	1.00		
Maint	.27*	.18	.05	-.46	.30*	.34**	1.00	
WAI	.85**	.87**	.86**	-.40**	.40**	.46**	.09	1.00
RTC	.45**	.43**	.18	-.84**	.74**	.80**	.74.	.34**

**p≤.01; * p≤.05

Table 8

Multiple Analysis of Variance of Differences between Subjects for Research Question 2: Differences in URICA Scale Scores between Child Sex Offenders and Adult Rapists

	Between Groups			
	Sum of Squares	Df	Mean Square	F
Pre-Con	1.92	1	1.19	5.26*
Cont	1.48	1	1.48	.08
Action	7.86	1	7.86	.36
Maint	2.52	1	2.52	4.28*
	Error			
	Sum of Squares	Df	Mean Square	
Pre-Con	12.97	57	.23	
Cont	9.63	57	.17	
Action	12.17	57	.21	
Maint	33.6	57	.59	
	Corrected Total			
	Sum of Squares	Df		
Pre-Con	14.18	58		
Cont	9.96	58		
Action	12.26	58		
Maint	36.07	58		

N=59; *p≤.05

Table 9

Descriptive Statistics for Length of Treatment (LOT), RTC and WAI total

Descriptive Statistics

LOT		RTC	WAI-Total
3 months	Mean	10.76	174.65
	N	17	17
	Std. Deviation	2.136	37.04
6 months	Mean	11.33	171.11
	N	9	9
	Std. Deviation	2.13	25.17
9 months	Mean	11.68	153.50
	N	10	10
	Std. Deviation	1.1	28.94
12 months	Mean	11.67	184.79
	N	14	14
	Std Deviation	1.37	22.00
24 months	Mean	10.73	186.33
	N	9	9
	Std Deviation	1.44	37.21
Total	Mean	11.21	174.71
	N	59	59
	Std Deviation	1.72	31.94

Table 10

Regression Analysis for WAI as predicted by Length of Treatment (LOT)

R-square	F	Df	N
.02	1.55	(1, 57)	59

*p≤.05

Table 11

Multiple analysis of variance for RTC among research groups

	Between Groups			
	Sum of Squares	Df	Mean Square	F
RTC	10.91	4	2.730	.91
WAI Total	5.60	4	1.39	1.89
	Error			
	Sum of Squares	Df	Mean Square	
RTC	161.47	54	3.00	
WAI Total	40.07	54	.74	
	Corrected Total			
	Sum of Squares	Df		
RTC	172.39	58		
WAI Total	45.66	58		

N=59, *p≤.05