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Therapist Style in Sexual Offender Treatment: Influence on Indices of Change

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This paper describes the results of our review of the broad process literature as well as summarizing two studies examining the influence of the therapist in generating changes in treatment targets among sexual offenders. We conclude that displays of empathy and warmth by the therapist as well as the provision of rewards for progress and some degree of directiveness, maximize the benefits derived from the procedures employed in treating sexual offenders. We also suggest the need for flexibility and encourage program designers not to so overly detail their treatment manuals that the influence of the therapist is minimized.

KEY WORDS: therapist influence; sexual offenders; process features.

In the early days of modern behavior therapy, its advocates adopted the position that specifying the procedures implemented in treatment was all that was necessary to exhaustively account for all relevant aspects of treatment (Kazdin, 1978). Indeed, it appears that this emphasis on procedures entailed the idea that the therapist exerted little or no influence. Perhaps this was historically necessary in order for behavior therapists to uniquely identify their nascent movement, but it did have the effect of all but consigning an interest in the role of the therapist to the scrapheap of history as far as behavior therapists were concerned. Although this was not entirely true, it was not until the publication of a book by Schaap, Bennun, Schindler, and Hoogduin (1993) that research on the therapeutic relationship in behavior therapy was given significant status. Schaap et al. found 40 papers considering the importance of the therapist in behavior therapy, although many of these were simply position papers. In the literature on cognitive behavioral treatment of sexual offenders, we (Marshall, Fernandez, et al., 2003) were able to

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find, at the time of our review, only four publications dealing with these issues with three of them being nonempirical comments on the importance of process issues.

As a result of these observations we decided to embark on an evaluation of the influence of the therapist on the cognitive behavioral treatment (CBT) of sexual offenders. Because the majority of CBT programs for sexual offenders deliver treatment within a group therapy context, we decided to limit our evaluations to group CBT. First, we conducted a review of the general literature on process variables in the treatment of various disorders employing a diversity of treatment orientations. Our review (Marshall, Fernandez, et al., 2003) included 197 articles, books and conference presentations from which we concluded there was sufficient evidence to propose that the behavior and personal style of the therapist exerts some influence on the changes observed in sexual offenders as a result of treatment. This set the stage for an empirical investigation of this possible influence.

To examine the influence of the therapist in sexual offender treatment, it was necessary for our purposes to have several different therapists lead different treatment groups according to the same detailed treatment manual. It was also necessary that all clients be assessed pre and post treatment on the same, (hopefully) comprehensive battery. Fortunately, just such circumstances existed within the British prison service programs. HM Prison Service operates treatment programs for sexual offenders in 26 prisons in England and Wales currently turning over in excess of 1000 clients each year. These programs have been in operation since 1991 from which time each session, in each program, in each prison, has been videotaped. These videotapes were recorded for the purpose of monitoring by the Offending Behaviour Programmes Unit of HM Prison Service to ensure the therapists were appropriately following the treatment manual. Given the detailed nature of the treatment manual, and this careful scrutiny of the therapists, we might expect that whatever influence the therapist's style and behavior could potentially have, it would be attenuated in these circumstances. As a result we assumed that were we to find an influence for the therapist in our studies, it would likely be an underestimate of the magnitude of this influence in circumstances that were less structured. Almost all manuals for sexual offender treatment essentially define procedures with little more than cursory remarks, if any, about how the therapist should behave. Although there is no doubt some merit to this enterprise, it does effectively reduce the influence of the treatment provider, which may or may not be a good thing.

To conduct our studies, HM Prison Service provided us with videotapes. Initially a random set of these tapes was chosen to train two raters both of whom were senior graduate students experienced in treating sexual offenders. These two raters jointly observed a series of tapes until they were satisfied that they agreed on the manifestations of 28 features of the therapist which we had extracted from our review. Once the raters felt comfortable that they could identify these features, we requested an additional six sets of tapes from six different programmes within

Table I. Identification of Therapist Features and Interrater Agreements

Feature	Identified as present (% of time)	Interrater agreement	
		Percentage agreement	Kappa coefficients
Empathic	42.9	87	.86
Sincere	54.3	89	.83
Warm	60.0	95	.94
Respectful	60.0	81	.68
Confident	48.6	100	1.00
Directive	51.4	83	.74
Rewarding	54.3	74	.67
Self-disclosure	8.6	100	1.00
Reasonable time on issues	60.0	100	1.00
Humor	25.7	89	.78
Appropriate body-language	71.4	100	1.00
Appropriate time speaking	68.6	92	.86
Appropriate voice tone	60.0	86	.68
Ensures participation	54.3	87	.80
Encourages prosocial attitudes	42.9	87	.80
Noncollusive	40.0	94	.88
Nonconfrontational	60.0	95	.93
Confrontational	57.1	100	1.00
Good communication	71.4	88	.57
Employs open-ended questions	60.0	95	.93
Deals effectively with problems	22.9	55	.35
Flexibility[a]	—	—	—
Interested[a]	—	—	—
Trustworthy[a]	—	—	—
Accepting[a]	—	—	—
Emotionally responsive[a]	—	—	—
Creates favorable expectancies[a]	—	—	—
Angry/hostile[a]	—	—	—

[a] Unable to observe reliably (adapted from Marshall et al., 2002).

HM Prison Service. The raters then independently rated the 28 features and kappa statistics were calculated to determine their degree of agreement on the presence of each of these features. Table I lists the agreements reported in this study (Marshall et al., 2002).

As can be seen, some of the features did not appear very often. For example, self-disclosures were rarely offered by these therapists although the general literature records their importance. On this point it is important to note that self-disclosure can be useful in illustrating issues but being overly self-disclosing, particularly with sexual offenders, can be counterproductive and usually serves the therapist's needs rather than the clients. These prison service therapists were also relatively humorless, presumably due to anxiety over being recorded for later evaluation. Again the general literature indicates the value of humor, but again overdoing it can reduce effectiveness.

Overall it is clear from Table I that the raters reached satisfactory, independent agreement on most of the features. On this basis we felt justified in

proceeding with studies examining the relationship between ratings of the presence of the therapist features and changes in the extensive pre and post assessment measures.

To conduct these evaluations we asked HM Prison Service to send us twelve 2-hr videotapes from seven different prisons. Our request included the requirement that the 7 different prisons be selected on the basis of producing variable treatment benefits; however we asked them not to divulge to us the treatment changes until we had completed our ratings. As it turned out by some unfortunate error, the programs all produced quite similar, moderate improvements on most measures. We wanted variability for the simple reason that correlational analyses (which were to be the basis for inferring the influence of therapist behaviors) require variability in both data sets (in this case the therapist behaviors and treatment-induced changes) to be meaningful. Thus whatever results we observe in this study might, as a result of the reduced variability in treatment changes, be an underestimate of the influence of the therapists.

Despite these problems we did find some significant relationships (Marshall, Serran, et al., 2003). Two sets of therapist features were quite influential. The first set included: empathy, warmth, rewardingness, and directiveness. These were all positively related to indices of beneficial change (range: $r = .31$ to $r = .38$, $p < .05$ to $p < .02$). The other set included confrontation and nonconfrontation. It is important to be clear about what these terms were defined as in our studies since these terms are used quite loosely in both the process literature generally and sexual offender treatment more specifically. Confrontation in our studies refers to a rather harsh approach to challenging clients which seems likely to be perceived by the clients as denigrating; indeed, this is what the more general literature indicates. A nonconfrontative approach was defined as firm but supportive challenges. Of course, the distorted, or dysfunctional perceptions, beliefs, attitudes and schemas of sexual offenders must be challenged if they are to accept responsibility for their offenses. The question is how are therapist to challenge these distortions and the answer from this first study seems clear: do not challenge harshly since such a confrontative style was negatively related ($r = -.31$ $p < .05$) to the achievement of treatment goals.

Since our first study of the relationship between therapist features and treatment-induced changes was somewhat less than ideal (due to low variance across groups in benefits), we decided to repeat the study with hopefully better data and with more extensive ratings. We were provided with videotapes from five different prisons with the program in each prison being run in the year 2000. This turns out to be important because between our first study and this second one, the training program for therapists who direct treatment, had been modified to emphasize the influential features we had observed in our initial evaluation. In particular, the current training program emphasizes the importance of being firm but challenging rather than being confrontational. As a result, in the second study confrontational approaches had all but disappeared.

Table II. Correlations of Ratings of Therapist Style and Improvements on Selective Treatment Targets

Treatment targets	Therapeutic style				
	Empathic	Warm	Rewarding	Directive	Nonconfrontational
Overall benefits	.39	.35	.29	.41	.14
Improved relationships	.65	.07	.09	.25	.08
Decreased denial of responsibility	−.45	−.45	−.35	−.46	−.16
Decreased denial of planning	−.45	−.58	−.48	−.42	−.06
Decreased victim blaming	−.58	−.42	−.45	−.61	−.38
Minimization of features of offense	−.57	−.74	−.57	−.54	−.02

Note. Marshall et al. (2002).

For each program from the five prisons, five videotapes were provided: one from the early stages of treatment, one from near the end of the program, and three from near the middle. For each tape the raters evaluated the therapists at five points: one from the near the beginning of the tape, one from near the end, and three from near the middle. This resulted in the raters having to make 1275 ratings. These are, indeed, arduous studies.

Table II presents results from this study (Marshall et al., 2002). Apparently the reason a nonconfrontational approach was not shown to significantly influence most of the indices of change was simply because all therapists were predominantly nonconfrontational in their challenges (i.e., there was little variance across therapists in this feature). This was no doubt because of the changes in the training program. It can be seen quite clearly from Table II that the four primary therapist features observed to be influential in the first study, were powerfully influential across various indices of change in the second study. In fact the magnitude of the correlations seen in this study between empathy, warmth, rewardingness and directiveness on the one hand, and behavior changes on the other, is quite striking with several of them being significant at or above $p = .025$. We also employed regression analyses to examine the degree to which the combination of empathy, warmth, rewardingness and directiveness predicted treatment benefits. We will not describe all the results of these analyses as this would occupy too much space. As illustrations of the magnitude of the effects, I note that the combination of the four therapist features accounted for between 32% and as much as 61% of the variance in specific indices of changes in the various treatment targets.

SUMMARY

The results of our series of studies, then, demonstrates that: (a) raters can be trained to reliably identify a wide range of therapist features displayed during treatment; and (b) a variety of therapist features exert an influence on treatment-induced benefits over-and-above whatever influence the procedures specified in the treatment manual have. Among the influential therapist behaviors, the most

important appear to be: empathy, warmth, rewardingnes, and directiveness. It does appear however that other features identified in the more general literature (e.g., supportiveness, genuineness, respectfulness, confidence) go hand-in-hand with the four features identified as influential. For example, it would be very difficult to be warm and empathic but not supportive and respectful, and attempts at warmth and empathy would likely not be perceived by clients as such unless the therapist was also seen as genuine. Likewise confident therapists might be more readily able to set aside their own issues and display genuine warmth and empathy.

Warmth and empathy, of course, have long been viewed as essential features of effective therapists by authorities from all therapeutic orientations (e.g., Frank, 1971; Kohut, 1990; Rogers, 1957). No comments are required on these two features as they are, or should be, familiar to readers. However, some remarks are necessary regarding rewardingness and directiveness. These two features, it is interesting to note, were the two characteristics that distinguished early behavior therapists from their psychotherapeutic colleagues in a comparative study by Staples, Sloane, Whipple, Cristol, and Yorkston (1975). Rewardingness in our studies primarily involved the therapists offering verbal encouragement to clients for small steps toward whatever goal was being sought. It is important not to overdo encouragement and it is essential to arrange for the behaviors to be rewarded outside the therapy room in order to ensure generalization. Directiveness can also easily be overdone. We need our clients to, as far as possible, develop their own solutions to problems with some guidance from the therapist when necessary. If a client cannot generate potential solutions remarks by the therapist such as "Have you thought of trying . . .?" or "Did you consider . . .?" In this way clients can be led to find their own solution. Directiveness of this sort falls between Rogerian nondirective therapy (which for some of our clients might leave them at a standstill) and direct instructions to act in a particular way (which takes away the client's responsibility for his behavior).

CONCLUSIONS

Our series of articles (Marshall, Fernandez et al., 2003; Marshall & Serran, 2004; Marshall, Serran et al., 2003; Serran, Fernandez, Marshall, & Mann, 2003) have led us to conclude that sexual offender therapists will maximize their influence, and increase the chances their clients will overcome their offending propensities, if they display empathy and warmth in a context where they provide encouragement and some degree of directiveness.

In addition, however, the general literature on therapist characteristics indicates quite clearly that flexibility is an essential feature of effective therapists. Flexibility by the therapist essentially captures what Andrews et al. (1990) have referred to as the "responsivity principle." Unfortunately the overly detailed treatment manuals of HM Prison Service reduced opportunities for their therapists to

be flexible and instead encouraged them to behave the same toward all clients; we were not, as a result, able to discern flexibility. Flexibility refers to the need for the therapist to adapt what he is doing to each client's particular way of approaching treatment and to adjust this in turn to how the client is feeling in each session. St. Benedict (ca. AD 480–547) on advising abbots how to guide their monks noted the need to use different approaches with each monk. He noted that "The abbot must adapt himself to cope with individuality" (see translation by Meisel & del Mastro, 1975, p. 45).

On the basis of our findings, and our reading of the more general literature, we have developed a training program meant to teach neophyte therapists the skills they need to effectively change their sexual offender clients (Fernandez, Mann, Yates, & Marshall, 2000). This training program has been implemented throughout both HM Prison Service and Correctional Service of Canada, and the results have been encouraging. Thus, not only can researchers identify characteristics of effective therapists, but these characteristics also appear to be readily trainable.

Finally, we believe that the trend evident in some parts of the literature on the treatment of sexual offenders to provide very detailed treatment manuals to guide therapists is a mistake. Such over specification in its quintessential form reduces treatment to a psychoeducational process (Green, 1995) and removes any possible influence of the therapist. We are convinced that it is the proper balance between specifying procedures (the touchstone of behavior therapy) and allowing sufficient flexibility for the therapist to use his/her influence (the contribution of our psychotherapeutic colleagues) to maximize treatment benefits.

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