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Treatment Experiences of Civilly Committed Sex Offenders

A Consumer Satisfaction Survey

Jill S. Levenson
Lynn University, Boca Raton, Florida
David S. Prescott
Sand Ridge Secure Treatment Center, Mauston, Wisconsin

The purpose of the study was to elicit feedback from sex offenders about the components of treatment that they believed to be most helpful in preventing reoffense. A sample of civilly committed sex offenders from the Sand Ridge Civil Commitment Center in Wisconsin (n = 44) was surveyed about their perceptions of treatment, including content, process, therapists, rules, and completion requirements. Clients were asked to rate the importance of treatment components to their recovery and to rate their satisfaction with the treatment they received for each component. Participants expressed fairly positive sentiments about their treatment experiences, though specific concerns were noted. There was an overall positive correlation between importance of and satisfaction with treatment, but ratings of importance were consistently higher than ratings of satisfaction. Implications for practice and future research are discussed.

Keywords: *sex offender; sexual predator; SVP; civil commitment; treatment*

Laws permitting the confinement of sex offenders for indeterminate lengths of time first appeared in the United States in 1937 and have been controversial ever since (Schwartz, 1999; Sutherland, 1950). Although the first 28 states that passed sexual psychopath laws abandoned them by the end of the 1970s, new statutes began to emerge in the 1980s. Contemporary civil commitment for sex offenders has been enacted in 20 states and allows for the detainment of particularly violent or predatory offenders beyond their criminal incarceration. Sex offender civil commitment typically requires at least one past conviction for a sex crime, the presence of a predisposing mental condition, and a likelihood of continued reoffending (Doren, 2002; Schwartz, 1999). Those who meet criteria are placed in involuntary inpatient treatment facilities where they remain until their risk to reoffend has diminished.

Early studies of sex offender treatment (Furby, Weinrott, & Blackshaw, 1989) stirred skepticism about the benefits of rehabilitation, but more recently, some researchers have reported significant treatment effects (Hanson et al., 2002; Losel & Schmucker, 2005). On the other hand, a 12-year follow-up of treated and untreated Canadian sexual offenders found no significant differences in recidivism between

the groups (Hanson, Broom, & Stephenson, 2004). Outcome research from the Sex Offender Treatment and Evaluation Project (SOTEP; a methodologically rigorous long-term investigation conducted in an inpatient program in California) revealed that offenders who received treatment generally reoffended at similar rates as those who did not receive treatment (Marques, Day, Nelson, & Miner, 1989; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). Of importance, however, is that SOTEP results indicated that offenders who successfully achieved treatment goals (as opposed to simply receiving treatment) sexually reoffended less often than those who did not seem to "get it" (Marques et al., 2005, p. 97). Debates persist regarding whether sex offender treatment is effective in preventing future sex crimes.

The effect of treatment on recidivism has been the most common empirical determinant of success described in the literature, but other scholars have stressed the importance of also measuring in-treatment behavioral changes, client attainment of treatment goals, therapeutic process, and therapist characteristics (Levenson & Prescott, 2007; Marshall, 2005; Marshall et al., 2002). It is vital to study treatment delivery for programs to improve their effectiveness. Unfortunately, few studies have examined sex offender perceptions of intervention programs or identified factors that contribute to successful treatment (Drapeau, Körner, Granger, Brunet, & Caspar, 2005).

Sex offenders in the United Kingdom were interviewed to gain insight into clients' views of the outpatient therapy they received (Garrett, Oliver, Wilcox, & Middleton, 2003). Opportunities to share and relate to others, peer support, and peer confrontation were identified as some of the benefits of group therapy. Most group members (97%) experienced their treatment as positive. Garrett et al. (2003) was limited by a very small sample size ($n = 32$) but provided an important pioneering attempt to better understand clients' perceptions of their treatment needs.

Other researchers have surveyed sex offenders to measure related treatment constructs such as group cohesion, motivation, and engagement. In a study of both outpatient and residential sex offender programs, group cohesion and supportive therapeutic style were found to have an important influence on in-treatment change, as measured by a reduction in pro-offending attitudes (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005). Levenson and Macgowan (2004) found that engagement in group therapy was inversely associated with denial and positively correlated with treatment progress. Sex offenders who were more actively engaged in the program displayed higher levels of accountability and fewer thinking errors about offending and were rated by therapists as having made more progress toward treatment goals. Similarly, Barrett, Wilson, and Long (2003) found that motivation increased throughout the time incarcerated, but once in the community, clients who demonstrated personal responsibility were more motivated to prevent reoffense.

Process variables are often neglected in the study of cognitive behavioral sex offender treatments even though these factors can profoundly influence therapy outcomes (Marshall, 2005; Marshall et al., 2003; Marshall et al., 2002). The use of therapeutic techniques, such as empathy, validation, collaboration, and flexibility as well

as directive but nonconfrontational therapist characteristics, were associated with general treatment benefits for sex offenders and, more specifically, with an increase in accountability and improvements in interpersonal relationships (Marshall, 2005; Marshall et al., 2003; Marshall et al., 2002).

Creating a therapeutic environment in which confined sex offenders maintain a motivation for change presents numerous challenges. The SOTEP project (Marques et al., 1989) administered an exit interview obtaining client feedback. Clients reported that they were only moderately satisfied with the therapy they received, though they indicated that the relapse prevention component of the program was helpful. They identified process issues, including staff attitudes, as areas needing improvement (Marques, Day, Nelson, Miner, & West, 1991). Because sex offending is such an egregious behavior and because sex offender treatment is usually not voluntary, treatment providers may take a paternalistic or confrontational posture when offering interventions (Glaser, 2003). Ironically, however, Beech and Fordham (1997) found that sex offender therapists tend to overestimate their own helpfulness, and Beech and Hamilton-Giachritsis (2005) found that group leaders had more positive views of groups than their members did.

Debates about sex offender treatment success have centered primarily on questions of the intervention's ability to decrease recidivism. Although prevention of future offending is obviously an essential goal, other measures of treatment effectiveness have seldom been researched. We propose that a better understanding of sex offender clients' perceptions of treatment can be useful in fashioning interventions that will ultimately help to reduce recidivism and enhance public safety. Especially in light of the discouraging treatment effects reported throughout the literature, treatment designs that incorporate sex offender client input might prove valuable. Obtaining sex offenders' viewpoints can potentially facilitate provision of therapeutic services that will be viewed as more meaningful and motivating to clients.

Purpose of the Study

The purpose of the study was to elicit feedback from civilly committed sex offenders about the components of treatment that they believed to be most helpful in preventing reoffense. Because civilly committed sex offenders are considered to be among the most dangerous, it is especially important to understand how to engage this population in a meaningful change process. Without formulating any *a priori* hypotheses, we sought to answer several research questions: (a) How do civilly committed sex offenders perceive their experiences in treatment? (b) Which treatment components do sex offenders find particularly helpful or useful? And (c) Are sex offenders satisfied with the help they receive regarding the treatment components they consider most important to their recovery? It is expected that this research will assist in facilitating the development of programming that can contribute to reduced recidivism rates.

Method

Participants

A convenience sample was recruited from the Sand Ridge Civil Commitment Center in Wisconsin. Sand Ridge is a comprehensive, long-term, secure inpatient treatment facility for adult males who have been convicted of sex offenses and found eligible for civil commitment. Sex offenders who meet criteria for civil commitment in Wisconsin display a mental disorder predisposing them to engage in acts of sexual violence. Typically, the mental disorder involves a DSM-IV-TR diagnosis of a paraphilia or personality disorder (American Psychiatric Association, 2000), with likelihood of reoffense determined by actuarial risk assessment. All adult male sex offenders attending treatment at the facility ($n = 210$) were invited to participate in the research survey; only those who voluntarily agreed to participate were selected ($n = 44$). Guidelines for the ethical treatment of human subjects were followed, and the project was approved by both a university institutional review board and the Sand Ridge facility.

Table 1 describes the characteristics of the sample. Most participants were between 26 and 64 years of age, and the majority of clients were White. The sample was fairly well educated, with 90% reporting high school completion or above, though most earned less than $30,000 when last employed. The majority had never been married, and only a few were currently married. Median time in treatment was slightly over 4 years. A minority (18%) said that their most recent victim was an adult; 21% had an index victim age 5 or younger, 33% described their most recent victim between the ages of 6 and 12, and 26% had most recently abused a minor teen. Participants were also asked to endorse (yes or no) categories reflecting various victim characteristics. Many offenders endorsed more than one category, demonstrating the variety of offending in which they had participated.

Because the response rate was fairly low (21%), we attempted to assess whether the sample was representative of the Sand Ridge population. It was not possible to determine the characteristics of those who chose not to participate in the survey. We were able, however, to compare some of the characteristics of the sample with some known demographics regarding the clients served by the Sand Ridge facility. For instance, 68% of the clients at Sand Ridge are White, and 32% belong to an ethnic or racial minority group. Comparatively, 84% of our respondents were White, indicating that minority residents were less likely to participate in the research study. Three quarters (73%) of those committed in Wisconsin had minor victims under the age of 12, as did exactly the same proportion of our sample. The mean number of total sex crime arrests was reported by our sample to be 3; on average, Sand Ridge residents have been convicted three times. Although we were admittedly limited in our ability to determine whether the sample represents the population, the sample appears to be similar in terms of offense history but less culturally diverse.

Table 1
Characteristics of Sample ($n = 44$)

		Percentage	Mean	Median	Mode
Age	Under 25	5			
	26-49	63			
	50-64	27			
	Over 65	5			
Racial background	White	84			
	Minority	16			
Marital status	Currently married	3			
	Never married	64			
	Divorced or separated	33			
Education	Some high school	10			
	High school graduate or GED	77			
	College graduate	13			
Income	$30,000 per year or less in last year of earned income	90			
Victims					
"Have you ever had . . ."	Age 12 or under	73			
	Minor teens	61			
	Adults	50			
	Female	93			
	Male	56			
	Family member	49			
	Acquaintance	73			
	Stranger	50			
	Ever used force or violence	56			
	Ever used weapon	24			
	Ever physically injured victim	25			
	Number of sex crime arrests		3	2	2
	Number of reported total victims, including undetected		41	11	6
Treatment	Number of months in current treatment		74	50	36
	Prior treatment	78			
	Community based	23			
	Prison based	30			
	Both	14			

Groups and Therapists

Wisconsin's sexually violent predator (SVP) program provides comprehensive cognitive-behavioral treatment to all clients willing to participate. Presently, more than 80% of civilly committed sex offenders have consented to treatment. This treatment takes place within a larger milieu of unit, recreational, and therapeutic work opportunities, and clients are expected to demonstrate change in these venues as well

as within treatment groups. Treatment for all clients follows a four-phase model. The first of these phases focuses on overall self-management, motivation for change, and treatment-interfering factors. Although the groups are largely psychoeducational in nature, facilitators spend considerable time on process issues relating to meaningful personal change. In the second phase, clients work with their treatment team to arrive at an agreed-on history of their sexual offending and the psychological factors that contributed to it. In the third phase, clients demonstrate an ability to manage these psychological factors in their daily functioning. The fourth phase takes place in the community, where clients continue to demonstrate change in the factors that contributed to their offending. Clients from all phases were represented in the survey.

Facilitators receive intensive training and supervision to maintain a treatment style that is warm, empathetic, rewarding, and directive (Marshall et al., 2002). The program works to make treatment goals personally relevant for each client. Each group has at least one facilitator who meets state licensure requirements for providing psychotherapy, and most groups have an additional facilitator with a related background who has received intensive training in working with this population.

Data Collection

Clients were invited to complete the survey during a regularly scheduled group therapy session. Clients were instructed not to write their names on the survey and to place the completed questionnaire in a sealed envelope. To further ensure anonymity, clients were not asked to sign an informed consent form. Completion of the survey was considered to imply informed consent to participate in the project.

Instrumentation

The survey instrument was developed by the authors for the purpose of collecting data regarding the perceptions of sex offenders about their treatment. The survey was created by drawing on questions from a previous similar survey described in the literature (Garrett et al., 2003) and adding other questions seen as theoretically relevant but not captured by prior research. The survey queried clients regarding their perceptions about various components of sex offender treatment, including content, process, therapists, rules, and completion requirements. Clients were asked to rate the importance of treatment components to their recovery, and to rate their satisfaction with the treatment they received for each component. Five-point Likert scales were used to indicate their degree of agreement with the issues in question. Client characteristics and offense history were elicited using forced-choice categorical responses to enhance anonymity.

Data Analysis

First, descriptive statistics were generated to illustrate participant perceptions about group and individual therapy, therapists, and the treatment program components.

Table 2
Perceptions About Group and Individual Therapy

	% Strongly Disagree	% Disagree	% Somewhat Agree	% Agree	% Strongly Agree
Please rate your agreement with the following statements:					
My group usually feels comfortable.	7	26	26	33	9
My group has enough structure.	16	14	35	21	14
My group members are pretty open and honest most of the time.	19	9	33	30	9
My group members are pretty nonjudgmental most of the time.	14	16	30	28	12
It is helpful to be able to talk with other people who have committed sex offenses.	9	16	21	33	21
I feel comfortable participating in my group.	7	14	35	19	26
I feel comfortable helping others in my group.	5	9	23	39	23
I trust the other members in my group.	16	21	39	16	7
	Strongly Disagree	Disagree	I Don't Know	Agree	Strongly Agree
My individual therapy has been helpful.	22	14	13	27	24
I wish I could attend individual therapy more often.	21	5	8	26	41
I would rather attend individual therapy instead of group therapy.	21	10	23	21	26

Note: Rows may not total 100% due to rounding or missing data.

Then, mean ratings for each item were calculated, and correlations were analyzed to determine the relationship between perceived importance and satisfaction with treatment. Finally, *t* tests were used to compare mean scores on importance and satisfaction, with significant differences identifying disparities.

Results

The majority of participants indicated that they were comfortable in their treatment groups and with other clients (Table 2). Nearly a third, however, perceived group members to be somewhat judgmental and had difficulty trusting other residents. Another area for improvement was identified as a lack of group structure. About a third of respondents indicated that they did not find their individual therapy helpful, though 70% expressed a preference for individual therapy over group sessions.

Table 3
Perceptions About Group Therapists

	% Strongly Disagree	% Disagree	% Somewhat Agree	% Agree	% Strongly Agree
Please rate your agreement with the following statements about your group leaders (sometimes called therapists, counselors, or facilitators):					
Usually, my group leaders make me feel comfortable and safe in therapy sessions.	7	23	33	19	18
I get along well with my group leaders.	12	14	30	28	16
I feel that my group leaders try to understand me.	12	14	26	35	14
My group leaders are pretty nonjudgmental most of the time.	14	12	37	26	12
I usually feel comfortable sharing personal things with my group leaders.	12	17	31	21	19
I usually feel comfortable with the feedback or advice my group leaders offer to me.	7	12	26	41	14
My group leaders are good at bringing out important points during group therapy.	10	12	33	21	24
My group leaders deal with difficult moments well in group therapy.	10	17	33	21	19
I feel my group leader has a positive attitude toward the group members.	7	10	38	24	21
I trust my group leaders.	17	17	33	21	12

Note: Rows may not total 100% due to rounding or missing data.

Overall, group therapists were viewed positively by most participants (see Table 3). About a quarter consistently expressed opinions that group leaders were sometimes judgmental and did not try to understand clients. Some clients experienced discomfort sharing personal information with group therapists. Most seemed to feel that group leaders held positive attitudes toward group members, but others disagreed that they were successful at facilitating a safe therapeutic environment. About 20% of participants reported having a female primary therapist, 20% had a male therapist, and 58% reported having both. A large majority of offenders (68%) expressed no preference regarding the gender of their group facilitator. About 13% preferred a male therapist, and about 15% preferred a female.

The majority of respondents agreed that program policies and procedures with regard to attendance and tardiness were clear and fair (Table 4). However, many (31%) felt that their confidentiality was not respected, and 38% did not agree with their treatment plan. Most clients thought that they were not given the right amount

Table 4
Perceptions About the Program

	% Strongly Disagree	% Disagree	% Somewhat Agree	% Agree	% Strongly Agree
Please rate your agreement with the following statements about program policies and procedures:					
The rules about attendance are fair.	7	7	12	46	28
The rules about lateness are fair.	9	7	16	42	26
My confidentiality is respected.	14	17	19	24	26
I agree with my treatment plan.	19	19	28	19	16
The expectations for successful completion and graduation are clear.	51	19	12	9	9
The expectations for successful completion and graduation are fair.	44	28	5	12	12
I am treated with respect by the staff.	14	10	31	29	17
I am here because I need to be here.	33	19	14	24	10
Now that I know what this program is like, I like it better than I thought I would.	30	21	19	14	16
Overall, my experience in this treatment program has been a positive one.	14	28	26	14	19
I have gained a great deal of understanding about my offenses from this program.	21	19	26	23	12
I have gained a great deal of understanding about preventing future offenses from this program.	19	14	21	23	23

Note: Rows may not total 100% due to rounding or missing data.

of homework, with 24% saying that there was too little homework assigned and 63% opining that there was too much. A large majority (70%) felt that the treatment program lasted too long, whereas 8% thought it was too short and 22% believed the program length was just right. Overwhelmingly, clients did not believe that the expectations for successful completion were clear or fair. Less than half of the participants agreed that they needed to be in treatment, but 49% said they liked the program better than they thought they would. Overall, most participants indicated that their experience in the program was positive, that they had gained an understanding of their offense patterns, and that they had learned something about preventing future sex crimes.

We asked the participants to rate the importance of program content to their recovery on a 5-point Likert scale. The mean ratings for each item are seen in Table 5. We also asked them to rate their level of satisfaction with the treatment they have received in each content area, and those mean ratings are also displayed. We then used paired sample *t* tests to determine whether clients believed that the quality of

help they received was commensurate with the emphasis they placed on each content area. All of the correlations were robust, and all were statistically significant. Many of the items demonstrated significant differences between means, however, with higher ratings on importance and lower rankings on satisfaction. In other words, though there was a generally positive association between perceptions of treatment importance and satisfaction, there were discrepancies in the strength of the ratings. It should be noted that importance and satisfaction were both skewed toward the upper bounds of the Likert scale, so the distributions did not fully conform to the statistical assumptions of comparisons of means.

Finally, ANOVA tests were performed to determine if there were significant differences in satisfaction between treatment groups. These groups consist of the Conventional, Compass, and Corrective Thinking tracks of the SVP Treatment Program. The Conventional track provides treatment to clients of average intelligence and low to moderate levels of psychopathic traits. The Compass track provides treatment to clients with below-average intelligence, and the Corrective Thinking track provides treatment to clients with high levels of psychopathic traits. There is also an Adapted Corrective Thinking track for those clients with lower levels of intelligence and higher levels of psychopathic traits.

There were no significant differences in group satisfaction on any of the items. As well, there were no significant differences when offenders were grouped by the age of their most recent victim (minor victims vs. adult victims). When grouped by prior treatment experience, there were significant differences only on one item—*feeling as though I can relate to other group members*—with those who had previously been in community-based treatment rating their satisfaction significantly higher than those who received prior prison treatment or both community and prison treatment ($F = 3.566$, $p < .05$).

Discussion

It is perhaps surprising that these civilly committed sex offenders expressed fairly positive sentiments about their treatment experiences. Because most sex offenders do not enter treatment voluntarily but are mandated to treatment by the criminal justice system, they often lack internal motivation and may resist engagement in treatment (Birgden & Vincent, 2000; Laws, Hudson, & Ward, 2000). We might have expected civilly committed offenders to be especially resistant given the potentially powerful perception of unjustness one might naturally feel when confined beyond one's criminal sentence. Indeed, many participants did express a belief that the duration of the treatment program was too long and that expectations for completion were unfair and unclear.

Most participants seemed to find the experience of participating in group therapy to be a useful endeavor, suggesting that opportunities to relate to others in a meaningful

Table 5
Relationship Between Ratings of Importance and Treatment Satisfaction Regarding Program Components

Treatment Component	Mean Rating of Importance	Mean Satisfaction Rating	Correlation Between Importance and Satisfaction	Differences Between Means (*t*)
Accepting responsibility for my sexual offense(s) (accountability)	4.76	4.19	.48**	3.106**
Learning about different types of denial. (denial)	3.74	3.35	.65***	2.064*
Understanding my own tendency to distort, deny, and make excuses (thinking errors)	4.24	3.67	.61***	3.106**
Understanding the impact of sexual abuse on victims and others in my life (victim empathy)	4.60	3.91	.49**	3.422**
Understanding my offense chains, cycles, and patterns	4.36	3.74	.63***	3.576**
Understanding my triggers and risk factors	4.45	3.74	.63***	3.941***
Learning about what motivated me to offend	4.46	3.63	.38*	3.668**
Learning about my grooming patterns or the behaviors I used to gain access to victims or offending	4.16	3.49	.43**	2.997**
Developing a relapse prevention plan (this would include a “maintenance” plan)	4.19	3.35	.46**	3.394**
Learning to change or control my deviant arousal	4.19	3.42	.46**	3.370**
Understanding the development of my sexual behavior problems	3.76	3.21	.44**	2.224*
Understanding how early experiences and family life affected me	3.56	3.19	.48**	1.581
Learning new relationship and communication skills	4.16	3.49	.51***	3.138**
Understanding the needs I met through sexual abuse and learning how to meet my needs in healthier ways	4.30	3.44	.59***	4.335***
Learning how to create a more satisfying life for myself	4.16	3.51	.48**	2.988**
Basic life skills	3.58	3.23	.66***	1.828
Basic human sexuality	3.57	3.19	.57***	1.686
Controlling compulsive sexual behavior (including masturbation and pornography)	3.42	3.12	.62***	1.361
Sharing my experiences with other sex offenders	3.24	3.07	.77***	1.022
Feeling as though I can relate to the other members of my group	3.60	3.10	.73***	2.979**
Hearing other perspectives and viewpoints	4.02	3.50	.65***	3.059**
Getting help and support from others	3.98	3.67	.54***	1.483
Confrontation among the group members	3.07	3.05	.55***	.106

Note: Importance and satisfaction were rated on 5-point Likert scales.
*$p \leq .05$. **$p < .01$. ***$p < .001$ (two-tailed tests).

fashion are helpful. When clients express emotion in a group therapy setting, an accepting response from peers can facilitate the individual's willingness and ability to interact with others more deeply and honestly (Yalom, 1995). Sex offenders have often had few opportunities for sharing and emotional connection with others (Seidman, Marshall, Hudson, & Robertson, 1994). Many have had few intimate relationships because of limited interpersonal skills and a desire to hide their deviant interests. Yalom (1995) contended that it is the discovery of others' problems similar to one's own and the ensuing disconfirmation of uniqueness that is important in group therapy; it is the affective sharing of one's inner world and acceptance by others that is a healing force. Group therapy also allows opportunities to develop and practice new social skills and constructive conflict resolution techniques (Jennings & Sawyer, 2003).

These clients also seemed to perceive their therapists as moderately engaging and effective, though some concerns about confidentiality and judgmental attitudes were noted. Clients in mandated sex offender treatment may be more difficult to engage than traditional psychotherapy clients (Beyko & Wong, 2005). The therapists in this study appear to be perceived as somewhat successful in utilizing motivational approaches, which increase engagement and produce cognitive dissonance that can lead clients to believe that change is possible (Kear-Colwell & Pollock, 1997). Confrontational approaches to sex offender treatment have traditionally been popular, but they may ultimately disempower and discourage clients from taking responsibility for personal change (Garland & Dougher, 1991; Kear-Colwell & Pollock, 1997). By challenging and confronting clients, therapists may invite resistance and inadvertently enable the client to become further entrenched in his own unhelpful ideas (Jenkins, 1990).

This "negative process" occurs when clinicians fail to respond effectively to client hostility or resistance (Binder & Strupp, 1997; Teyber & McClure, 2000). Therapists are vulnerable to responding to clients' negativity with anger, emotional withdrawal, or even rejection (Binder & Strupp, 1997). Negative therapeutic process has seldom been researched but may account for treatment failures across every modality, and treatment providers should be willing to examine their role in client attrition and dropout (Beyko & Wong, 2005). Marshall, Anderson, and Fernandez (1999) suggested that cognitive behavioral sex offender treatment and attention to process are not mutually exclusive and that when a challenging but supportive style of treatment is offered, resistance may be reduced. It appears that the therapists in this program were perceived as fairly successful in accomplishing such a goal.

Most treatment components were seen as important, with none receiving such low ratings that they were deemed irrelevant. The components seen as most important to an offender's recovery (4.5 or above) appear to be accountability and victim impact. Components with an importance rating of 4 or more included thinking errors, offense patterns, triggers and risk factors, grooming, relapse prevention, deviant arousal management, relationship skills, meeting needs in healthy ways, and

creating a more satisfying life for oneself. These last two components are "good lives" model constructs (Ward & Brown, 2004), which focus on seeking and obtaining interpersonal resources that lead to increased self-esteem and emotional stability.

An interesting finding of this study was the discrepancy between client ratings of treatment component importance and their ratings of satisfaction. Although there was an overall positive correlation between the two, ratings of importance were consistently higher than ratings of satisfaction. This survey did not allow us to specifically identify the ways in which satisfaction could be improved. However, the findings might provide opportunities for discussion not only at Sand Ridge but also in other programs. Therapists are encouraged to query clients about the ways in which their treatment experiences could be enhanced.

This study is limited by its small sample size, low response rate, nonrandom participant recruitment, and self-selection bias. The responses were somewhat positively skewed, indicating a possible social desirability bias toward affirmative responding. On the other hand, some research participants might have agreed to participate to vent negative experiences. The results may not be generalizable to other programs, though they provide some preliminary information about treatment perceptions of civilly committed sex offenders.

In conclusion, client perceptions have rarely been studied in sex offender treatment populations. Consumer satisfaction is a common area of research in most service industries and has gained importance in the evaluation of mental health service provision (Substance Abuse and Mental Health Services Administration, 2004). Although consumer survey research has inherent limitations, including lack of control groups, self-report and self-selection bias, and the vagueness of Likert scale measures, it can offer insight into clients' views of therapy as it is actually delivered in clinical (rather than research) settings (Seligman, 1995). Such inquiry should become an integral part of our collective research agenda, as this type of data can inform our development of effective interventions to reduce sex offense recidivism.

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