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Abstract

The purpose of this study was to obtain feedback from civilly committed sex offenders (*N* = 113) about the components of treatment that they believed to be most important and helpful in preventing reoffense. Participants were also asked to rate their satisfaction with the treatment process and therapists. Victim empathy and accountability were rated as the most important elements of treatment, along with skills for preventing relapse and methods for controlling sexual arousal. There was a fairly robust correlation between client perceptions of importance and satisfaction on most treatment components. Some clients expressed concerns about respect, confidentiality, and judgmental attitudes of some therapists. Because civilly committed sex offenders are considered to be among the most likely to reoffend, strategies are discussed for engagement of this population in a meaningful process of change.

Keywords

sex offender, treatment, consumer satisfaction, civil commitment

Introduction

The effectiveness of sexual offender treatment remains ambiguous and controversial. While some studies of sexual offender treatment (Furby, Weinrott, & Blackshaw, 1989; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005) created doubt about the possibility of rehabilitation, other studies have suggested more promising

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outcomes (Hanson, Bourgon, Helmus, & Hodgson, 2009; Hanson et al., 2002; Losel & Schmucker, 2005). The well-known Sex Offender Treatment and Evaluation Project (SOTEP) study (Marques et al., 2005), considered by almost all researchers to be the best-designed study to date, found no differences in reoffense between the treated and untreated groups. However, a confounding aspect of SOTEP was that those participants who "got it" and meaningfully completed their treatment goals did indeed have lower rates of sexual reoffense. The SOTEP study has been used to argue both that there remains no meaningful evidence that treatment works (Seto et al., 2008) and that treatment can work under the right conditions (Levenson & Prescott, 2007; Prescott, 2009).

Against the backdrop of this evolution, observers have questioned whether long-term recidivism rates are the only outcomes that matter in measuring the effectiveness of sexual offender treatment (Levenson & Prescott, 2007; Marshall & McGuire, 2003). Some have suggested that an important area of research should be studying in-treatment change in variables known to be associated with recidivism (Barbaree, 1997; Marshall, 2005). Barbaree further cautioned against Type II error due to low base rates (i.e., concluding that treatment is not effective in reducing recidivism when in fact it is) with respect to the existing knowledge about sexual recidivism. Laws (1996) has argued that treatment progress should be measured as harm reduction and that professionals should construe as positive any reduction in the frequency or intensity of sexual offending following treatment.

Empirical ambiguities and clinical debates about the treatment of sexual aggression beg the questions of how clients experience their treatment, what they find to be helpful and important, and what professionals can learn from their clients. Soliciting client feedback has gained increasing currency in recent years, and can help to improve services and prevent treatment failure (Lambert, 2010). We believe that the views of sex offenders can inform our ongoing efforts to improve treatment effectiveness. Consumer satisfaction is a common area of research in most commercial enterprises and has become an important topic of study in the provision of mental health services (Substance Abuse and Mental Health Services Administration, 2004). The goal of this study was to elicit perceptions about treatment from sex offender clients in a civil commitment program.

Background

Most sex offender treatment in the United States occurs in the community (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010), and civil commitment remains a controversial means for managing those sex offenders whom courts deem to be at highest risk for continued sexual aggression (Wilson, Looman, Abracen, & Pake, 2012). There are presently 20 states with sex offender civil commitment laws in the United States, allowing for the involuntary treatment of sex offenders in a secure environment following incarceration. Residential treatment programs in the United States tend to keep clients for much longer durations than those in Canada (McGrath et al.,

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2010; Wilson et al., 2012). In a recent survey of sexual offender civil commitment programs, 4 of 15 programs had never discharged a client, whereas 8 programs had discharged 1 to 20 clients, 1 program had discharged less than 100 clients, and 2 programs had discharged upwards of 150. Across programs in the United States, it was more likely that clients were discharged by the court without a recommendation from the treatment team than with the support of treatment providers (Jackson, Schneider, & Travia, 2010).

Many civil commitment programs share similar treatment plans and approaches (e.g., requiring disclosure of past sexually abusive acts, a reliance on cognitive-behavioral therapy, the use of an early phase of treatment to build group cohesion, and providing psychoeducation separately from process groups), but treatment dosage can vary from 1.5-hr to 18-hr a week (Jackson et al., 2010). Some civil commitment programs have come under fire for not discharging clients even after many years of operations (Stahl, 2011).

A recent study comparing populations at the Florida Civil Commitment Center (FCCC) and the Regional Treatment Center (RTC) in Kingston, Ontario, found positive effects on recidivism. Of 31 residents released from FCCC, 3.2% had recidivated after 2.5 years, and 5.5% of the RTC sample had recidivated at the same length of follow-up (Wilson et al., 2012). The recidivism differences between the programs were not statistically significant, and were well below rates projected by Static-99 (27.7%) and Static-99R (25.3%), two actuarial measures of sexual offender recidivism (Helmus, 2009).

Few researchers have surveyed consumers of sex offender treatment services to elicit opinions about what they find most beneficial, but existing empirical investigations have provided some valuable information. The SOTEP, an inpatient program for prisoners in California, obtained client feedback via an exit interview (Marques, Day, Nelson, & Miner, 1989; Marques, Day, Nelson, Miner, & West, 1991). Relapse prevention, individual therapy, stress and anger management, and behavioral therapy were rated by clients as most important to their recovery. The least important area was sex education. Many clients reported that they were only moderately satisfied with the therapy they received, opined that staff attitudes could sometimes be judgmental, and suggested that interpersonal relationship skills should receive greater emphasis in the treatment program (Marques et al., 1991).

Researchers in England interviewed outpatient sex offender clients about their perceptions of therapy (Garrett, Oliver, Wilcox, & Middleton, 2003). Most (97%) rated their experience in group therapy as positive. About half said they preferred group sessions over individual therapy, though 13% said they would have liked more individual therapy. Clients reported that sharing experiences, learning from others, relating to others, support, and peer confrontation were important benefits of group therapy. The small sample size ($n = 32$) limited generalization of findings, but the study provided important insights in an understudied area.

Levenson and Prescott (2009) surveyed 44 civilly committed sex offenders in Wisconsin. The clients reported unexpectedly positive sentiments about their treatment

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experiences, though some raised concerns about a perceived lack of confidentiality and counselors who seemed judgmental at times. Higher ratings about the importance of treatment components were positively associated with satisfaction, though participants gave higher rankings to the importance of treatment components than to satisfaction with the help they received (Levenson & Prescott, 2009).

A different study of the civil commitment program in Wisconsin investigated whether therapeutic climate varied depending on client risk scores or phase of treatment (Harkins, Beech, & Thornton, 2012). Client risk did not significantly alter the group environment, but clients in later phases of treatment showed higher levels of group cohesion, leader support, and organization, and lower levels of client anger and aggression. The general group psychotherapy literature concurs that over time, as group members build trust and intimacy, group cohesion is enhanced (Yalom, 1995). Levenson and Macgowan (2004) found that length of time in sex offender outpatient treatment also was associated with stronger cohesion and engagement.

Sex offenders in outpatient therapy in Florida and Minnesota ($n = 338$) reported being generally satisfied with their treatment programs and held positive perceptions of treatment effectiveness (Levenson, Macgowan, Morin, & Cotter, 2009). Clients ranked accountability and victim empathy as the most important components of their therapy, and other popular content areas included thinking errors, relapse prevention concepts, uncovering motivations to offend, and offense-related arousal control. Most sex offenders valued the sharing, support, and peer confrontation offered by group therapy. The majority believed that learning how to meet needs in more adaptive ways and creating more satisfying lives for themselves were very important. Engagement in therapy was positively correlated with treatment satisfaction (Levenson et al., 2009). In other studies, engagement in group therapy has been inversely correlated with denial and positively associated with sex offender treatment progress; actively engaged treatment clients had greater levels of accountability and less distorted thinking about their offenses, and displayed more progress toward treatment goals (Levenson & Macgowan, 2004). Other researchers concurred that sex offenders who display more remorse and accountability are more motivated to prevent reoffense (Barrett, Wilson, & Long, 2003).

In an outpatient program in Connecticut, a robust correlation was found between engagement and treatment satisfaction (Levenson, Prescott, & D'Amora, 2010). Clients rated accountability and victim empathy as the most important components of treatment. The authors concluded that while reduced recidivism is clearly a crucial measure of treatment success, clients who are engaged in the treatment process and develop healthy interpersonal skills by participating in therapy may be less likely to engage in abusive behavior. These areas provide examples of how *good lives* concepts (Ward & Brown, 2004) can help clients develop and sustain the emotional resources that lead to increased self-esteem and lifestyle stability. Other researchers have found that group cohesion and supportive therapists are associated with reductions in pro-offending attitudes over the course of treatment (Beech & Hamilton-Giachritsis, 2005).

Variables such as empathy, validation, collaboration, and flexibility, along with a directive but nonconfrontational therapeutic style, have been found to influence treatment outcomes for sex offenders as measured by increases in accountability and

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improvements in interpersonal relationships (Marshall, 2005; Marshall et al., 2002). Because sex offender treatment is usually nonvoluntary, client resistance and denial are common, and treatment providers may tend to adopt a paternalistic, condescending, or confrontational approach to service provision (Glaser, 2003). A survey of 540 sex offender treatment providers revealed that 63% voiced little hope for a "cure" for sexual predators (although the authors gave no definition for this term and, if asked, the providers might have endorsed the notion that treatment can promote responsible sexual behavior rather than provide a "cure"; Engle, McFalls, & Gallagher, 2007). It has been noted that a clinician's skepticism can influence the therapeutic alliance (Beyko & Wong, 2005; Marshall, 2005). Negative process can result in a mismatch of treatment delivery to the needs of the client and adversely affect treatment outcomes (Andrews & Bonta, 2007; Binder & Strupp, 1997).

Purpose of the Study

The purpose of this study was to obtain feedback from civilly committed sex offenders about the components of treatment that they believed to be most important and helpful in preventing reoffense. Because sex offenders who are civilly committed are considered to be among the most likely to reoffend, it is particularly important to understand how to engage this population in a meaningful process of change. Without formulating any a priori hypotheses, we sought to answer several research questions about how civilly committed sex offenders perceive their experiences in treatment:

Research Question 1: Which treatment components do sex offenders find particularly important to their recovery and to the prevention of future offenses?
Research Question 2: Do sex offenders rate their satisfaction with the treatment they receive to be commensurate with the importance they attribute to treatment components?
Research Question 3: In general, how do clients perceive the treatment process, their therapists, and the program?

It is expected that this research will help to facilitate the development of programming that can contribute to reduced recidivism rates.

Method

Participants

A convenience sample was recruited from the Illinois Department of Human Services Treatment and Detention Facility (TDF). The treatment center is a comprehensive, long-term, secure, inpatient facility for adult males who have been convicted of sex offenses and found eligible for civil commitment or are undergoing civil commitment proceedings after a court finding of probable cause for commitment. Sex offenders who meet criteria for civil commitment in Illinois must be diagnosed with a mental disorder

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predisposing them to engage in acts of sexual violence. Generally that mental disorder involves a *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; American Psychiatric Association [APA], 2000) diagnosis of a paraphilia or personality disorder, with the likelihood of reoffense determined by actuarial risk assessment. The treatment center is a modern, freestanding, maximum security facility located in a rural community. The structure was originally built to house maximum security juvenile prisoners, but was never utilized for this purpose. The sexually violent predator (SVP) program is the first and only occupant of the newly constructed structure.

All adult male sex offenders attending core sex offender treatment at the facility ($n = 123$) were invited to participate in the research survey; only those who voluntarily agreed to participate were selected ($n = 113$). The sample contained individuals who were civilly committed as well as detained individuals undergoing civil commitment proceedings. The project was approved by both a university Institutional Review Board and the Illinois Department of Human Services. All guidelines for the ethical protection of human subjects were followed.

Table 1 depicts the characteristics of the sample. Most participants were between 26 and 50 years of age, and the majority was White. The sample was fairly well-educated, with 74% reporting high school completion or above, though the average income when last employed was below the U.S. median. The majority had never been married, and few are presently married. Median time in treatment was 3.5 years. Table 1 also displays various victim characteristics. Most of the victims were female and minors, but many offenders endorsed more than one category, demonstrating the variety of offending in which they have participated.

The sex offender treatment program survey was completed by 92% of the residents invited to participate. It was not possible to determine the characteristics of those who chose not to participate in the survey. The sample seemed to be representative of the clients served by the treatment facility. For instance, 66% of the clients at the TDF are White, and 34% belong to an ethnic or racial minority group. Comparatively, 66% of our respondents were White, suggesting that the respondents' racial background was similar to that of the entire TDF population. Sixty-nine percent of the TDF sample for whom victim data were available ($n = 229$) had minor victims under the age of 13, while 77% of those responding to the survey reported victims under age 12. The mean number of total sex crime arrests was reported by our sample to be 2.61; on average, TDF residents have been convicted 3 times. Though we were admittedly limited in our ability to determine whether the sample represents the population, the sample appears to be similar both in terms of offense history and cultural diversity.

Groups and Therapists

Illinois' SVP program provides comprehensive cognitive-behavioral treatment to all clients willing to participate. Presently, more than 50% of civilly committed sex offenders have consented to treatment. This is in line with other civil commitment programs (Jackson et al., 2010). This treatment takes place within a larger milieu of

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Table 1. Sample Characteristics

	Valid *n*		%	*M*	Median	Mode	*SD*
Age	108	<25	3				
		25-49	70				
		50 or more	23				
Current marital status	108	Never married	56				
		Married	6				
		Divorced	34				
		Separated	4				
		Widowed	.9				
Racial background	105	White	66				
		Minority	34				
What is the number of years of school you completed?	106	8th grade or less	12				
		Some HS	14				
		HS grad/GED	54				
		College grad	20				
Household's total income before taxes the past year (or, in the previous year that you earned income)	94	<US$10,000	61				
		US$10,000-US$19,999	15				
		US$20,000-US$29,999	6				
		US$30,000-US$49,999	11				
		US$50,000 or more	7				
Months in this treatment program	105			59.18	42.00	18	45.937
If in aftercare, indicate how long	13			61.15	50.00	24	46.238
In most recent sex offense arrest, the age of victim(s) at the time of the offense	104	5 years old or less	13				
		6-9 years old	19				
		10-12 years old	14				
		13-17 years old	27				
		18 years old or more	28				
I have had female victims	108		93				
I have had male victims	105		61				
I have had family member victims	108		56				
I have had victims who I knew but was not related to	106		87				
I have had victims who were strangers	102		65				
I have had child victims age 12 or under	102		77				
I have had teen victims	100		80				
I have had adult victims	102		68				
How many times arrested for a sex crime?	107			2.61	2.00	2	2.136
Total victims (including those not arrested for)	105			47.79	14.00	4	158.794

(continued)

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Table 1. (continued)

	Valid *n*		%	*M*	Median	Mode	*SD*
Ever used force or violence when committing a sex offense	108		69				
Ever used a weapon when committing a sex offense	108		31				
Ever physically injured a victim while committing a sex offense	107		31				
Ever been in sex offender treatment before entering this program	108		64				
If yes, where	57	In the community	29.8				
		In prison	47.4				
		Both	22.8				

Note: HS = high school; GED = general educational development test.

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 five-phase model, with objectives in later phases building on work completed in earlier phases of the program. Program completion is not a prerequisite for release; rather, clients may be ordered to continue their treatment in a less restrictive environment based on their preexisting level of risk and treatment success at any point along the treatment continuum. Clients leave the facility on a conditional release status with extensive community monitoring and support. Residents in Phase 2 through Phase 5 were included in the subject pool.

In the first phase, the client participates in an extensive psychological and psychophysiological assessment process that guides his course of treatment throughout the program. Phases 2 through 5 each contain three tracts emphasizing different aspects of sex offender treatment—relapse prevention, cognitive restructuring, and journaling. In the second phase, clients work with their treatment groups to fully disclose and take responsibility for their sexual offending and begin the process of self-exploration they will need for later phases of treatment. The third phase involves breaking down patterns of offending behavior to lay the groundwork for future intervention opportunities, understanding emotional and cognitive elements of offending, and rehearsing self-monitoring strategies. In Phase 4, clients demonstrate an ability to manage these emotional elements in their daily lives. The fifth phase of the treatment program focuses on active preparation for transition back to the community. Clients from all phases were represented in the survey.

Intensive group psychotherapy is the primary treatment modality. A cofacilitator model is utilized in all treatment groups, and all facilitators receive extensive ongoing

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training and weekly individual and group supervision. Facilitators receive intensive training and supervision to maintain a treatment style that is warm, empathic, rewarding, and directive (Marshall, 2005). 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. All program clinical staff are members of the Association for the Treatment of Sexual Abusers and are Illinois Sex Offender Management Board approved treatment providers. Thirty-six masters- and doctoral-level clinicians were involved in the provision or direct clinical supervision of sex offender treatment. The mean group size for the 15 sex offender treatment groups was just under nine residents per group. Group sizes ranged from 7 to 10 residents per group. Residents received an average of 18 hr of group therapy per week.

Data Collection

Clients were invited to complete the survey during a regularly scheduled group therapy session in January 2009. Clients were instructed *not* to write their names on the questionnaire and to place the completed survey in a sealed envelope. Therapists were not in the room when residents completed the survey. To ensure anonymity, clients were not asked to sign an informed consent form. Completion of the survey was considered implied consent to participate in the project.

Instrumentation

The survey instrument was modified slightly from earlier surveys developed by the authors for the purpose of collecting data regarding the perceptions of sex offenders about their treatment. The questions were created by drawing upon 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 inquired about clients' perceptions of various components of sex offender treatment, including content, process, therapists, policies, 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. To indicate their degree of agreement with the issues in question, 3- and 5-point Likert-type scales were used. Client characteristics and offense history were elicited using forced-choice categorical responses to protect the identities of participants.

Data Analysis

First, descriptive statistics were generated to illustrate participant perceptions about group and individual therapy, therapists, and the treatment program components. Then, mean ratings for each item were calculated, and correlations were analyzed to

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determine the relationship between perceived importance and satisfaction with treatment. Finally, *t* tests were used to compare mean scores on importance and satisfaction ratings, with significant differences indicating disparities.

Results

When asked what treatment components they viewed as most important to their recovery, clients rated accountability, victim empathy, relapse prevention skills, and arousal control as most important (see Table 2). The least important items appeared to be human sexuality, life skills, and understanding early life experiences.

Table 3 displays client satisfaction with treatment components. Participants seem to find accountability, victim empathy, and relapse prevention components the most helpful. Least helpful items appear to be life skills and human sexuality.

We then determined whether clients believed that the quality of help they received was commensurate with the emphasis they placed on each content area. There was a fairly robust correlation between client perception of importance and satisfaction on most items, and all correlations were statistically significant (Table 4). Differences between the means on all items were analyzed with a *t* test to identify discrepancies between importance and satisfaction. Because multiple comparisons can lead to a higher probability of a Type 1 error (rejecting the null hypothesis when it is, in fact, true), the Bonferroni correction for multiple comparisons was used to set the alpha level more conservatively by dividing the alpha value (.05) by the number of comparisons (18). Using the adjusted alpha level of .003, none of the mean differences were statistically significant, indicating that the importance of each content item to the clients was rated similarly to their ratings of the help they received.

Most participants indicated that they were comfortable in their treatment groups and with other clients (Table 5). More than a third, however, perceived group members to be somewhat judgmental and 30% had difficulty trusting other residents. Almost one third identified an area for improvement as a lack of group structure. Most respondents indicated that they found their individual case management sessions to be very helpful, and 74% wished they could attend individual case management sessions more often. Less than a third attended individual case management sessions on a weekly basis (32%), with 20% saying they had individual sessions once or twice a month and nearly half indicating that they attended individual case management sessions rarely or never.

Perceptions about group process were mixed, with about half of clients reporting that sharing and relating with other group members and hearing other perspectives was important and helpful (Table 6). Getting help and support from others was viewed by most as important and helpful, whereas confrontation between members was seen by most as not important and not helpful.

Overall, group therapists appear to be perceived positively by most participants (see Table 7). About a quarter expressed that group leaders were sometimes judgmental and did not try to understand clients. A small minority of clients experienced

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Table 2. Importance of Treatment Components

Item	Least important (%)	Somewhat important (%)	Most important (%)
Accepting responsibility for my sex offense(s)	5	4	91
Learning about different forms of denial	34	36	30
Understanding my own tendency to distort, deny, and make excuses	15	35	50
Understanding the impact of sexual abuse on victims and others in my life	9	24	67
Understanding my offense chains, cycles, and abuse	6	22	71
Understanding my triggers and risk factors	6	23	71
Learning about what motivated me to offend	17	39	44
Learning about my grooming patterns or the behaviors I used to gain access to victims or offending	19	44	38
Developing a relapse prevention plan	12	33	55
Learning to change or control my deviant arousal	13	35	52
Understanding the development of my sexual behavior problems	24	46	30
Understanding how early experiences and family life affected me	52	25	23
Learning new relationship and communication skills	45	28	27
Understanding the needs I met through sexual abuse and learning how to meet my needs in healthier ways	29	30	41
Learning how to create a more satisfying life for myself	49	20	31
Basic life skills	55	19	26
Basic human sexuality	62	24	14
Controlling compulsive sexual behavior (including masturbation and pornography)	31	32	37

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Table 3. Satisfaction With Treatment Components

	Least helpful (%)	Somewhat helpful (%)	Most helpful (%)
Accepting responsibility for my sex offense(s)	8	11	81
Learning about different forms of denial	37	40	24
Understanding my own tendency to distort, deny, and make excuses	9	43	48
Understanding the impact of sexual abuse on victims and others in my life	6	25	69
Understanding my offense chains, cycles, and abuse	7	31	61
Understanding my triggers and risk factors	8	25	66
Learning about what motivated me to offend	17	36	47
Learning about my grooming patterns or the behaviors I used to gain access to victims or offending	26	36	38
Developing a relapse prevention plan	17	20	64
Learning to change or control my deviant arousal	20	41	39
Understanding the development of my sexual behavior problems	22	42	36
Understanding how early experiences and family life affected me	47	32	21
Learning new relationship and communication skills	47	30	23
Understanding the needs I met through sexual abuse and learning how to meet my needs in healthier ways	27	33	40
Learning how to create a more satisfying life for myself	48	24	28
Basic life skills	58	18	24
Basic human sexuality	58	21	21
Controlling compulsive sexual behavior (including masturbation and pornography)	33	32	35

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Table 4. Relationship Between Importance and Satisfaction

	n	*r*	Significance	Mean difference	*t*	Significance
Accepting responsibility for my sex offense(s)	108	.39	.000	.130	2.198	.030
Learning about different forms of denial	106	.55	.000	.085	1.174	.243
Understanding my own tendency to distort, deny, and make excuses	108	.53	.000	−.065	−1.000	.320
Understanding the impact of sexual abuse on victims and others in my life	106	.51	.000	−.057	−0.948	.345
Understanding my offense chains, cycles, and abuse	108	.49	.000	.130	2.198	.030
Understanding my triggers and risk factors	103	.36	.000	.068	0.961	.339
Learning about what motivated me to offend	105	.53	.000	−.038	−0.542	.589
Learning about my grooming patterns or the behaviors I used to gain access to victims or offending	104	.54	.000	.058	0.800	.425
Developing a relapse prevention plan	106	.53	.000	−.057	−0.831	.408
Learning to change or control my deviant arousal	102	.48	.000	.186	2.494	.014
Understanding the development of my sexual behavior problems	105	.49	.000	−.086	−1.174	.243
Understanding how early experiences and family life affected me	105	.50	.000	−.057	−0.726	.469
Learning new relationship and communication skills	105	.52	.000	.048	0.609	.544
Understanding the needs I met through sexual abuse and learning how to meet my needs in healthier ways	107	.36	.000	−.009	−0.104	.917
Learning how to create a more satisfying life for myself	105	.50	.000	−.029	−0.336	.737
Basic life skills	104	.55	.000	.029	0.360	.720
Basic human sexuality	101	.57	.000	−.109	−1.521	.131
Controlling compulsive sexual behavior (including masturbation and pornography)	104	.50	.000	.029	0.355	.724

Note: Bonferroni correction $p = .003$

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Table 5. Perceptions About Group and Individual Therapy

	Strongly disagree (%)	Disagree (%)	Somewhat agree (%)	Agree (%)	Strongly agree (%)
My group usually feels comfortable	12	16	27	31	15
My group has enough structure	13	19	23	36	9
My group members are pretty open and honest most of the time	7	19	32	36	7
My group members are pretty nonjudgmental most of the time	17	19	28	30	7
It is helpful to be able to talk with other people who have committed sex offenses	6	3	26	35	30
I feel comfortable participating in my group	5	8	22	38	28
I feel comfortable helping others in my group	2	6	22	34	37
I trust other members in my group	10	20	36	24	10
My individual therapy has been helpful	20	6	21	27	25
I wish I could attend individual therapy more often	6	5	15	21	53
The reason I don't attend individual therapy more often is because I don't request it	43	17	18	17	6
I would rather attend individual therapy instead of group therapy	9	23	24	9	35

discomfort sharing personal information with group therapists. Most seemed to feel that group leaders held positive attitudes toward group members and that they were successful at facilitating a safe therapeutic environment. About 41% of participants reported having a female primary therapist, 9% had a male therapist, and 50% reported having both. A large majority of offenders (63%) expressed no preference regarding the gender of their group facilitator. About 13% preferred a male therapist, and about 24% preferred a female.

The majority of respondents agreed that program policies and procedures with regard to attendance and tardiness were clear and fair (Table 8). Most felt that their

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Table 6. Perceptions About Group Process

	Least important (%)	Somewhat important (%)	Neutral (%)	Very important (%)	Most important (%)	Least helpful (%)	Somewhat helpful (%)	Neutral (%)	Very helpful (%)	Most helpful (%)
Sharing my experiences with other sex offenders	13	15	31	15	27	15.2	14.3	28.6	13.3	28.6
Feeling as though I can relate to the other members of the group	13	23	17	24	24	9.5	18.1	20.0	27.6	24.8
Hearing other perspectives and viewpoints	4	12	30	32	22	8.6	12.4	24.8	28.6	25.7
Getting help and support from others	8	10	11	23	47	3.8	14.3	11.4	27.6	42.9
Confrontation among the group members	35	11	18	14	22	41.9	11.4	14.3	11.4	21.0

confidentiality was respected and agreed with their treatment plan. Clients were less convinced of the clarity and fairness of expectations for successful completion of the program. Most clients thought that they were not given the right amount of homework, with 6% saying that there was too little homework assigned and 12% opining that there was too much. A large majority (81%) felt that the treatment program lasted too long, while 1% thought it was too short and 18% believed the program length was just right.

More than half of the participants agreed that they needed to be in treatment (67%), and 60% 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.

Discussion

As noted earlier, sexual offender treatment remains controversial on several fronts. Some researchers (e.g., Marques et al., 2005) have called into question its efficacy whereas others have addressed relevant ethical considerations (Ward, 2010; Ward & Salmon, 2011). Others have asked whether sexual offender treatment is not simply a form of punishment and questioned the ethics of mandatory treatment (Glaser, 2010, 2011). The present study provides some confirmation that many sexual offenders themselves (two thirds of this sample) believe that they need treatment and are satisfied with the therapy they receive. It is noteworthy that this study took place in a civil commitment program, where resistance and dissatisfaction might be expected to be greater considering the circumstances.

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Table 7. Perceptions About Therapists

	Strongly disagree (%)	Disagree (%)	Somewhat agree (%)	Agree (%)	Strongly Agree (%)
Usually, my group leader makes me feel comfortable and safe in therapy sessions	5	14	22	28	31
I get along well with my group leaders	4	9	23	31	33
I feel that my group leaders try to understand me	6	8	21	33	31
My group leaders are pretty nonjudgmental most of the time	9	16	22	24	29
I usually feel comfortable sharing personal things with my group leaders	6	10	23	29	33
I usually feel comfortable with the feedback or advice my group leaders offer to me	6	9	13	49	23
My group leaders are good at bringing out important points during group therapy	5	6	21	28	40
My group leaders deal with difficult moments well in group therapy	9	18	13	32	27
I feel my group leader has a positive attitude toward the group members	7	9	19	30	34
I trust my group leaders	9	7	28	25	31

Most empirical research has found that denial and victim empathy are not consistently predictive of future reoffense (Hanson & Bussiere, 1998; Nunes et al., 2007; Yates, 2009). Yet, these participants rated these two aspects as the most important elements of treatment, along with skills for preventing relapse and methods for controlling sexual arousal. The findings were congruent with other studies (Levenson et al., 2009; Levenson et al., 2010; Levenson & Prescott, 2009) and may reflect the importance that treatment providers place on accountability and victim empathy. Or it may

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Table 8. Perceptions About Policies and Procedures

	Strongly disagree (%)	Disagree (%)	Somewhat agree (%)	Agree (%)	Strongly agree (%)
The rules about attendance are fair	3	9	14	41	33
The rules about lateness are fair	4	9	12	48	28
My confidentiality is respected	15	15	19	27	25
I agree with my treatment plan	5	11	26	27	31
The expectations for successful completion and graduation are clear	29	10	19	20	22
The expectations for successful completion and graduation are fair	24	18	22	24	11
I am treated with respect by the staff	14	10	28	28	20

be that even though they are not predictive of recidivism, these factors are important to sexual offenders trying to come to terms with their own harmful behavior and thus contribute to a stronger belief that one has changed his ways (Bem, 1972; Maruna, 2001). Some researchers, noting the relationship between denial, engagement, and treatment progress, have suggested that denial, accountability, and empathy be viewed as responsivity factors in assessing treatment needs and therapeutic gains (Levenson, 2011; Levenson & Macgowan, 2004).

The results also speak to the importance of group structure and group cohesion, including establishing an atmosphere in which clients are more likely to trust one another. A number of studies have discussed the importance of group climate (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005), and it seems that many sexual offenders themselves agree. These factors may also be related to the responsivity principle (Andrews & Bonta, 2010; Hanson et al., 2009) and highlight the importance of "getting the context right for change" (Mann, 2009). Group cohesion can model healthy intimacy while offsetting the loneliness and alienation often felt by sex offenders who have held on to their deviant secrets with deep shame. We suggest that when offenders are engaged in a genuine therapeutic process and experience an honest connection with others, clients can become more motivated to develop and practice intimacy skills that are relevant for reducing recidivism risk (Jennings & Sawyer, 2003; Prescott, 2009). The present findings also point to the need to attend to factors related to the therapeutic alliance, including respect, confidentiality, and nonjudgmental attitudes (Binder & Strupp, 1997; Marshall, 2005; Marshall et al., 2002; Marshall et al., 2003; Teyber &

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Table 9. Overall Perceptions of the Program

	Strongly disagree (%)	Disagree (%)	Somewhat agree (%)	Agree (%)	Strongly agree (%)
I am here because I need to be here	18	16	22	27	18
Now that I know what this program is like, I like it better than I thought I would	16	24	21	30	9
Overall, my experience in this treatment program has been a positive one	15	13	31	29	13
I have gained a great deal of understanding about my offenses from this program	5	6	14	42	34
I have gained a great deal of understanding about preventing future offenses from this program	7	3	12	33	45

McClure, 2000). Although it is encouraging that so many sexual offender clients found their treatment experience to be worthwhile, their comments and concerns point to the need for professionals to collaborate with clients on the nature of the goals and tasks of treatment to the greatest degree possible. Several meta-analyses in the psychotherapy literature have found that the therapeutic alliance, especially when measured early in therapy, is robustly associated with outcomes (Wampold, 2010).

Limitations

Self-report data always present questions of reliability in any survey study, but sex offenders, and particularly those in a treatment program, may tend to engage in impression management. Although the surveys conducted in this study were administered anonymously, it is likely that some participants skewed their responses in socially desirable directions, and in so doing biased the findings. In fact, most of the ratings were skewed toward positive responding. In retrospect, we might have asked participants to rank-order the importance of treatment components. This would have limited the tendency to answer in a desirable direction and might have provided useful information about how clients prioritize treatment components. As well, many offenders had been in treatment for longer than 6 months and reportedly liked it,

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possibly creating a halo effect. The moderately small sample size limits generalizability, but the findings are congruent with results from related studies.

Overall, these results can provide some important and valuable information for practitioners about the utility of sex offender treatment for clients. In general, sex offenders perceive treatment to be helpful when delivered in a safe and supportive therapeutic environment. They seem to perceive sexual abuse-related treatment components as more important and helpful than more general topics such as relationships, communication, life skills, and human sexuality. Therapists in nonvoluntary settings need to be mindful of the rights of clients to receive ethical counseling services and to maintain a respectful and nonjudgmental atmosphere. There is a continuing need for further research regarding perceptions of sex offender treatment content, process, measures of in-treatment changes, and their influence on long-term recidivism outcomes.

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