Sex Offender Treatment: Engagement and Satisfaction

By

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Abstract

Sexual offending has become one of the most important and controversial areas in the field of criminal justice. One component of particular importance is the rehabilitation of sex offenders. Each day sexual offenders are released back into society and sexual reoffending becomes one of the biggest concerns for researchers and policy makers. Treatment programs have attempted to address sexual reoffending, but few have sought to understand the perceptions of sexual offenders and their levels of engagement while in treatment. The purpose of this study is to understand sex offenders' level of satisfaction with the treatment they received while attending treatment in rural South-Western, Virginia. Sex offenders were surveyed about their experience in treatment and their satisfaction with the treatment they received. Sex offender engagement was also measured through facilitator-completed monthly progress reports: examining attendance, participation rating score, and phase in treatment. Ultimately, sex offenders who engage in the treatment process may be more likely to be satisfied with the treatment they received.

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Chapter 1

Introduction

Sex offenders have received a substantial amount of attention in recent years from both policymakers and the public. This is due at least in part to the widespread and deep impact that sex crimes have on victims and the larger community. In the United States, it is estimated that every two minutes an American is sexually assaulted, with approximately 288,820 victims, ages 12 or older, raped and sexually assaulted each year (Rape, Abuse, and Incest National Network, 2016). It is also estimated that 1 out of every 6 American women and 1 out of 10 American men will be the victim of an attempted or completed rape in their lifetime. Currently, 20 million out of 112 million women (18%) in the United States have been raped or sexually assaulted during their lifetime, with the number steadily increasing daily (Bureau of Justice Statistics, 2016). In most instances, perpetrators of sex crimes have close relationships with their victims, interacting as family, friends, babysitters, childcare providers, or even neighbors, which can increase the traumatic impact on victims and their families (Lievore, 2003).

Sex crimes have been defined as criminal offenses of a sexual nature (Blasko, 2016; Hanson & Morton-Bourgon, 2005; Simons, 2000). These include rape, sexual battery, lewd conduct, child molestation, possession and distribution of child pornography, indecent exposure, and penetration of the genital or anal region by a foreign object. While rates of violent crime have substantially decreased since the late 1990s, sex crimes have remained a large concern for law enforcement and political officials (Bureau of Justice Statistics, 2016). Currently, there are approximately 747,408 registered sex offenders nationwide in the United States and 265,000 total sex offenders under the supervision of a corrections agency (Greenfeld, 1997; National Center for Missing & Exploited Children, 2015). Of the sex offenders who are arrested and attend the pretrial release/adjudication process, about 5 out of 10 are released prior to trial and 8

out of 10 convicted for a sex crime have entered a guilty plea to a given offense (Greenfeld, 1997). Sentences of guilty offenders often range from 5-13 years, with additional penalties such as a fine, victim restitution, and/or required treatment (Greenfeld, 1997). As convicted sex offenders enter the criminal justice system every day, the same sex offenders will eventually be released from the system that is required to treat and hold these offenders accountable.

Similar to many other criminal behaviors, the misconception that all sex offenders will repeat their deviant behavior in the future still remains, with society speculating that resources like treatment will not effectively reduce their rates of reoffending. Currently, the effectiveness of treatment is debatable, with some researchers indicating that treatment is effective (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009), while others find it ineffective (Doren & Yates, 2008; Harkins & Beech, 2007; Keeling, Rose, & Beech, 2007; Losel & Schmucker, 2005; Marques, Nelson, West, & Day, 1994). However, research regarding the effectiveness of treatment has been primarily measured on the concept of recidivism, which in this case means being rearrested for another sexual offense. In the largest single study of sex offender recidivism conducted to date, Langan et al. (2003) examined the recidivism patterns of 9,691 male sex offenders released from prisons in 15 states in 1994. They found a sexual recidivism rate of 5.3%for the entire sample of sex offenders based on an arrest for a sexual offense during the 3-year follow up period. Langan et al. (2003) also found that "violent and overall arrest recidivism rates for the entire sample of sex offenders were much higher; 17.1% of sex offenders were rearrested for a violent crime and 43%were rearrested for a crime of any kind during the follow-up period" (p. 8).

Hanson et al. (2009) conducted a meta-analysis of 23 studies examining recidivism based on outcomes to determine whether the risk, need, and responsivity principles associated with

effective interventions for general offenders also apply to sex offender treatment. They found that when examining only sexual offenses, on average treated sex offenders have a recidivism rate of 10.9%, compared to untreated offenders who have a recidivism rate of 19.2%, based on an average follow up period of 4.7 years. Losel and Schmucker (2005) also found positive findings with their meta-analysis studying the effectiveness of sex offender treatment. In the analysis, Losel and Schmucker (2005) included 69 independent studies and combined a total of 22,181 subjects. The researchers found that when examining only sexual offenses, on average treated sex offenders have a recidivism rate of 11.1%, compared to untreated offenders who have a recidivism rate of 17.5%, based on an average follow up period of 5 years.

A review of existing research also indicates that the efficacy of sex offender treatment has primarily used recidivism as the measure of treatment effectiveness (Cabeen & Coleman, 1960; Hall, 1995; Harris & Hanson, 2004; Harkins & Beech, 2007; Moertl, Buchholz, & Lamott, 2010; Nelson, 2007;). Using this outcome variable, the effectiveness of treatment is based solely on whether or not an offender reoffends over a particular period. Research has found that methodological flaws were inherently associated with examining sex offender treatment and could lead to inconclusive treatment effects when measuring rates of recidivism (Jones & Tatman, 2007). In addition, simply measuring treatment efficacy through rates of recidivism is difficult because only a small fraction of all sexual offenses are reported, and of those reported, only a small segment are prosecuted, causing a natural bias in the data (Jones & Tatman, 2007).

Although recidivism is the most commonly used measure of treatment effectiveness, some researchers have argued that other measures and factors can contribute to an understanding of the effectiveness of sex offender treatment. Some examples include client attainment of therapeutic goals, treatment implementation, therapist characteristics, and in-treatment

behavioral changes (Levenson, Macgowan, Morin, & Cotter, 2009; Levenson Prescott, & D'Amora, 2010; Levenson, Prescott, & Jumper, 2014; Marshall et al., 2002; Marshall, 2005). Levenson et al. (2009, 2010, & 2014) found that examining offenders' level of satisfaction and engagement in the overall treatment could ultimately help to ensure that treatment is relevant and responsive to patients' needs, which will lead to positive post-treatment outcomes.

Past research findings by Levenson et al. have shown to be favorable, indicating that surveying sex offenders' perceived importance of treatment content, satisfaction with the help they receive, and engagement in therapeutic services can help ensure that treatment meets the need of offenders to reduce sexual recidivism outcomes (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). The current study seeks to add to the literature by assessing the perception of sex offenders only in rural environments where crime rates are not as high or observed. In addition, this study extends Levenson's past work by excluding the use of self-reported engagement to prevent the possibility of over-desirability and over-reporting their engagement in treatment. Instead, this study uses a new group engagement measure that examined facilitator-completed monthly progress reports that assess offenders' level of engagement by looking at the number of absences, participation rating score, and phase in treatment. Lastly, this study used Levenson's self-reported satisfaction survey to assess level of satisfaction among sex offenders in treatment groups in rural environments. Using these measures, the current study will address the following research question: Is there a relationship between engagement in treatment and satisfaction with treatment? As an extension of previous research, this study has proposed the following hypotheses:

H_1 – As the total number of absences increases, the level of satisfaction will decrease.

H_2 – As the facilitator's participation rating score increases, the level of satisfaction will increase.

H_3 – The further a patient is in the treatment process, the level of satisfaction will increase.

Chapter 2

Literature Review

In the field of criminal justice, there is a general understanding that the primary objectives of the criminal justice system are to stop criminal activity and prevent criminal offenders from reoffending. These objectives are still apparent in the fight to combat sex crimes in United States. To facilitate consistency, integrity, and effectiveness, sex offender treatment programs have been used as models of change to enhance interpersonal skills and redirect deviant sexual behavior and attitudes of offenders to prevent future sex crimes. Currently, the cognitive behavioral approach is the most widely used model of treatment for both juvenile and adult sex offenders (McGrath, Cumming, & Burchard, 2003). Cognitive behavioral therapy addresses the interrelatedness of thoughts, emotions, and most importantly behavior, through modes of skill building, reinforcement, and intervention centered around replacing maladaptive thoughts and unhealthy coping strategies with positive strategies (Butler, Chapman, Forman, & Beck, 2005). This approach has been designed to assist offenders with meeting several goals, including impulse control, developing and enhancing interpersonal skills, practicing healthy coping skills, and expanding positive support systems.

Prior research has evaluated the effectiveness of sex offender treatment programs by examining the relationship between the sex offenders' experiences while in treatment programs and changes in their sex offending behavior. Several studies have found that sex offender treatment programs that utilize psychotherapy, cognitive behavioral therapy, relapse prevention, and motivational enhancement therapy are effective at reducing recidivism (Hall, 1995; Harkins & Beech, 2006; Losel & Schmucker, 2005; Marques, Nelson, West, & Day, 1994; Moertl, Buchholz, & Lamott, 2010; Nelson, 2007). Although the purpose of treatment is to prevent recidivism (Furby, Weinrott, & Blackshaw, 1989; Hall, 1995; Harris & Hanson, 2005), each

therapeutic approach seeks to provide relief from stress and anxiety that comes from feelings of isolation, while offering support and understanding (Nelson, 2007). Nelson (2007) found that therapy, simply as a mechanism, not only enhances self-esteem, but addresses compassion and remorse towards the victims. In most cases, group treatment utilizes lectures, discussions, exercises, instruction videos, movies, written and oral treatment plans, homework assignments, role-playing, and daily journals (Nelson, 2007). Since sexual aggression and deviance is a serious offense, ultimately it demands an effective solution.

Group Therapy

Today, most treatment programs for sex offenders are delivered in a group setting (Hall, 1995; Harkins & Beech, 2006; Losel & Schmucker, 2005; Marques, Nelson, West, & Day, 1994; McGrath, Cumming, & Burchard, 2003; Moertl, Buchholz, & Lamott, 2010; Nelson, 2007). Researchers have found group treatment to have a series of advantages, not including its resources and time efficiency. Group treatment provides the opportunity for sex offenders to go through the rehabilitation process with other offenders who can relate to them. Treatment in a group format also increases offenders' receptiveness to feedback because it comes from peers, allows for positive interactions and skill building with peers, and instills self-efficacy through observing the progress of other offenders (Berenson & Underwood, 2000; Jennings & Sawyer, 2003; Marshall, Anderson, & Fernandez, 1999; McGrath, Cumming, & Burchard, 2003).

Within the context of the principles and goals of group treatment, implementing effective intervention, which will affect rates of recidivism, has remained the primary treatment goal. Researchers have stated that recidivism is most likely to be reduced when the treatment primarily targets reoffending predictors such as deviant sexual interests, antisocial personality, intimacy deficits, and pro-offending attitudes (Andrews & Bonta, 2007). Therefore, treatment providers

should focus their efforts on the factors that are most frequently associated with sexual recidivism. However, a large majority of treatment programs have sought to also target non-criminogenic needs such as self-esteem, social skills, stress management, trauma resolution, and victim awareness. Unfortunately, when non-criminogenic needs are addressed over criminogenic needs in treatment, the overall impact of the program may become undermined because the content does not match with the goals to change the thoughts, emotions, and behaviors of the offender (Andrews & Bonta, 2007). Latessa and Lowenkamp (2005) found that while a vast majority of treatments focus on non-criminogenic factors, these types of treatment programs will not have much effect on reducing criminal conduct, because many non-criminogenic factors have not been found to be correlated with criminal behavior. In a more recent study, Gendreau et al. (2002) found that criminogenic needs targeted were strongly related to program effectiveness in reducing rates of recidivism. They found that programs that focused on four to six more criminogenic than non-criminogenic needs reduced recidivism by 30%. While programs that targeted one to three more criminogenic than non-criminogenic needs were associated with a small rate of recidivism (Gendreau, French, & Gionet, 2002).

Nevertheless, researchers have still found positive findings regarding group therapy, especially when comparing its effectiveness to individual therapy. In 2003, Garrett et al. sought to understand the clients' perception of the treatment they received while enrolled at an outpatient therapy facility. They found that 97% of all group members identified their treatment experience as positive (Garrett, Oliver, Wilcox, & Middleton, 2003). Most importantly, they found that about half of all clients preferred group therapy to individual therapy, with only about 13% identifying individual therapy as preferable. Specifically, the researchers found that group

members believed that sharing thoughts, supporting, learning, and relating to others were the most beneficial components to treatment and their individual recovery.

Researchers have found that recidivism rates among sexual offenders enrolled in individual treatment and group treatment do not significantly differ from one another (Looman, Abracen, & Fazio, 2014; Serran, Marshall, Marshall, & O'Brien, 2013). However, group treatment does appear to offer unique benefits in comparison to individual treatment. According to Looman et al. (2014), group treatment was more time consuming as group members were more likely to identify factors that contribute to reoffending (pro-offending attitudes, deviant arousal, and antisocial orientation) and develop new social skills. In addition, group treatment allows group members to focus on social and relationship skills by sharing thoughts and learning from others. Serran et al. (2013), through their meta-analysis, found that there were more benefits to running group treatment that make it somewhat different than individual treatment. They found the following benefits: (1) therapists are able to treat far more offenders; (2) group treatment can be offered at a lower cost; (3) offenders can benefit by learning from others; (4) offenders develop trust and social support from a group; and (5) offenders are able to deal with issues they may have, such as shame, anxiety, and antisocial orientation.

Sexual Offender Treatment and Recidivism

Since group treatment seeks to target proximate outcomes to see whether treatment brings about change, researchers have used these mechanisms to measure if those participating in treatment have been successfully treated. Typically, researchers have focused on the concept of recidivism to understand the effectiveness of sex offender treatment. Recidivism is a concept that is measured by whether an individual has been rearrested and reconvicted for a new sexual offense (Harris & Hanson, 2004). To evaluate the efficacy of group sex offender treatment,

researchers have primarily focused on measuring recidivism rates post-treatment. Marques et al. (1994) conducted one of the few early studies yielding promising results regarding the effectiveness of group treatments. Interested in the effectiveness of group cognitive behavioral treatment among sex offenders, Marques et al. (1994) chose to examine three groups: a treatment group, a volunteer control group, and a non-volunteer control group. Treatment group subjects were sex offenders who volunteered for the treatment program and were randomly selected for the treatment program. Volunteer control group subjects were sex offenders who volunteered for the treatment program but were not randomly selected for treatment. They were matched to the treatment subjects on the characteristics of age, offense type, and criminal history. Non-volunteer control group subjects qualified for the program but chose not to participate. Like the volunteer controls, they were matched to the treatment subjects on the characteristics of age, offense type, and criminal history. The researchers found promising results, with treatment subjects being less likely to commit new sex offenses than non-volunteers. Marques et al. (1994) found that the treatment group had a sexual re-offense rate of 7.9%, the volunteer control group had a sexual re-offense rate of 10.1%, while the non-volunteer control group rate was 12.8%. In addition, researchers found that early treatment dropouts were at a greater risk for committing new sex crimes, than were those who stayed in the group program for a year or more.

In 2005, Losel and Schmucker completed a meta-analysis of 80 comparisons between treatment and control groups containing a total of more than 22,00 individuals. Known as one of the largest meta-analyses, Losel and Schmucker (2005) assessed the effectiveness of sex offender treatment by examining 69 studies. Losel and Schmucker (2005) found significant differences between treated and untreated offenders, with an average sexual recidivism rate of 11.1%for treated sex offenders and 17.5%for untreated sex offenders, based on an average

follow-up period of just over 5 years. According to Losel and Schmucker (2005), treated offenders were able to reflect and visualize goals and think about techniques that allow them to arrive at a better self-understanding of their actions. Lastly, Losel and Schmucker (2005) found that sex offenders who complete treatment in one of the three invention mechanisms (including cognitive behavioral therapy, behavioral therapy, or psychological therapy) had lower rates of recidivism than those offenders who dropped out or went untreated. A lack of completed treatment doubled the odds of recidivating.

Examining sex offenders in group settings, MacKenzie (2006) and Hanson et al. (2009) also found that treated sex offenders have lower rates of recidivism than untreated offenders. MacKenzie (2006) found that treated sex offenders had a sexual recidivism rate of 12%after enrolling in group treatment compared to untreated sex offenders who recidivated at a rate of 22%. MacKenzie (2006) also found that the use of relapse prevention treatment, cognitive-behavioral treatment, behavioral treatment, and even hormonal medication had a significant impact on sex offenders as it reduced the rate of sexual recidivism. According to MacKenzie (2006), relapse prevention treatment, cognitive-behavioral treatment, behavioral treatment, and even hormonal medication had better human service delivery, allowing facilitators to teach to the needs of each offender as well as target criminogenic and dynamic risk factors among sex offenders. Ultimately, by focusing on the individual changes or cognitive transformation, offenders will experience a significant change in their criminal lifestyle over time (MacKenzie, 2006).

Hanson et al. (2009) also found similar results in their comparative study, finding that treated offenders were less likely to recidivate after experiencing group treatment. On average, treated sexual offenders had a sexual and overall recidivism rate of 10.9%, and 31.8%based on a

follow-up period of 4 years. In comparison, untreated offenders had an average sexual and overall recidivism rate of 19.2%and 48.3%. Hanson et al. (2009) found that treatment programs adhering to the risk-need-responsivity (RNR) (i.e. whether or not treatment components bring about change) principles of effective intervention increased treatment effectiveness. Ultimately, treatment programs that adhered to criminal thinking/cognitive restricting, self-improvement, management, and development of interpersonal or life skills were more likely to result in effective outcomes among sex offender groups.

Harris and Hanson (2004) conducted one of the largest meta-analyses assessing the effectiveness of sex offender treatment. Harris and Hanson (2004) found that most sexual offenders do not reoffend over time. In most cases, 73% of sex offenders are not charged with, nor convicted of, another sex offense. However, when examining sex offenders' recidivism rates, Harris and Hanson (2004) suggest that not all sex offenders should be treated the same. Ultimately, higher risk sex offenders should have higher levels of intervention and supervision, while lower level offenders should receive a lower level of response and monitoring as it fits the needs of the offenders.

Limitations in Measuring Effectiveness

The effectiveness of sex offender treatment has long been an important research topic and has been extensively studied using a variety of methodological designs (Doren & Yates, 2008; Harkins & Beech, 2006; Keeling, Rose, & Beech, 2007; Losel & Schmucker, 2005; Marques, Nelson, West, & Day, 1994). These methodological designs include random assignment, descriptive studies, risk band analysis, incidental cohort, statistical control, change within treatment, and meta-analysis. However, in spite of the significant efforts and numerous studies, empirical evidence regarding the effectiveness of sex offender treatment may not be as

conclusive as many studies would suggest, because research has rarely evaluated effectiveness through understanding the perceptions of patients who are able to reflect on the content and treatment they receive. While a sufficient amount of studies would suggest that sex offender treatments have positive outcomes (Hanson & Bussiere, 1998; Jones & Tatman, 2007; Losel & Schmucker, 2005; Rice & Harris, 2003), some studies have methodological inadequacies and inconsistent results, which has created criticism regarding the efficacy of sex offender programs such as cognitive behavioral therapy, psychological treatment and behavioral therapy (Hanson, Steffy, & Gauthier, 1993; Looman, Abracen, & Nicholaichuck, 2000; Marques, Day, Nelson, & West, 1994; Miner & Dwyer, 1997).

Different methodological designs introduce different ways to examine the effectiveness of therapy, with varying outcomes. However, the flaws that are currently found in most studies originate from sampling issues. Some researchers have been found to manipulate their study's groups by only reporting their recidivism rates without capturing or using a comparison group of untreated offenders (Bate, Falshaw, Corbett, Patel, & Friendship, 2004; Miner & Dwyer, 1997). With no control group, researchers are not able to determine whether differences observed are actually due to the intervention or due to other factors. Also, most studies tend to select the less dangerous offenders for treatment and those who are believed to be less likely to recidivate or reoffend (Hanson & Bussiere, 1997). Hanson and Bussiere (1997) found that offenders who completed treatment are traditionally at lower risk of reoffending than those who do not participate in treatment, drop out, or fail out of treatment. This allows researchers to not only make assumptions, but to examine and record one-sided variable outcomes from non-controlled experiments that do not entirely constitute proof that treatment is effective.

Many studies also experience problems in their treatment and process components of their research. In an evaluation of sex offender treatment efficacy, researchers Harkins and Beech (2007) stated that although many studies provide adequate examinations about the ways treatment and intervention are applied to a particular sex offender group, many studies are biased because they do not allow a systematic examination of how well sex offenders adhere to treatment components.

Harkins and Beech (2007) also found an inconclusive outcome in a review of various methods (i.e. random assignment, descriptive, risk band analysis, incidental cohort, matched comparison, within treatment change, and meta-analysis) for examining treatment effectiveness. According to Harkins and Beech (2007), in most studies (Hanson, Steffy, & Gauthier, 1993; Looman, Abracen, & Nicholaichuck, 2000; Marques, Day, Nelson, & West, 1994; Miner & Dwyer, 1997), researchers were not considering treatment integrity, the inclusion of dropouts and refusers, the type of outcome variables examined, and acceptable length of follow-up. As mentioned previously, sampling issues in many studies created problems with internal validity because they did not take into account comparison groups to determine that differences observed are actually due to the intervention and not to other factors.

A review of existing research also indicates that the efficacy of sex offender treatment has primarily used recidivism as the measure of treatment effectiveness (Cabeen & Coleman, 1960; Hall, 1995; Harris & Hanson, 2004; Harkins & Beech, 2007; Nelson, 2007; Moertl, Buchholz, & Lamott, 2010). Using this outcome variable, the effectiveness of treatment is based solely on whether or not an offender reoffends over a particular period. In an evaluation of sex offender treatment efficacy, Furby et al. (1998) reviewed 42 comprehensive descriptive reviews and meta-analyses on treatment; they found that most researchers displayed no real evidence that

clinical treatment of sexual offenders, in general, could successfully reduce recidivism. Furby et al. (1998) found that studies are typically flawed in their group comparisons of treated and untreated offenders because they only examine trends and patterns based on single designs and data collection. Ultimately, researchers limit means of assessing multiple statistical differences between groups. Lastly, Furby et al. (1998) found that given the underreporting of sex offenses, many studies have been too short and need longer follow-up periods to examine if there are greater percentages of sex offenders who committed another sex offense or criminal offense. Furby et al. (1998) suggested that to examine the number of sex offenders who continued their sexual behavior, researchers would need long-term follow-up periods to obtain a greater understanding of recidivism rates and treatment effectiveness over time.

In an evaluation of sex offender treatment efficacy, researchers Jones and Tatman (2007) found methodological flaws were inherently associated with examining sex offender treatment and could lead to inconclusive treatment effects when measuring rates of recidivism. According to Jones and Tatman (2007), sexual reoffending is relatively low, as compared with other types of offending behavior, with recidivism rates ranging from 20% to 30% (also see Hanson & Bussiere, 1997; Prentky & Lee, 2007). Similar studies examining sex offenders often use quasi-experimental designs, which seek to identify a comparison group that is as similar as possible to the treatment group. Measures of recidivism simply assess whether a person returns to prison for another sexual offense. While there is no right measure of recidivism, studies have commonly used comparison and pre- and post-test analysis. Unfortunately, empirically identifying a significant treatment effect would require researchers to identify a large comparison group to compensate for this low rate of reoffending. By using comparison groups, researchers can capture what would have been the treatment outcome if a subject did not experience the program.

Ultimately, the treatment would be responsible for any differences in outcome between the treatment and comparison groups.

Farrugia et al. (2011) state that the design of any study should be chosen based on the specific question(s) and hypotheses to be investigated. A very broad question also makes it difficult to calculate a specific sample size and choose the outcome variable (Farrugia, Petrisor, Farrokhyar, & Bhandari, 2010). In some cases, the process by which researchers arrange the comparison group is inappropriate. For instance, for some studies it is not proper to withhold the program from one group while it is being given to another. As studies seek to acquire large sample sizes, some subjects do not meet the criteria for one single treatment category. Another issue with acquiring a comparison group is that different individuals function under different environmental influences. Since many subjects may not come from one location, selecting a comparison group can often be challenging as a subject's environmental difference may influence the individual's willingness to participate or follow protocols of the program. Assigning participants to a comparison group may create a great chance of selection bias within the selection process.

Jones and Tatman (2007) also suggest that simply measuring treatment efficacy through rates of recidivism is difficult because only a small fraction of all sexual offenses is reported and of those reported only a small segment is prosecuted, causing a natural bias in the data. Therefore, only 20% of offenders will be reported and re-arrested or re-convicted for another sexual act, leaving 80% of the offender treatment effectiveness unidentifiable (Jones & Tatman, 2007). As mentioned, quasi-experimental design is the primary approach to evaluate treatment effectiveness, using a comparison of pre-test and post-test measures that examine how treatment programs work over time. To conduct a large study with a perfectly randomized treatment and

comparison group, researchers must implement treatment follow-up, which allows researchers to analyze if the treatment received helps participants in their recovery. However, the criticism regarding follow-up periods are often due to the length of the follow-up itself (Lievore, 2003). Researchers who have used experimental design have used follow-up periods ranging from 1 to 5 years. However, many studies indicate that when examining sexual recidivism usually 5- to 10-year follow-up periods are generally regarded as adequate (Lievore, 2003). Typically, longer follow-up periods compensate for delays between arrest and conviction, as the observation periods are wider. Most studies acknowledge the need for a long follow-up period, but only a few are able to implement these measures (Lievore, 2003). This is largely due to budget, relocation of participants, and personnel to track offenders during the study.

Therefore, the lack of methodologically sound studies does not permit the conclusion that sex offender treatment reduces recidivism (Doren & Yates, 2008; Harkins & Beech, 2006; Keeling, Rose, & Beech 2007; Losel & Schmucker, 2005; Marques, Nelson, West, & Day, 1994). Harkin and Beech (2007) stated that to overcome some of the shortcomings of recidivism outcomes, researchers must examine more proximate outcomes, such as change within treatment, to provide a better understanding of the usefulness of treatment. Often the results from comparison groups and control groups alike are one-dimensional as they look at one effect of the intervention (commonly recidivism). Ultimately, this suggests that other research methods and outcome variables are needed to understand the causes of reoffending after participation in a treatment program.

Researchers have argued that other outcome measures can contribute to an understanding of the effectiveness of sex offender treatment. In 2010, researchers Moertl et al. found a positive treatment effect in a qualitative data analysis involving 11 male sex offenders from a group

treatment setting in Germany. Specifically, the researchers examined 21 videotapes of the prison group's therapy sessions where offenders talked about their crimes and other personal stories. The treatment used in this study sought to enable understanding and insight into intra and interpersonal conflicts, relating to the offenders' crimes, thus trying to provide better strategies regarding social behavior, self-esteem, and unsolved internal conflicts (Moertl, Buchholz, & Lamott, 2010). Moertl et al. (2010) found that psychotherapy and behavior modification treatment allowed sex offenders to talk about and reflect on techniques that allow them to arrive at a better self-understanding of their actions. Ultimately, Moertl et al. (2010) found that after treatment, offenders had increased accountability, self-image, and personal responsibility by approaching their individual images and relationship fantasies, which allowed them to reflect and visualize goals. Arguably, research would suggest that increasing accountability and personal responsibility, and allowing offenders to understand their sexual arousal, would help prevent recidivism. According to Hanson and Morton-Bourgon (2015), major predictors of general and violent recidivism were variables associated with antisocial orientation and sexual arousal. Sexual deviancy and antisocial orientation are major predictors of sexual recidivism because they are strongly associated with rule violation and impulsive behavior, reckless behavior, and willingness to engage in risk/unsafe practices. Ultimately, as treatment groups focus on major predictors of recidivism that are associated with pro-offending attitudes, antisocial orientation, and sexual arousal, this should decrease rates of recidivism as treatment seeks to identify and change characteristics of persistent sexual offenders.

In 2007, Jones and Tatman examined sex offenders sanctioned to 24 months of outpatient group treatment; they found that by participating in the treatment group, sex offenders significantly improved in their personalities. Specifically, the researchers found that after being

in the treatment program, offenders had improved in their emotional and cognitive maturity (Jones & Tatman, 2007). Also, offenders who originally had difficulty with distorting reality to fit their wants and needs later illustrated the ability to identify and process personal thought and feelings, and improved their levels of self-esteem and interpersonal interaction with others. Since improvements in psychological and interpersonal behavior were factors known to predict sexual recidivism, Jones and Tatman (2007) indicate that these positive changes were positive indicators that sex offender treatment effectively impacts criminogenic factors such as sexual reoffending.

Satisfaction

Although recidivism is the most identifiable outcome measure of treatment effectiveness, some researchers have argued that measures other than recidivism can contribute to an understanding of the effectiveness of sex offender treatment. Some examples include client attainment of therapeutic goals, treatment implementation, therapist characteristics, and in-treatment behavioral changes (Levenson, Macgowan, Morin, & Cotter, 2009; Levenson, Prescott, & D'Amora, 2010; Levenson, Prescott, & Jumper, 2014; Marshall et al., 2002; Marshall, 2005). However, with clinical debates about the efficacy of sex offender treatment, this begs the question of how patients feel about their treatment, what they find to be most important, and what can be learned from patients' thoughts. Only a few studies have examined the perspective of sex offenders themselves and factors that contribute to successful treatment such as engagement and satisfaction (Levenson, Macgowan, Morin, & Cotter, 2009; Levenson, Prescott, & D'Amora, 2010; Levenson, Prescott, & Jumper, 2014). Levenson et al. (2009, 2010, & 2014) found that through understanding measures of engagement and satisfaction, researchers

could understand key factors that may eventually contribute to the possible success and efficacy of sex offender treatment.

Using the rationale of Levenson et al. in their numerous studies, this study argues that obtaining views of sex offenders can add to the limited research about sex offender treatment and improve treatment effectiveness overall. Since sex offenders are the targeted audience when examining sex offender treatment, its only appropriate to explore their individual thoughts of the treatment they are receiving daily. Measurements of satisfaction have been one of the most common ways to assess the thoughts of people of all sorts. For example, commercial enterprises have used satisfaction surveys to assess the way consumers view the services they have received or products they purchased (Levenson, Prescott, & D'Amora, 2011). Satisfaction measures have also been used in the world of treatment, especially among sex offender treatment groups. In 1995, using a consumer report survey, researcher Martin Seligman analyzed data from a group of patients who responded to a survey about their experiences in psychotherapy. Seligman (1995) found that a large majority of clients reported that psychotherapy helped, and that through therapy they experienced a reduction in symptoms and an increase in their overall well-being. Seligman (1995) specifically found that consumer report surveys not only showed how the treatment worked, but how participants felt about the process, by capturing measures of self-reported changes, interpersonal relations, well-being, insight, and growth. Seligman (1995) also found that consumer report surveys leave little doubt about the human significance of their findings because respondents answered questions directly about how much therapy helps the problem that led them to treatment. Lastly, Seligman (1995) stated that consumer report surveys overall have the ability to assess the effectiveness of psychotherapy and many other treatment types, as it is performed in the field with the population that seeks positive treatment outcomes.

Hartman and Zepf (2003) also found consumer report surveys to be successful with their replication of Seligman's 1995 study. Using a sampling 2,147 German patients, Hartman and Zepf (2003) sought to assess the effectiveness of several kinds of psychotherapeutic treatment of psychological disturbances from the patients' viewpoint. This includes the process, the content, duration, and resources/benefits. Using a consumer report survey Hartman and Zepf (2003), "found that patient's positive relationship between duration of treatment and rate of improvement, long-term produced more changes in behavior than short-term therapy, with an overall improvement with 7-11 months' treatment as well as with more than 2 years of treatment" (p. 236).

Levenson et al. (2009) used a consumer satisfaction survey constructed of questions drawn from previous surveys asking about clients' perceptions of various components of cognitive behavioral treatment in several domains (importance and satisfaction). Using the consumer satisfaction survey, Levenson et al. (2009) found that sex offenders believed treatment to be helpful in learning to prevent re-offense. Levenson et al. (2009) also found that a majority of patients reported that they were comfortable in their treatment and agreed that program policies and procedures about tardiness, attendance, and successful completion were clear and fair. Approximately 75% of the participants felt that they needed to be in treatment and they enjoyed the treatment program better than they originally thought they would. Lastly, Levenson et al. (2009) found that a vast majority of patients rated their experience in a treatment program as positive, and felt that they gained a great deal of understanding about their past issues and patterns. They also believed that learning how to meet their needs in more adaptive ways and to create more satisfying lives for themselves were very important.

Using a consumer satisfaction survey, Levenson et al. (2010) surveyed 88 adult male sex offenders, and Levenson et al. (2014) surveyed 123 adult male sex offenders about their level of satisfaction with the treatment received. According to their findings, a majority of participants rated treatment processes as very important. Levenson et al. (2010; 2014) found that participants believed the most helpful items within their treatment program were: accepting responsibility, victim empathy, understanding triggers and factors, relapse prevention, and learning how to create a more rewarding life for oneself. Patients also found support and help from other group members to be the most useful to their recovery (Levenson, Prescott, & D'Amora, 2010). Similar to previous studies (see Levenson, Macgowan, Morin, and Cotter, 2009), Levenson et al. (2010; 2014) found that a majority of respondents agreed that program policies and procedures concerning tardiness, attendance, and successful completion were clear and fair.

While some studies have found positive outcomes from a consumer satisfaction survey (Levenson, Macgowan, Morin, & Cotter, 2009; Levenson Prescott, & D'Amora, 2010; Levenson, Prescott, & Jumper, 2014; Marshall et al., 2002; Marshall, 2005), some scholars have argued that consumer satisfaction surveys have methodological limitations (Seligman, 1995; Goldfried & Wolfe, 1998). These limitations include sampling bias, lack of control groups, and inadequate outcomes. However, unlike many other research designs, consumer satisfaction surveys are not only able to examine the efficacy of treatment programs, but also capture how and to whom treatment is delivered (Seligman, 1995). Therefore, in this study, I do not seek to address all these flaws, but to simply examine the satisfaction based on upon the research question used to inquire on the perception of patients. Sampling bias, control groups, and inadequate outcomes are not a concern because each subject had the opportunity to participate and express true thoughts of the treatment without being forced by another individual.

Group Engagement

Similar to consumer satisfaction, group engagement methods (GEM) can also inform researchers and improve treatment effectiveness (Levenson, Macgowan, Morin, & Cotter, 2009; Levenson Prescott, & D'Amora, 2010; Levenson, Prescott, & Jumper, 2014; Macgowan 1997; Macgowan & Newman, 2005). Since most sex offenders do not enter treatment voluntarily, but are mandated to treatment by the court system, many offenders may initially lack interest and only feel compelled to enter treatment to escape legal consequences and remain out of incarceration. Ultimately, offenders may only be compelled to attend treatment but not be as engaged in the overall structure of the treatment program. In 1997, researcher Mark J. Macgowan chose to examine the role of group engagement through assessing the process of group work and levels of engagement for members of therapeutic groups. This led to the creation of a GEM that can be used in therapeutic settings to understand treatment groups (Macgowan & Newman, 2005). Macgowan (1997) developed a 37-item GEM arranged across seven dimensions: (1) attendance, (2) contributing, (3) relating to the worker, (4) relating with members, (5) contracting, (6) working on their own problems, and (7) working on other members' problems. Using a confirmatory factor analysis involving a combined clinical and nonclinical sample of 207 adults, Macgowan and Newman (2005) found that two of the seven dimensions, attendance and contracting, contributed marginally to the engagement model, "while the five dimensions of contributing, relating to worker, relating with members, working on own problems, and working on other members' problems appeared to be the most robust elements of engagement across groups, as group members may engage in some areas more than others" (p.113).

In two separate studies, Levenson et al. (see Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009) used Macgowan's original 1997 Group Engagement instrument to measure the level of engagement of offenders and to examine the relationship between engagement in group therapy and satisfaction rating. Levenson et al. (2009; 2010) found a significant relationship between engagement and treatment satisfaction by calculating the bivariate correlation between the total GEM score and the overall satisfaction subscale. Specifically, Levenson et al. found that the strongest correlations were between engagement and the satisfaction scales related to process and group therapy, suggesting that a positive, empowering therapeutic environment fosters engagement and leaves clients feeling satisfied with the services they receive (Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). Levenson and Macgowan (2004) found that engagement in treatment was indirectly correlated with denial and positively associated with treatment progress. Levenson and Macgowan's (2004) results show that sex offenders who were more actively engaged in treatment had significantly higher levels of accountability, less distorted thinking or pro-offending attitudes, and displayed increased progress toward treatment goals.

Satisfaction and Engagement

As noted earlier, sexual offender treatment remains controversial with some studies calling into question its effectiveness; ultimately, this has prompted researchers to analyze the relationship between engagement and satisfaction (Bate, Falshaw, Corbett, Patel, & Friendship, 2004; Levenson & Macgowan, 2004; Levenson, Macgowan, Morin, & Cotter, 2009; Levenson, Prescott, & D'Amora, 2010; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005; Miner & Dwyer, 1997). When an offender engages in the therapeutic process, the more satisfied the offender is with the treatment and its practices, which are relevant for reducing recidivism

risk (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009).

A majority of researchers also found that by gathering the perspective of therapy patients, they will be able to learn how to meet the needs of these individuals in more adaptive ways and create more satisfying lives for sex offenders. As mentioned earlier, engagement and satisfaction have been examined to understand sex offenders' outcomes and treatment progress. Levenson and Macgowan (2004) found that sex offenders who indicated that they were engaged and were satisfied with treatment had greater levels of accountability and less distorted thinking about their offenses, which creates more progress toward treatment goals. Levenson et al. (2014) also found that when an offender is engaged and satisfied with the treatment process and experiences a true connection, the offender could become more motivated to develop and practice skills that are relevant for reducing recidivism risk.

Treatment Variables and Recidivism

While Levenson et al. (2004; 2010; 2014) highlight the importance of satisfaction and engagement, other studies have surveyed clients to measure direct and indirect constructs that may have direct correlations to lower rates of recidivism. Previous studies have found that indirect mechanisms such as group cohesion, motivation, and accountability, which are positively correlated with satisfaction, tend to decrease rates of recidivism among sex offenders (Beech & Hamilton-Giachritsis, 2005; Mullen & Copper, 1994; Shea & Sedlacek, 1995; Yalom, 1995).

A number of studies have described cohesiveness as indirect in nature as it indirectly relates to predictor variables such as dropout rates and wanting to stay in the group. Shea and Sedlacek (1997) completed a correlation analysis regarding differences in group cohesiveness

and client satisfaction in therapy; they found that both variables showed to have a significant, positive correlation. Shea and Sedlacek (1997) found that as cohesion within the group process increased, so would a client's level of satisfaction. Ultimately, this level of satisfaction would affect an offender's rate of attendance in treatment and the probability of reoffending during or while enrolled in the treatment group. Since variables such as attendance impact how much knowledge offenders retain, learn, and most importantly, how willing they are to change, indirect satisfaction can potentially reduce the likelihood of reoffending among offenders (Shea & Sedlacek, 1997).

Conceptual Framework

This study explores the relationship between engagement in treatment and satisfaction in a group therapy program. Previous studies have found correlations between engagement and satisfaction by looking primarily at urban areas and using self-report measures of satisfaction and engagement (see Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). The current study seeks to add to the literature by exploring the relationship between group engagement and offender satisfaction in a rural area, moving away from self-reports of engagement that can be misleading, and instead using a measure of group engagement through a facilitator report of participation in a group. While Levenson et al. (2009; 2010; 2014) found positive results when examining engagement through self-report measures, this study seeks to move beyond self-reports of engagement because of the issues with over desirability and the possibility that offenders overreport the level of engagement in the treatment program. Using facilitator-completed monthly progress reports, this study seeks to identify a possible relationship between engagement and satisfaction because (1) the fewer absences a patient has will ensure that the individual receives treatment information; (2)

participation rating scores will show how active an offender is in treatment; and (3) phase in treatment will dictate how far along and possibly adjusted to the treatment program an individual is. Ultimately, this study seeks to contribute to the literature by bringing light to rural environments and sex offender treatment programs in these environments. Typically, research has been examined in urban environments where large sample sizes can easily be obtained (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). However, this study believes it is important to look at sex offender treatment in all environments to ensure that all treatment programs seek to reduce rates of recidivism and help offenders who are enrolled in these programs.

Patient satisfaction and engagement are also important to the foundation of this study. As stated in previous sections, exploring satisfaction and engagement provides us an understanding of the treatment process. First, satisfaction is the best indicator of each patient's opinion on the treatment received (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). Asking patients to rate their level of satisfaction with the treatment program in a survey allows the facilitators and researchers to understand whether they are satisfied with the service, whether they find it important, and whether they are at risk of dropping out. Patient satisfaction is also important because it can help improve services and prevent treatment failure (Levenson, Prescott, & Jumper, 2014). Also, by understanding patients' level of satisfaction, researchers can identify the least helpful and the most helpful components in treatment.

Patient engagement is also an important part in the prevention of recidivism. In most cases, treatment programs are created with the patients' perspectives in mind and are encouraging greater patient participation to ensure development and growth. Researchers have

also found that engagement leads to a reduction in health care cost, improves patient outcomes, and most importantly motivates patients to develop and practice skills that are relevant for reducing recidivism risk (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). According to Levenson et al. (2014), actively engaging in treatment also indicates increased levels of accountability and less distorted thinking about crime, and more progression toward treatment goals.

Although engagement and satisfaction are two separate variables, when patients are more satisfied and engaged, it establishes an atmosphere in which patients are more likely to trust one another, treatment facilitators, and the treatment itself (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). Examining the effects of engagement on satisfaction means a better understanding of treatment and the potential effects of treatment.

Unlike past research, this study uses a self-report of satisfaction, but a facilitator report of engagement. In previous studies, researchers have highlighted potential issues with self-reports of engagement. It is relatively evident that participants are less likely to be dishonest about their satisfaction with treatment because it only reflects their personal needs, emotions, and feelings. Since self-reports of engagement showed to be a limitation in previous studies, this study has chosen to use facilitator report of engagement because the document is something that has been used in the facility and is recorded by trained personnel. Since each facilitator does not have a specific agenda when recording information, there is less chance of bias because it is simply a form required by the Blue Counseling Center.

Chapter 3

Procedure

The data utilized in this research comes from clients attending sex offender treatment programs in Virginia. Between January 16, 2017 and February 9, 2017, I visited five counseling centers throughout Southwestern, Virginia to gather information on satisfaction and engagement. Before entering each facility, I was given permission by the owner and operating officials of the Blue Ridge Counseling Center to attend group therapy sessions to ask patients if they would be willing to participate in a study designed to explore their satisfaction with the sex offender treatment they were currently attending. Upon entering each group therapy session, the group facilitator would introduce me to the treatment group. After being introduced to the group, the introductory script was read to all patients who were in attendance. The statement read: "this study is conducted independent of the Blue Ridge Counseling Group, and there will be no penalties for not participating and all information you give will remain confidential except when required by law to disclose. You can choose not to be in this study. If you decide to be in this study, you may choose not to answer certain questions or not to be in certain parts of this study. If at any time, you want to stop being in this study, you may stop being in the study without penalty or loss of benefits by speaking with myself or the Radford University's Department of Criminal Justice during the group session".

After reading the introductory script, an informed consent sheet was handed out to all patients in attendance (see Appendix A). Patients were asked to read over the consent form carefully and ask any questions they may have. Once questions were addressed, those who were willing to participate were given writing utensils to sign the forms and return it. Those who consented to completing the satisfaction survey, allowing me access to their facilitator-completed

monthly progress report to examine level of engagement, were then handed the satisfaction survey. After each patient completed the satisfaction survey, each individual was asked to bring the consent form and survey to the front of the room where each survey and consent form was given a participant ID for confidential purposes. Upon adding a participant ID, each survey and consent form was separated into different sealed folders. Lastly, monthly progress reports were assessed to record each consenting patient's number of absences, participation rating score, and phase in treatment. Progress reports were completed by the group facilitators once at the start of each month that the offender was in treatment. Only the most recent monthly progress report was collected from the facility.

Data and Methods

Data Collection

Data for this study has been gathered from a consumer satisfaction survey and monthly progress reports. The consumer satisfaction survey was administered to the sex offenders, but their group facilitator completed the monthly progress reports. Approximately one hundred surveys were distributed throughout eight groups to sex offender treatment clients, and the most recent monthly progress report of those who volunteered to participate in the study was collected to examine their current status of engagement and satisfaction. Each survey contains seven domains about satisfaction, which serve as my main dependent variable. The research participants were guaranteed confidentiality although they were asked to write their names on the informed consent form to identify each participant's file. None of their identifying information was linked with their responses. Surveys were distributed and returned during a regularly scheduled group therapy session. Each patient's most recent progress report was assessed independently and recorded quantitatively after the collection of each sex offender's survey. The

monthly progress reports are documents used by the counseling center to evaluate each sex offender's progress while in treatment. This study examines each patient's most recent progress report, which reflects the four group therapy sessions that occurred throughout the month. As documented, each participant's monthly progress report is a critical tool for evaluating engagement because it helps to demonstrate the total number of absences over the course of treatment, lists the participation rating score based on four independent therapy sessions, and how far along this individual is in the treatment process. Through the use of both the consumer satisfaction survey and monthly progress report, this study examined the relationship between group engagement and satisfaction among sex offenders.

Instrumentation

The survey instrument employed in this research is a consumer satisfaction survey (see Levenson, Macgowan, Morin, & Cotter, 2009; Levenson & Prescott, 2009; Levenson, Prescott, & D'Amora, 2010; Levenson, Prescott, & Jumper, 2014), in which three domains are used to assess clients' perceptions of (1) treatment importance, (2) treatment satisfaction, and (3) satisfaction with treatment components while attending the Blue Ridge Counseling Center. Dr. Jill S. Levenson and colleagues developed the survey by drawing from questions described in previous surveys used in sex offender research and adding other questions not used in prior research (Levenson, Macgowan, Morin, & Cotter, 2009; Levenson & Prescott, 2009; Levenson, Prescott, & D'Amora, 2010; Levenson, Prescott, & Jumper, 2014). The survey inquires about a patient's level of satisfaction with various components of sex offender treatment, including process, therapists, policies, content, and overall treatment requirement. Levenson et al. (2009; 2010; 2014), in three separate studies, have found the consumer satisfaction survey to have high internal consistency (Cronbach's alpha of 0.84 and higher in all three domains).

The first domain in the consumer satisfaction survey (treatment importance) includes 20 items asking about the importance of the treatment content at the Blue Ridge Counseling Center to each patient's recovery, rated on a 5-point scale ("not important" to "very important"). These 20 items have been summed together to create a subscale of "content importance."[1] The second area in the treatment importance domain includes five items asking about the importance of the group process at the Blue Ridge Counseling Center to the patient's recovery, rated on a 5-point Likert scale ("least important" to "most important"). These five items also created a subscale called "group process importance."

The second domain in the consumer satisfaction survey is treatment satisfaction. This section includes 20 items asking patients to rate their satisfaction with treatment at the Blue Ridge Counseling Center using a 5-point Likert-type scale ("not helpful" to "very helpful"), creating a "content satisfaction" scale. The second area in the treatment satisfaction domain includes five items asking about how satisfied each patient is with the group process areas at the Blue Ridge Counseling Center, rated on a 5-point Likert scale ("not helpful" to "very helpful"). These five items also created a subscale called "process satisfaction."

The third domain measured satisfaction with program components, which includes 32 items rated on a 5-point Likert scale ("strongly disagree" to "agree strongly"). It included eight items about a patient's satisfaction with group therapy. Patients were also asked about their level of satisfaction with individual therapy (5 items). Next, patients were asked to disclose their satisfaction with the group leader (10 items). Patients were also asked to rate their level of satisfaction with the program policies and procedures (9 items). The final subscale asked patients

[1] A factor analysis was not implemented because the sample size was not large enough to run this analysis.

to rate their overall satisfaction with the Blue Ridge Counseling Center (5 items). The final sections of the consumer satisfaction survey asked for a patient's background information; these included age, race, income, education, length in the treatment program, criminal background, and victim characteristics.

Independent Variables

Although some researchers have attempted to examine group engagement using a validated measure of self-reported level of engagement in treatment (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009), a self-report group engagement measure may not have high validity among sex offenders. Sex offenders in treatment may be more motivated to portray themselves in a positive light than the traditional psychiatric populations for which the group engagement measure was developed (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). In this study, monthly progress reports have been used to assess the patient's level of engagement in treatment. The monthly progress report is already implemented in all Blue Ridge Counseling Center facilities throughout Virginia.

In this study, I have identified three independent variables from the monthly progress reports used by the Blue Ridge Counseling Center; all three independent variables assess the concept of group engagement. The first independent variable collected from the monthly progress reports is the total number of absences since the onset of treatment. The second independent variable collected from the monthly progress reports is the facilitator's participation rating score. This measure examines each offender's level of engagement in treatment by rating the offender's participation on a 4-point Likert scale from (1) "participation in group is mostly negative and characterized by behaviors such as blaming, complaining, poor response to

confrontation, failure to complete homework assignments and using group time on nonconstructive discussions" to (4) "participation in group includes not only discussing his/her issues and presenting treatment work but by keeping the group focused, effectively confronting peers, encouraging peers and taking an active role in orienting new grow members." The final independent variable is the phase of treatment to which each offender has currently progressed.

Dependent Variable

The dependent variables are based on the seven domains indicated in the self-report satisfaction survey that seeks to measure patients' satisfaction with the treatment they received at the Blue Ridge Counseling Center. As mentioned previously, a reliability analysis was run to examine internal consistency among items in each domain. Through the use of the reliability analysis, the majority of the domains (see results) in the satisfaction survey used in this study had a high level of internal consistency (Cronbach's alpha scores of 0.8 or higher). Patients have been asked a series of questions represented in each of three domains of the consumer satisfaction survey labeled as treatment importance, satisfaction, and satisfaction with treatment components. As mentioned before, patients are invited to rate their perspective of treatment importance, satisfaction, and satisfaction with treatment components on numerous 5-point Likert scales.

Control Variables

Several control variables that were used in previous studies by Levenson et al. have been included in this analysis (Levenson, Macgowan, Morin, & Cotter, 2009; Levenson & Prescott, 2009; Levenson, Prescott, & D'Amora, 2010; Levenson, Prescott, & Jumper, 2014). As a part of the implementation of the survey, patients have been asked to give background information.

These include age, race, education level, time in treatment, group location, facilitator ID variable, whether they have been in treatment before, type of offender, and gender of victims.

Analytic Strategy

In this study, participant satisfaction with group treatment was examined by looking at the overall mean scores from each domain in the satisfaction survey component. I also examined background information about the sample such as age, race, education, length of time in treatment, employment, facilitator ID, and group location using descriptive statistics/frequencies.

In this study, my three independent variables, (1) number of absences (continuous), (2) facilitator's participation score (continuous), and (3) phases in treatment (categorical), were also examined using descriptive statistics. The continuous variables, number of absences and the participation rating score, have been examined using measures of central tendency and measures of variability, while the categorical variable has been reported using the frequency of each value.

Since this study is testing whether engagement is related to patients' level of satisfaction, I first ran a correlational analysis to determine whether the dependent variables, independent variables, and control variables were significantly correlated. Before running the correlation analysis, phase in treatment was recoded into three dummy variables to examine each phase separately. I created a "Phase 3" variable with 0 equaling all other phases and 1 equaling the individual is in phase 3. The "Phase 2" variable had 0 equaling all other phases and 1 equaling the individual is in phase 2. The "Phase 1" variable had 0 equaling all other phases and 1 equaling the individual is in phase 1.

Using my total sample, bivariate correlations were used to examine the relationship between engagement variables (number of absences, participation rating score, and phase in treatment), satisfaction variables, and control variables, including age, race, education, time in

treatment, group location, and group facilitator ID. If necessary, significant bivariate correlations were followed up with a one-way analysis of variance.

Chapter 4

Results

The counseling centers visited were in Covington, Martinsville, Radford, Roanoke, and Rocky Mount, Virginia (see Table 1). All of these locations are rural areas (excluding Roanoke) and made up of a predominantly White/Caucasian demographic (United States Census, 2017). All treatment centers were only visited once to minimize the amount of time taken away from the treatment process. All patients who were absent the day of the survey did not have the chance to participate. Patients who did attend the counseling center were asked to participate in the study, and of those asked to participate, only those who voluntarily agreed to participate are currently represented in this study. Among all five counseling centers, there were more than 75 total patients that were asked to participate within this study. Each treatment group was facilitated by one of four staff members; all are licensed therapists and Certified Sex Offender Treatment Professionals (CSOTP). Two thirds of all current facilitators have been leading the current treatment groups for more than six months or longer. Group facilitator 1 led a majority of the treatment groups; facilitator 1 led a group for 63.60% of the patients. Approximately 27.2% of the patients were instructed by group facilitator 2 or group facilitator 4, and 9.1% of all patients were instructed by group facilitator 3 (see Table 2).

The sample consisted of 44 adult male sex offenders (see Table 3). A majority of patients were White (77.3%) and between the age of 25 and 49 years old. Almost half (40.9%) of all patients have never been married, and 29.5% were currently married. More than half (56.8%) of the patients were high school graduates or earned their GED, and 29.5% were college graduates. About 52.2% earned an annual income of less than $19,000 per year.

About 40% of participants reported that they spent 6 months to 1 year in treatment, while only 11.4% reported spending more than 2 years in treatment. Most patients at the Blue Ridge Counseling Center remained in treatment for an average length of 2 years. Approximately 43.2% of participants reported that they had been in their current treatment program for up to 6 months to 1 year; 27.3% reported less than 6 months; 22.7% reported 1 year to 2 years; and 4.5% reported they had been in the current treatment program for more than 2 years. The percentage of current participants who reported that they had not been in a previous treatment program prior to entering the current program was 68.2%.

All of the sex offenders attending treatment at the Blue Ridge Counseling Center were convicted of felony sex crimes (i.e. aggravated sexual battery, indecent liberties, rape, and object sexual penetration) (see Table 4). All subjects reported being arrested at least one time, while the average number of arrests was estimated as 1.43. Approximately 75% reported having minor victims ages 17 years old and younger. More than half (52.3%) of patients reported having victims they knew but were not related to, 36.4% had a victim that was a family member, and 31.8% had a victim that was a stranger. A majority of patients reported having female victims (90.9%) and 15.9% reported victimizing a male. Percentages for the victim variables do not add up to 100% because some individuals indicated having multiple victims of varying relationships to the offender, as well as both male and female victims. Patients were also asked to disclose information regarding violence, and 77.3% reported that they have never used any form of force or violence when committing a sex offense. Almost all patients reported that they have never used a weapon during the commission of a sex offense (97.7%), while 15.9% reported that they have physically injured a victim while committing a sex offense. Patients were also to disclose their total number of victims, and they reported having at least one victim (although one patient

stated vicariously). However, the average number of victims reported by patients was 9.93. There were three patients who noted that they had more than 30 victims (one patient said he had more than 240 victims), which greatly skewed the mean of the number of victims reported.

While it may be considered a limitation that the treatment groups are both (1) in different locations and (2) have different facilitators, each treatment group is contracted through Blue Ridge Counseling Center and each group has specific guidelines and components sanctioned to help suppress sexual arousal, enhance accountability and victim empathy, and most importantly, behavior modification. Therefore, regardless of the treatment group, each of the eight groups should receive the same quality of therapy because each phase is designated to touch on a particular prevention method assigned by the counseling center. To account for different facilitators and locations, I created a group facilitator ID and group location ID variable. Ultimately, to control for each variable, I ran bivariate analysis to assess the relationship between the facilitator and location variables among other controlled variables as well as the engagement and satisfaction.

Descriptive Statistics for Satisfaction Survey

Descriptive statistics were used to obtain the results from each domain of the satisfaction survey (Table 5). Each domain uses content items relating to one of three content areas regarding patients' satisfaction with the treatment program. The first domain asked patients to rate what they found to be important within the treatment they received in each content area. Table 5 displays how patients rated content importance (Cronbach's alpha = 0.975). Patients were able to rate each content item on a scale of *not important* (1) to *very important* (5). Importance recorded a minimum score of 69 and a maximum score of 100. The mean for content importance was 90.67 (SD = 9.61). The majority of patients rated the content areas as very important with very

few indicating a single content item lower than somewhat important. The items that were noted to be most important were accepting responsibility, understanding the impact of sexual abuse on victims and others in the offender's life, and developing a relapse prevention plan. The items individuals rated as least important were basic life skills, basic human sexuality, and learning new relationship and communications skills.

The second domain was patients' level of satisfaction with the treatment they received in each content area (Cronbach's alpha = 0.959). Individuals could rate each content item on a scale that ranged from *not at all helpful* (1) to *very helpful* (5). Satisfaction recorded a minimum score of 31 and a maximum score of 100. The mean for content satisfaction was 87.78 (SD = 14.56). The majority of patients rated the content areas as very helpful, with very few indicating a single content item lower than somewhat helpful. The items that were most helpful were accepting responsibility, understanding the impact of sexual abuse on victims, understanding triggers and risk factors, understanding the impact of sexual abuse on victims and others in the offender's life, and developing a relapse prevention plan. The least helpful items were again basic life skills and basic human sexuality.

Patients were also asked to rate their level of satisfaction with the treatment components by examining separately their satisfaction with their treatment group, individual therapy, group leader, and the center's policies and procedures. Using a scale that ranged from *strongly disagree* (1) to *strongly agree* (5), patients disclosed their level of comfort and degree of trust in the treatment group. Group treatment recorded a minimum score of 22 and a maximum score of 40 (Cronbach's alpha = 0.781). The mean for group treatment was 33.69 (SD = 4.24). Approximately 56.3% of patients agreed that they had a high level of comfort with the treatment group. Over half of patients also strongly agreed that they felt comfortable participating (54.5%)

and helping others (56.8%) while in group. When examining patients' trust with the group, 70.5% of patients stated that they agreed or strongly agreed that they trusted the other members in their group.

Individual therapy recorded a minimum score of 5 and a maximum score of 21 (Cronbach's alpha = 0.498). The mean for individual therapy was 14.90 (SD = 4.05). When asked about their satisfaction with individual therapy, the majority (63.6%) of patients stated that they never attended individual therapy at any given time. On the other hand, 13.6% stated that they have attended therapy and do so once per week; 11.4% went a few times per year; 6.8% rarely attended; and 2.3% said they attended individual therapy once or twice per month. However, when asked about if they wish they could attend individual therapy more often, patients' responses were spread out. About half (45.4%) of patients said that they agreed or strongly agreed they wish they could attend individual therapy more often.

Group leaders were also viewed positively by most patients. Group leader satisfaction recorded a minimum score of 32 and a maximum score of 50 (Cronbach's alpha = 0.915). The mean for content importance was 46.06 (SD = 4.80). Approximately, 88.6% of patients either agreed or strongly agreed that their group leaders made them feel comfortable and safe in therapy sessions. A majority of patients also agreed or strongly agreed that their group leaders were mostly non-judgmental and tried to understand them individually. Patients were also asked about trust; a majority of patients said that they strongly agreed that they trusted their group leaders (65.9%) and felt comfortable with sharing personal information with their group leaders (56.8%). About 6.8% of patients reported having a female group leader; 84.1% had a male group leader; and 6.8% reported having both male and female. When asked about comfort with a group leader's gender, 52.3% of patients expressed no preference regarding the gender of their group

leader (Table 5). Approximately 36.4% of patients said that they were more comfortable with a male group leader, and 6.8% were more comfortable with a female group leader.

Patients were also asked about satisfaction with program policies and procedures. Program policies and procedures recorded a minimum score of 18 and a maximum score of 38 (Cronbach's alpha = 0.726). The mean for program policies and procedures was 31 (SD = 4.97). A majority of patients agreed or strongly agreed that program policies and procedures with regard to attendance, lateness, and successful completion were fair and clear. About 60% of all patients strongly agreed that their confidentiality was respected and that the staff at the Blue Ridge Counseling Center treated them with the utmost respect. When asked about homework and assignments, 84.1% reported that they received just the right amount of homework and assignments. For treatment length, 54% of patients thought that length of treatment was just right, while 31.8% felt it was too long.

Overall, patients appeared to be satisfied with the treatment program at the Blue Ridge Counseling Center (see Table 5). Overall satisfaction recorded a minimum score of 8 and a maximum score of 25 (Cronbach's alpha = 0.885). The mean for overall satisfaction was 20.67 (SD = 4.37). More than half (56.9%) of patients agreed or strongly agreed that they were in treatment because they needed to be in the program. About 80% of all patients reported that their experience in the treatment program had been a positive experience, and through treatment they had gained a great deal of understanding about their offense and preventing future offenses.

Descriptive Statistics for Group Engagement Measures

Within this study group, engagement was measured several ways to examine the relationship between engagement and treatment satisfaction. These multiple measures included attendance, patients' participation rating score given by the group facilitator, and phase in

treatment. As an open-ended measurement, the number of absences was recorded with a minimum score of 0 and a maximum score of 15. The mean number of absences was 2.02 (SD = 3.372) (see Table 6). However, this finding may have been affected by the treatment program's policy, which requires each participant to attend treatment one time per week. When asked about the number of sessions they missed, 50% of patients reported they never missed a session, and 13.6% missed one session (see Table 6).

The participation rating score had a minimum score of 2 and a maximum score of 4, and the mean of the participation rating score was 2.59 (SD = 0.622) (see Table 7). Since group leaders reported participation rating scores, patients were only rated based on the perspective of the group leaders using a 4-point scale. Table 7 displays that about half (rating score 2; 47.7%) of all patients were rated as attentive and appropriate in group, but participated only minimally; 45.5% (rating score 3) of patients were rated as active participates: relevant issues, presenting treatment assignments, and taking responsibility for their own behavior; and only 6.8% (rating score 4) discussed their issues, effectively confronting peers and taking an active role in orienting new groups.

Table 8 displays phases in treatment by examining each patient and which of the three phases in treatment they were currently in, as rated by the group leader. Overall, 40% of patients were in phase 3 at the Blue Ridge Counseling Center. One fourth of patients were in phase 1 of treatment. Approximately 34.1% were in phase 2. Phase in treatment was also a measure that was completed by the group facilitator and part of the client's legal file.

Bivariate Analysis

Table 9 displays a correlation matrix of the bivariate relationships between the engagement, satisfaction, and control variables. A majority of the variables did not have a

significant relationship between engagement and satisfaction. However, when calculating the bivariate correlations, there was a significant relationship between several of the survey components, including significant correlations between content satisfaction and overall satisfaction ($r = 0.577$; $p = 0.000$), content importance ($r = 0.569$; $p = 0.000$) and group leader ($r = -0.373$; $p < 0.21$).

Table 9 also displayed significant relationships between other variables included in the analysis. Phase in treatment was significantly correlated with overall satisfaction ($r = 0.396$; $p = 0.009$) and length in treatment ($r = 0.538$; $p = 0.000$). Therefore, as phases in treatment increase, so does offenders' overall satisfaction with treatment. Also, as length in treatment increases, so does phase in treatment. Attendance had a significant correlation with education ($r = -0.340$; $p = 0.024$); as education increases, the number of absences decreases. Those who previously attended treatment had a lower number of absences ($r = -0.327$; $p = 0.030$).

Upon running a bivariate analysis, I found that participation rating score was also significantly correlated with group leader ID ($r = 0.374$; $p < 0.012$). Since group leader ID is a multiple nominal category variable, which means it has no true order within a sequence, it is highly favorable to run a follow-up analysis of variance to assess the level of significance between both variables. Length in treatment had a negative correlation with type of offender ($r = - 0.373$; $p = 0.015$). Since length in treatment and type of offender are represented as two categorical variables from a single sample, a chi-square was used to determine whether there was a significant association between the two variables. Ultimately, running the chi-square analysis, I found that the amount of time a patient receives treatment is not dependent on the type of patient. Finally, there was a positive correlation between length in treatment and group location ID ($r = 0.315$; $p = 0.042$). Since length in treatment and group location were also represented as two

categorical variables in this study, a chi-square analysis was necessary to determine whether there was a significant association between the two variables. After running the chi-square analysis, I also found that the amount of time a patient receives treatment is not dependent on the group location.

Since there were very few significant relationships between the engagement measures and satisfaction measures specifically within the bivariate correlation, running a regression would prove unfruitful to determine the relationship between satisfaction and engagement. Using the results from the bivariate correlation showed only one significant relationship between the overall satisfaction and phase in treatment.

Analysis of Variance

Since a regression was not necessary to examine the relationship between satisfaction and engagement, I utilized an analysis of variance to assess potential differences in categorical and continuous variables that had statistically significant correlations. Of the correlations listed in Figure 1, I found that group leader (nominal) had a significant correlation with the content satisfaction. Specifically, by looking at the bivariate analysis, this meant that group leaders may actually predict how satisfied each participant is with treatment. Ultimately, this prompted the current study to run an analysis of variance to assess how statistically significant the relationship was, or if the correlation simply happened by chance. However, running the analysis of variance, I found that there was not a significant interaction between different group leaders and content satisfaction, $F\ (3, 34) = 4.65$, $p = 0.091$. People were equally satisfied with treatment content regardless of the group leader they had. Of the correlation listed in Figure 2, group leader (nominal) also had a significant correlation with the participation rating score. However, after running the analysis of variance, I found that there was not a significant interaction between the

different group leaders and the participation rating score, F (3, 40) = 2.298, p = 0.092. Therefore, participants were given similar participation rating scores regardless of the group leader they had.

To examine the statistically significance of the relationship between overall satisfaction and phases in treatment, an analysis of variance was completed. Through running the analysis of variance, I found that there was a significant difference in overall satisfaction across the different levels of phase in treatment, F (2, 39) = 4.438, p = 0.018 (see Figure 3). Individuals in phase 3 had the highest mean overall satisfaction score (Mean = 22.41; SD = 2.59). This may be due to the length of time patients have been in treatment, and those who have been in treatment the longest are the most adjusted to the treatment program.

Chapter 5

Discussion

As noted earlier, sex offenders have received a substantial amount of attention in recent years from both policymakers and the public. Some researchers have called into question the effectiveness of treating sex offenders, with some researchers finding treatment programs to be effective when examining satisfaction (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009), while others measuring recidivism find it ineffective (Doren & Yates, 2008; Harkins & Beech, 2006; Keeling, Rose, & Beech 2007; Losel & Schmucker, 2005; Marques, Nelson, West, & Day, 1994). The present study sought to examine sex offender treatment by looking beyond the concept of recidivism as a measure of effectiveness, focusing on the satisfaction of sex offenders to explore whether engagement in treatment and satisfaction with treatment were correlated. This study did not find a significant relationship between a majority of the engagement and the satisfaction variables using bivariate correlations. Ultimately, running an ordinary least square regression to examine the relationship between engagement and satisfaction would not have been helpful because the regression indicated that there was not a significant relationship between engagement and satisfaction. Since the bivariate analysis could identify which variables were significant versus those that were not significant, I was able to run alternative analyses to assess the results of the bivariate analysis. Therefore, running several regressions to predict the satisfaction measures using the engagement measures would have been unfruitful. Since the sample size in my study was too small, the statistical power was not as reliable, which made it unable to detect relationship between engagement and satisfaction. However, there was a significant interaction between one engagement measure, phase in treatment, and one satisfaction measure, overall satisfaction. Individuals in phase 3 of treatment were more satisfied with treatment overall than

individuals in phase 1 or 2. This finding speaks to the importance of each phase in treatment. Each phase in treatment seeks to ensure that the patient acquires more accountability, understanding, and tools needed to prevent recidivism. Table 15 displayed that phase 3 had the largest group of participants (38.6%), while phase 2 had 34.1%, and phase 1 had 25%. Findings were similar when examining rates of satisfaction and phases. Phase 3 had a higher mean overall satisfaction rating than any other phase in treatment (Phase 3 mean = 22.41, Phase 2 mean = 18.8, and Phase 1 mean = 18.3). It seems that when offenders move along in the treatment process, they become more satisfied with treatment and, hopefully, receptive to the role of treatment in motivating them to develop and practice new skills that are relevant for reducing recidivism risk.

The present study overall provides some confirmation that a portion of participants believe that they are satisfied with the treatment they received at the Blue Ridge Counseling Center. Most of the empirical research in this area has found that self-reports of sex offender engagement positively predict self-reports of satisfaction (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). Unfortunately, for the current study I did not find a direct relationship between engagement and satisfaction, which may have resulted from several limitations within the study. Using only self-reports of satisfaction in the current study, participants' perceived thought about the content areas provided in the Blue Ridge Counseling Center's treatment groups were found to be important and helpful, with only a small portion of participants stating one or more items were not as helpful or important.

A majority of the participants in this study were very similar to samples that Levenson and her colleagues recruited from outpatient programs in Illinois, Florida, and Minnesota,

because participants rated items related to accepting responsibility, victim empathy, and arousal control as much more important than other items (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). When asked about content importance, patients rated the importance of three treatment items higher than any other items that they received while at the counseling center. These included (1) accepting responsibility, (2) understanding the impact of sexual abuse on victims and others in their life, and (3) developing a relapse prevention plan. Since treatment programs incorporate several activities that seek to help clients better understand their behavior, accepting responsibility, understanding the impact of their crime, and developing a relapse prevention plan may be three of the most helpful tools for behavioral change. First, accepting responsibility indicates that patients are taking accountability for their actions and decisions (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). Second, understanding the impact of their crime on victims indicates that patients have an understanding that their actions and decisions contribute to the victimization and harm of others (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). Finally, developing a relapse prevention plan may help to suppress the need to engage in sexually deviant activity, as the prevention plan acts as a reminder to control their deviant arousals (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009).

In addition, patients' level of satisfaction may also reflect the level of emphasis each facilitator placed on accountability, victim empathy, and relapse prevention management. Since facilitators seek to change the behaviors that have brought patients into treatment programs, I believe it is reasonable to assume that facilitators affect how much content the clients receive

overtime, allowing them to have a voice and express themselves, and helping with many of their insecurities. As treatment items used to help patients, these three are important factors because they not only allow offenders to come to terms with their own deviant behavior, but contribute to the assumption that patients will change their behaviors (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). The content areas that patients deemed not as important were basic life skills, basic human sexuality, learning new relationships, and communications skills. Patients may have found these to be least important because facilitators chose not to discuss them or may not have placed a sufficient emphasis on these items within the treatment program.

The content areas that participants perceived as important were also content areas that they perceived as most helpful to their treatment progress. These included accepting responsibility for sexual offense(s), understanding the impact of sexual abuse on victims and others in the offender's life, and developing a relapse prevention plan. It is not surprising that the areas they found most helpful overlap with areas they found most important because their overall scores for both importance and satisfaction were significantly correlated. When asked about their level of satisfaction with the program's treatment components, patients stated that the items that were most helpful were accepting responsibility, understanding the impact of sexual abuse on victims, understanding their triggers and risk factors, understanding the impact of sexual abuse on victims and others in their life, and developing a relapse prevention plan. Again, the least helpful items were basic life skills and basic human sexuality.

The results also show each patient's level of satisfaction with treatment components, individual therapy, group leaders, and overall treatment. Overall, a majority of patients stated that their individual groups established an atmosphere of trust and group cohesion. More than

half of the participants stated that they felt a high level of comfort within their treatment group, and they felt comfortable participating and helping others while in group. Levenson et al. (2010) also stated that the vast majority of patients were comfortable with their group and therapist, and did not mind sharing personal information with either party. Ultimately, Levenson et al. (2014) stated that "group cohesion can model healthy intimacy while offsetting the loneliness of and alienation often felt by sex offenders who have held on to their deviant secret with deep shame" (p. 490). Therefore, patients who have secured a bond or level of trust with others are more likely to express their own deviant thoughts after hearing the perspective of others who they believe would not judge them. A majority of the patients in this study stated that they trusted other members in the treatment program, and that being able to talk with other people who have committed sex offenses was very helpful.

When asked about their satisfaction with individual therapy, most patients stated that they never attended an individual therapy session. However, many of the participants stated that if they had the opportunity to take individual therapy, they would have liked to participate in those sessions. When asked about their group facilitators, many of the participants reported that the group leaders established a positive atmosphere for trust, comfort, and safety. Participants reported that their group leaders were non-judgmental and tried to get a full understanding of each individual patient. Patients had also reported having feelings of comfort about sharing things with the group leaders, and that being comfortable made the individual willing to receive feedback or advice from group leaders.

Finally, three fourths of all patients reported that their experience in the treatment program had been a positive experience, and that through treatment they gained a great deal of understanding about their offense and preventing future offenses.

Limitations

Problems regarding the lack of findings within this study are likely due to the several limitations. The engagement measurement used in this study influenced the first limitation. Since there is reasonable suspicion that self-reports of engagement create possible chances of social desirability, this study chose to examine participant engagement by using monthly progress reports completed by the group facilitators. The monthly progress reports were used to examine three specific engagement measures: (1) attendance, (2) participation rating scores, and (3) phases in treatment. Although licensed sex offender counselors completed the monthly progress reports, measurement validity is a potential concern. Measurement validity seeks to ensure that measurements distinctly measure what they are presumed to measure (Bachman & Schutt, 2014). In retrospect, the measurements used by the counseling center may not have appropriately measured engagement. Attendance may not have been an appropriate measure of engagement because offenders were court sanctioned to attend treatment. As a requirement of the court, offenders who did not attend treatment were rearrested for violation of their probation. Ultimately, the offenders are less likely to miss treatment to ensure that they would not be reprimanded. Therefore, attendance may not measure engagement because offenders are not making the purposeful decision to attend group out of their own willingness to go and talk, but to escape repercussions.

The participation rating score may also not be a true measurement of engagement. The participation rating score was decided by the group facilitator and intended to evaluate how engaged each participant was using a range from (1) being mostly negative, blaming, complaining, poor response to confrontation, to (4) willingness to discuss his/her own issues, effectively confronting peers, and taking an active role in orienting new group. However,

facilitators never gave a participant lower than a 2 on the participation rating scale. Measurement validity should be called into question with this specific measure because it seems odd that no individual participant was given the lowest participation rating score. It is possible that facilitators may have been more inclined to award participants moderate participation rating scores to avoid negative consequences for the offenders.

Of all variables represented in this study, phases in treatment may have been the most objective variable of measuring engagement. Each of the five counseling centers has a strict rubric regarding phases in treatment and what allows a patient to move to the next phase in treatment. Phase in treatment could be considered the only variable that measured engagement because of the strict guidelines among facilitators for when to designate whether a patient should be moved along in treatment. While phase in treatment did have a significant relationship with overall satisfaction in treatment, it is worth discussing that phase in treatment may also not truly measure engagement. It is possible that facilitators may have moved patients through treatment simply based upon the amount of time they spent in treatment rather than their participation in group and acknowledgement of their issues.

Measurement validity was also a concern for the satisfaction survey. As stated previously, the satisfaction survey that was used in this study was the exact survey that Levenson and colleagues used in their engagement and satisfaction studies. While the survey sought to examine satisfaction, it is a possibility that the importance and helpfulness many not actually measure how satisfied they are with the treatment. As a researcher, I can only hope that the satisfaction survey was evaluated and tested to properly measure satisfaction.

The sample size influences the second limitation for this study. Samples are one of the most important components in research as they represent statistical power. Specifically, sample

sizes have the ability to statistically test the relationship between the samples and show traits that exist in an entire population (Bachman & Schutt, 2014). As a sample size decreases, the power associated with that sample also decreases. Ultimately, if the sample size of a study is too small, then the statistical power of a study is not as reliable because researchers are unable to detect medium to small effect sizes (Bachman & Schutt, 2014). This notion is apparent in this study because of the small sample of participants represented in my study. Specifically, in this study there were only 44 participants. Since there was a low number of participants, I was unable to find a significant relationship between engagement and satisfaction. In addition, with the total number of participants being lower than past studies (see Levenson 2009, 2010, & 2014), the total number of participants does not have enough statistical power to demonstrate statistically significant relationships between variables in the study. For example, when running the bivariate analysis, overall satisfaction was the only satisfaction domain that demonstrated having a relationship with engagement (phases in treatment). The purpose of estimating an appropriate sample size is to produce a study that has the ability to detect relevant differences (Faber & Fonseca, 2014).

Although I was able to determine small relationships between select variables with this sample, it is likely that the number of participants was too small to detect a relationship between engagement in treatment and satisfaction with treatment if one existed. Levenson et al. (2009, 2010, & 2014) indicated a sample size as high as 338 and as low as 66 participants. Given the range among participants in previous studies, using only a sample of 44 adult sex offenders, it is reasonable to assume that my sample size was not large enough to detect whether a true relationship was present between the key variables in this study. Using a G*Power analysis, I also found that in order to find a relationship between the engagement and satisfaction variables

in this study, with a medium to large effect, there should have been a total of 55-120 participants. I originally sought to collect 100 participants for my study. After attending treatment centers, I only acquired 44 total participants. Therefore, I can conclude that the overall lack of significant relationships between the independent and dependent variables may be attributed to the small sample size in this study.

The third limitation of this study is the location. As a result, the area where a participant lives can influence this study's ability to gather a reasonable sample size. Since rural environments typically have smaller populations, it is understandable why I did not acquire a large sample. However, among the five counseling centers, there were more than 75 patients currently enrolled in the treatment program, so I believed that I would acquire a sample size that would have statistical power. Working in an environment that is almost completely rural, acquiring an appropriate sample size is difficult because rates of crimes are not as high. At the time of this study, the counseling centers had nine patients or fewer in each treatment group; therefore, obtaining a reasonable amount of participants may have been difficult from the beginning.

The fourth limitation is the low rate of responses from the participants. While many of the problems mentioned in this study come from inadequacy with sampling, another issue that was present in this study was the ability to use each participant's data. Response rates help to signify the number of surveys completed by individual respondents who were assembled in the sample (Bachman & Schutt, 2014). Typically, a survey's response rate is the result of dividing the number of participants who completed the survey by the total of number of people in the population who were eligible to participate in the study (Bachman & Schutt, 2014). However, in this study low response rate was also the result of having missing data. Initially, this study

acquired a sample of 53 total participants who agreed to participate. While assessing the responses of patients who completed the survey, several participants were removed from the sample for answering too few questions or simply not answering questions. If participants were missing items from any of the satisfaction domains, they had to be removed in order to have properly calculated scores for each satisfaction domain. By removing participants with missing data, the overall sample size in this study decreased.

The fifth limitation is the potential of nonresponse bias. Similar to previous studies, this study may have yielded a systematic bias as a result of patients refusing to participate in the study (Bachman & Schutt, 2014). Nonresponse bias is based on the concept that individuals who do not participate differ than those who choose to participate in research (Bachman & Schutt, 2014). Although I collected data from a decent number of respondents, when examining the overall population from which the sample was selected, the rate of nonresponse is considerable. In this study, non-respondents may have differed from those who did participate, meaning that those who did not give consent may have a tendency to not be satisfied with treatment, compared to those who participated in the study. Since a majority of participants had been in treatment for longer than 6 months, acquiring the perspective of non-respondents could provide some important and valuable information that may have influenced the relationship between engagement and satisfaction. Non-respondents who had been in treatment for the same amount of time as respondents acquired the same amount of information; therefore, they may have viewed things differently that could have an effect on the relationship between the variables. In this study, the assumption that certain groups were more inclined to answer is worth exploring because not all participants were satisfied with treatment, especially potentially those who chose not to participate in this study. Since there was no true way to compare the responders to non-

responders, it is impossible to estimate the extent to which selection bias influenced the results. Ultimately, participants have the right to choose not to participate in research, but my findings are limited because they did not express all individuals' satisfaction with the treatment program and the treatment they have received since joining the counseling center. In addition, I could not compare demographic differences across those who participated and those who did not because I would need consent from each patient to access personal files.

As mentioned previously, those who participated in this study perceived content areas from the Blue Ridge Counseling Center's treatment program as important and helpful, with only a small portion of participants stating that one or more items were not helpful or important. However, limitations regarding validity and accuracy are also worth mentioning. Problems of self-report data are inherent in any survey study (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). Although the surveys used in this study only examined satisfaction and not engagement, it is possible that some participants slanted their responses in a socially desirable manner, which could create bias within the findings. Social desirability may have presented itself the moment participants were asked to participate in this study. Although participants consented to participate in the study, patients may have felt coerced to participate from the fear of negative consequences from the program (Levenson & Macgowan, 2004; Levenson, Prescott, & D'Amora, 2010; Levenson, Macgowan, Morin, & Cotter, 2009). Although participants were assured that their results and information would be confidential, it is possible that patients may have overreported their satisfaction with the program.

Another issue for validity is that reports of satisfaction may have been skewed toward positive responses due to a lack of understanding of the content areas (Bachman & Schutt, 2014).

More than half of all participants in this study reported having only a high school diploma or GED. Past research has found that education levels are correlated to comprehension skills and literary abilities (Pearson, 1985). Therefore, participants may have been more inclined to choose very important and very helpful without reading or comprehending the item's description.

Conclusion and Implications

While this study did not identify a significant relationship between measures of engagement and self-reports of satisfaction, the current study did offer some valuable information about sex offender treatment. However, if I were to do this study over, I would seek to address the limitations stated above. These include acquiring a larger sample size and using a better measurement of engagement. In this study, sampling was one of the greatest limitations. To acquire a larger sample size, I would attend different treatment centers until I acquire the designated number of participants. Upon acquiring the selected number of participants for the study, I would run the same analytic strategies planned for this study.

Since there were limitations with the engagement measures, I would not use facilitator-completed monthly progress reports to measure engagement. Instead, I could measure engagement in three different ways: (1) examine the number of assignments (classwork/homework) participants complete; (2) observe treatment groups in person; and (3) create a group engagement measure using the phase in treatment component. First, using counseling center assignments should be quite promising to measure engagement because as a part of treatment, patients are typically evaluated on the content and assignments they complete. Examining the total number of assignments each participant completes by the total number of assignments that should be completed in each program could help to develop a better measure of engagement. Second, measuring engagement through observation may be also favorable because

as a researcher, I will be able to have firsthand understanding of how frequently an individual engages in the session. There are still limitations with this, as it may create social desirability because participants may engage since an outside individual is examining them. The observations may also take away from the treatment groups. However, observing the group first-hand may ensure more objectivity and accuracy because participants are not able to lie, nor are the facilitators able to rate the participants in an ambiguous manner. Finally, I could alter the phases in treatment measure that was previously used in this study, by examining components that each patient must acknowledge to move to the next phase in treatment. This means that I would categorize the items in each domain to understand how engaged each patient is in the treatment program.

Overall, while this study did not find a significant relationship between the engagement and satisfaction variables, this research study did add to the literature by highlighting rural environments. Since most researchers often overlook rural environments, acknowledging patients in these specific areas in this study helps research to have an overall view of sex offenders in all environments. This study also adds to the literature by examining the ways in which sex offenders' treatment can be evaluated. As mentioned previously, past researchers have focused on rates of recidivism; my research contributes by examining engagement and satisfaction with a smaller sample. Although my findings did not show significant relationships, I did find that examining engagement and satisfaction is worth pursuing to contribute to the quest to improve the study of sex offender treatment outcomes. Since sex offenders are a vulnerable population to study, I was able to contribute to the literature by making sure that patients in treatment programs are heard by allowing them to express their overall feelings about the treatment they are receiving.

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Table 1. ***Group Location ID***

Location	Mean (SD) or %
Radford	15.9%
Roanoke	63.6%
Covington	6.8%
Rocky Mount	13.6%
Martinsville	0.0%

Table 2. ***Group Leaders***

Leaders	Mean (SD) or %
Group Leader 1	63.6%
Group Leader 2	13.6%
Group Leader 3	9.1%
Group Leader 4	13.6%

Table 3. ***Descriptive Statistics for Background Information***

Variables	Mean (SD) or %
Age	---
Under 25 years old	2.3%
25 to 49 years old	54.5%
50 to 64 years old	31.8%
65 years old or more	11.4%
Marital Status	---
Never Married	40.9%
Married	29.5%
Divorced	20.5%
Separated	6.8%
Widowed	2.3%
Race	---
White/Caucasian	77.3%
Minority	22.7%
Education	---
8th grade or less	4.5%
Some high school	9.1%
High school graduate or GED	56.8%
College graduate	29.5%
Household Income	---
Under $10,000	29.5%
$10,000 to $19,000	22.7%
$20,000 to $29,000	22.7%
$30,000 to $49,000	13.6%
$50,000 or more	11.4%
Length in Treatment Program	---
Less than six months	15.9%
Six months - one year	38.6%
One year - two years	29.5%
More than two years	11.4%
Length in Current Treatment Program	---
Less than six months	27.3%
Six months - one year	43.2%
One year - two years	22.7%
More than two years	4.5%
Length with Current Facilitator/Primary Therapist	---
Less than six months	20.5%
Six months - one year	43.5%
One year - two years	29.5%
More than two years	4.5%

Age of Victims	
5 years old or less	9.1%
6 to 9 years old	18.2%
10 to 12 years old	6.8%
13 to 17 years old	40.9%
18 years old or more	13.6%

Table 4. ***Type of Offense(s)***

Crimes	**Mean (SD) or %**
Indecent Liberties	15.9%
Child Pornography Related	18.2%
Sexual Battery	4.5%
Attempted Rape	2.3%
Aggravated Sexual Battery	6.8%
Rape	2.3%
Forcible Sodomy	2.3%
Attempted Forcible Sodomy	2.3%
Sodomy	2.3%
Carnal Knowledge	9.1%
3rd Degree sexual assault with intent to commit sexual penetration	2.3%
Two or more crimes	25.0%
Three or more crimes	4.5%
Produce, Distribute, Facilitate Child Pornography	2.3%

Table 5. ***Satisfaction Domains***

Domain	**Mean (SD) or %**
Importance	90.67 (9.60)
Satisfaction	87.78 (14.56)
Group Component	33.69 (4.24)
Individual Therapy	14.90 (4.05)
Group Therapist	46.06 (4.80)
Policies and Procedures	31.00 (4.97)
Overall Satisfaction	20.18 (4.37)

Table 6. ***Attendance***

Absences	Mean (SD) or %
0	50.0%
1	13.6%
2	9.1%
3	9.1%
4	6.8%
6	2.3%
9	2.3%
10	2.3%
11	2.3%
15	2.3%

Table 7. ***Participant Rating Score***

Rating Score	Mean (SD) or %
Mostly negative: blaming, complaining, poor response to confrontation	0.0%
Attentive and appropriate in group but participates only minimally	47.7%
Actively participates: relevant issues, presenting treatment assignments and taking responsibility for own behavior	45.5%
Discussing his/her own issues, effectively confronting peers, and taking an active role in orienting new group	6.8%

Table 8. ***Phase in Treatment***

Phases	Mean (SD) or %
Phase 1	25.0
Phase 2	34.1
Phase 3	38.6

Table 9. ***Correlation Matrix of All Variables***

		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	Con. Sat.	1															
2	Ovr. Sat.	.577**	1														
3	Phases	-.011	.396**	1													
4	Absence	-.081	.162	.218	1												
5	Rating Sc.	-.219	.063	.308*	.160	1											
6	Con. Imp.	.569**	.421**	.054	.029	-.009	1										
7	Age	-.020	-.047	-.038	.201	.058	-.126	1									
8	Race	-.232	.075	-.042	.183	.080	-.183	.144	1								
9	Edu.	-.092	-.014	-.027	-.340*	.201	-.189	-.071	-.136	1							
10	Length	.317	.276	.538**	.256	.106	.197	.061	-.261	-.275	1						
11	Prev. Treat.	.038	-.087	-.060	-.327*	-.101	-.094	.193	-.328*	.158	-.151	1					
12	Female Vic.	-.133	.220	.049	.163	-.028	-.150	.047	.083	.066	.110	-.005	1				
13	Male Vic.	.137	.068	-.157	-.022	-.014	.182	-.128	-.061	.267	-.119	-.164	-.374*	1			
14	Type Off.	-.316	-.240	-.147	-.191	.259	-.211	.024	-.027	.082	-.373*	.290	-.168	-.014	1		
15	Location	.108	.281	.232	.086	.098	-.002	.189	-.138	.287	.315*	-.088	.164	.053	-.224	1	
16	Gr. Leader	-.373*	-.117	.166	.120	.374*	-.091	-.076	-.234	.149	-.028	.126	-.312*	.108	.239	.149	1

*p < .05, **p < .01

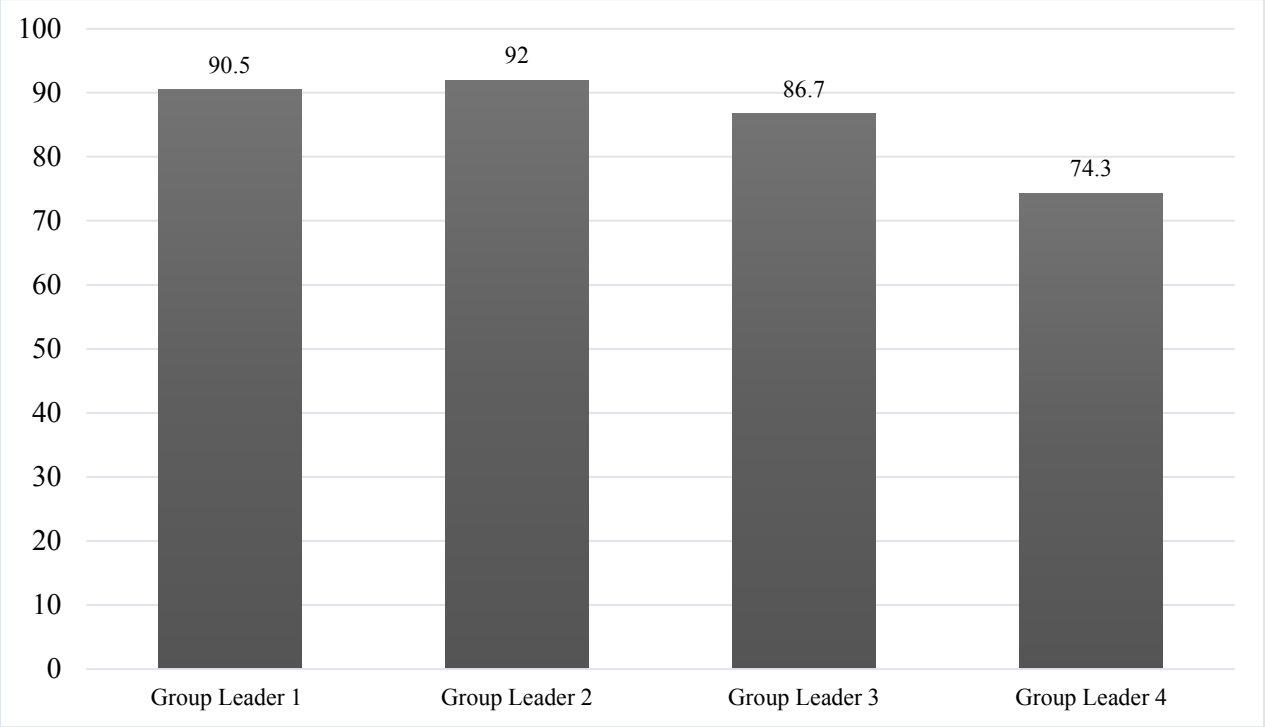

Figure 1. ***Content Satisfaction by Group Leader***

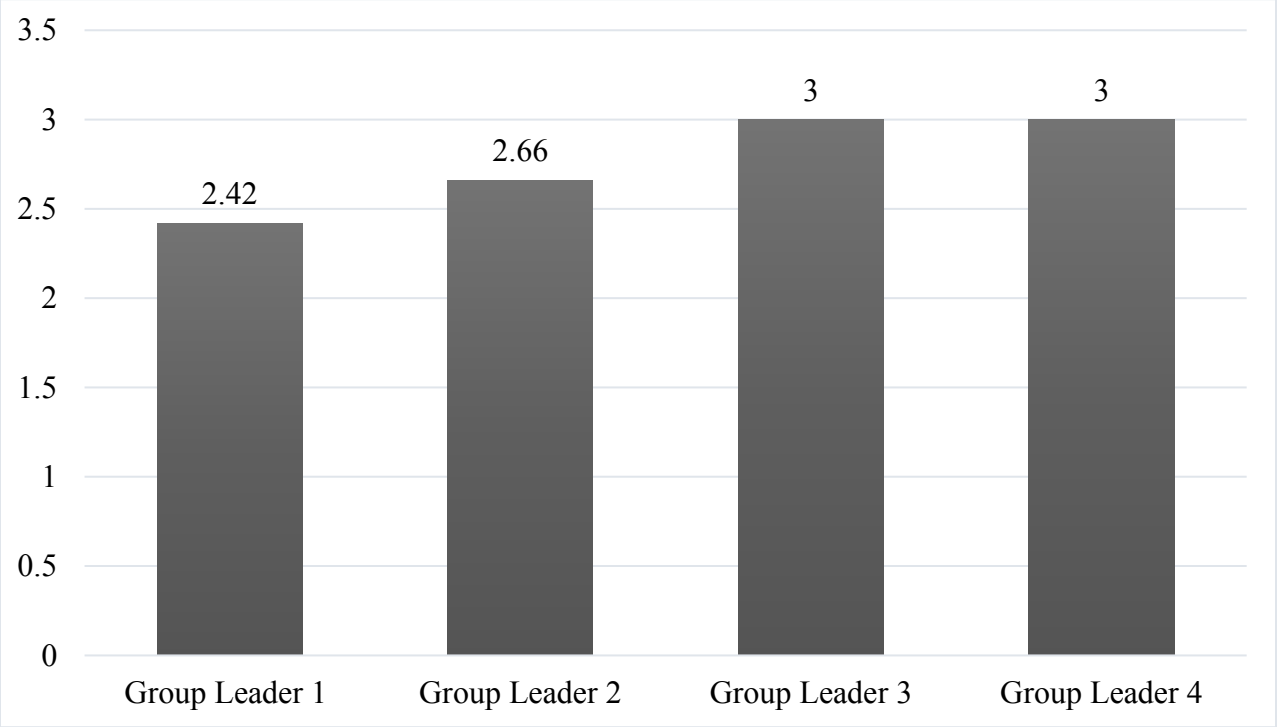

Figure 2. ***Participation Rating Score by Group Leader***

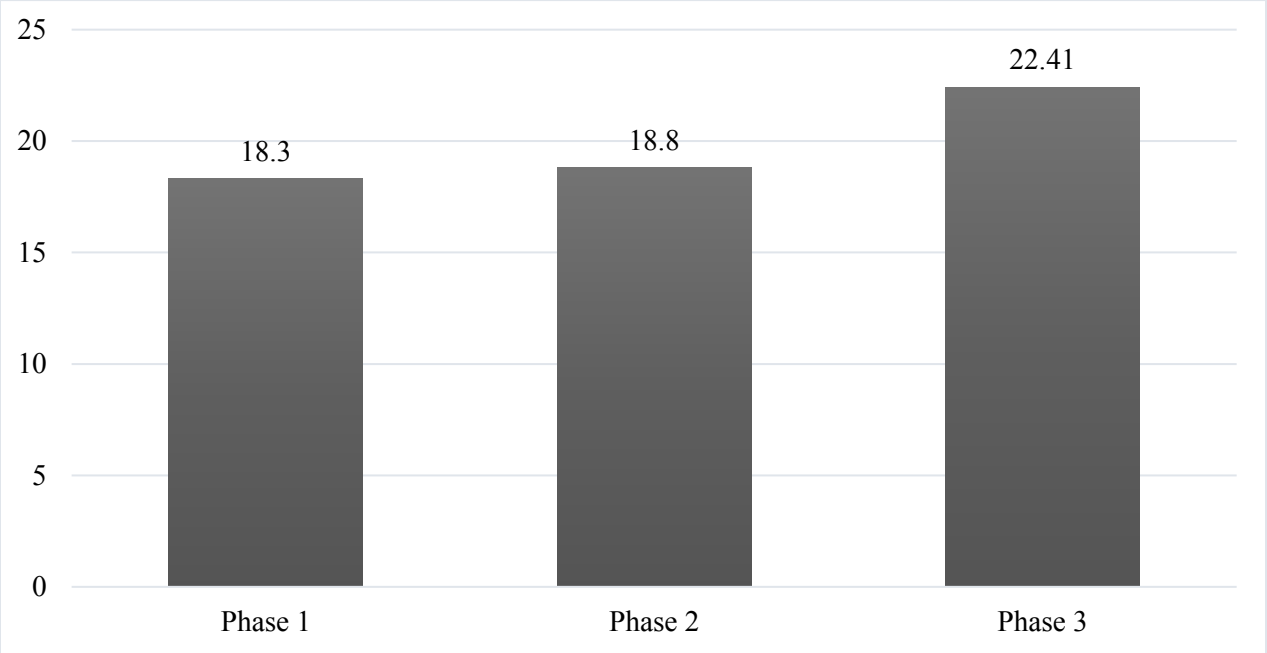

Figure 3: ***Overall Satisfaction by Phases in Treatment***

Appendix A

Informed Consent Document

Participant ID:

Title of Research: Sex Offender Treatment Satisfaction from the Offenders' Perspective

Researcher(s): Dr. Margaret Pate, mpate1@radford.edu

Stephan Pennix, spennix@radford.edu

We ask you to be in a research study designed to explore your perceptions of and overall satisfaction with the sex offender treatment you are currently attending. If you decide to be in the study, you will be asked to complete a survey during our session with you. We are also requesting permission from you to view your one most recent monthly progress report from your file at Blue Ridge Counseling. These reports are completed by your group facilitator. Approximately 90 people from Blue Ridge Counseling's sex offender treatment program will be asked to participate in the study.

This study has more risk you may find in daily life. Given that you are currently enrolled in a sex offender program, any information you provide us could have potentially negative social consequences. However, all information that you give us will be treated as strictly confidential. We are also maintaining confidentiality by only collecting identifying information from you (i.e. your name) on your consent form in order to determine which clients have granted us permission to access their files. Your name will not be linked to the data and a unique code number will be used to link surveys to progress reports. **Please do not write your name or others' names on your survey.** No information that could potentially identify you will be published or made available to the police, probation, corrections, or anyone else.

There are only two situations when information about you may be reported. First, if you report that you intend to harm yourself or someone else. Second, if you report current or past abuse of a child. In those cases we may be legally required to pass that information on to make sure that no one is hurt. **None of our survey questions ask you to provide this type of information.**

There is no compensation from being in this study.

There are no direct benefits to you for being in the study.

You can choose not to be in this study. If you decide to be in this study, you may choose not to answer certain questions or not to be in certain parts of this study. If at any time you want to stop being in this study, you may stop being in the study without penalty or loss of benefits by speaking with Dr. Pate or Stephan during the group session.

If you have questions now about this study, ask before you continue on.

If you have any questions later, you may talk with Dr. Margaret Pate.

If this study raised some issues that you would like to discuss with a professional, you may discuss this with your group facilitator at Blue Ridge Counseling.

This study has been approved by the Radford University Institutional Review Board for the Review of Human Subjects Research. If you have questions or concerns about your rights as a research subject or have complaints about this study, you should contact Dr. Dennis Grady, Dean, College of Graduate and Professional Studies, Radford University, dgrady4@radford.edu, 1-540-831-7163.
It is your choice whether or not to be in this study. What you choose will not affect any current or future relationship with Radford University or the Radford Counseling Group, Inc.

If all of your questions have been answered and you would like to take part in this study, then please indicate through s response to one the options below and sign at the bottom.

_____ I voluntarily consent to allow information from my monthly progress report to be used AND to participate in the survey portion of this study

_____ I do **not** voluntarily consent to the survey portion or to the collection of information from my monthly progress report (if you select this option, you do not need to sign below).

_____ _____ _____

Signature Printed Name Date

I/We have explained the study to the person signing above, have allowed an opportunity for questions, and have answered all of his/her questions. We believe that the subject understands this information.

_____ _____ _____

Signature of Researcher Printed Name Date

Note: A copy of this consent will be provided for your records upon request.

Appendix B

Satisfaction Survey

REMINDER: Please do **NOT** write your name anywhere on this survey

Thank you agreeing to take part in this survey about sex offender treatment. Please read each statement below carefully and choose the answer that best describes how you feel about it. If you feel an item does not apply to you, please do your best to answer it anyway.

Please tell us your opinion about the importance of the following treatment content areas by putting a check in the appropriate box.	*Not Important 1*	*Slightly Important 2*	*Moderately Important 3*	*Important 4*	*Very Important 5*
1. Accepting responsibility for my sexual offense(s)					
2. Learning about different types of denial.					
3. Understanding my own tendency to distort, deny, and make excuses.					
4. Understanding the impact of sexual abuse on victims and others in my life.					
5. Understanding my offense chains, cycles, and patterns.					
6. Understanding my triggers and risk factors.					
7. Learning about what motivated me to offend.					
8. Learning about my grooming patterns or the behaviors I used to gain access to victims or offending.					
9. Developing a relapse prevention plan. (This would include a "maintenance" plan)					
10. Learning to change or control my deviant arousal.					
11. Learning to identify and recognize cognitive distortions.					
12. Learning to change (restructure) cognitive distortions.					
13. Understanding the development of my sexual behavior problems.					
14. Understanding how early experiences and family life affected me.					
15. Learning new relationship and communication skills.					
16. Understanding the needs I met through sexual abuse and learning how to meet my needs in healthier ways.					
17. Learning how to create a more satisfying life for myself.					
18. Basic Life Skills					
19. Basic Human Sexuality					
20. Controlling Compulsive Sexual Behavior (including masturbation & pornography).					

Please tell us your opinion about the importance of the following group processes by putting a check in the appropriate box.	*Not Important 1*	*Slightly Important 2*	*Moderately Important 3*	*Important 4*	*Very Important 5*
21. Sharing my experiences with other sex offenders					
22. Feeling as though I can relate to the other members of my group.					
23. Hearing other perspectives and viewpoints.					
24. Getting help and support from others.					
25. Confrontation among the group members.					

REMINDER: Please do **NOT** write your name anywhere on this survey

Please tell us your opinion about <u>your satisfaction</u> with the following treatment content areas by putting a check in the appropriate box.	*Not Important 1*	*Slightly Important 2*	*Moderately Important 3*	*Important 4*	*Very Important 5*
26. Accepting responsibility for my sexual offense(s).					
27. Learning about different types of denial.					
28. Understanding my own tendency to distort, deny, and make excuses.					
29. Understanding the impact of sexual abuse on victims and others in my life.					
30. Understanding my offense chains, cycles, and patterns.					
31. Understanding my triggers and risk factors.					
32. Learning about what motivated me to offend.					
33. Learning about my grooming patterns or the behaviors I used to gain access to victims or offending.					
34. Developing a relapse prevention plan. (This would include a "maintenance" plan)					
35. Learning to change or control my deviant arousal.					
36. Learning to identify and recognize cognitive distortions.					
37. Learning to change (restructure) cognitive distortions.					
38. Understanding the development of my sexual behavior problems.					
39. Understanding how early experiences and family life affected me.					
40. Learning new relationship and communication skills.					
41. Understanding the needs I met through sexual abuse and learning how to meet my needs in healthier ways.					
42. Learning how to create a more satisfying life for myself.					
43. Basic Life Skills					
44. Basic Human Sexuality					
45. Controlling Compulsive Sexual Behavior (including masturbation & pornography)					

Group Process: Please RANK the following topics from 1-5 in order of their <u>helpfulness to your recovery, with 5 being MOST helpful and 1 being LEAST helpful</u>.	*Not Important 1*	*Slightly Important 2*	*Moderately Important 3*	*Important 4*	*Very Important 5*
46. Sharing my experiences with other sex offenders					
47. Feeling as though I can relate to the other members of my group.					
48. Hearing other perspectives and viewpoints.					
49. Getting help and support from others.					
50. Confrontation among the group members.					

REMINDER: Please do **NOT** write your name anywhere on this survey

Please rate <u>your agreement</u> with the following statements by circling the item that best describes your agreement: 1- strongly disagree 5- strongly agree	*Strongly Disagree*	*Disagree*	*Somewhat Agree*	*Agree*	*Strongly Agree*
	☹				☺
51. My group usually feels comfortable	*1*	*2*	*3*	*4*	*5*
52. My group has enough structure.	*1*	*2*	*3*	*4*	*5*
53. My group members are pretty open and honest most of the time.	*1*	*2*	*3*	*4*	*5*
54. My group members are pretty non-judgmental most of the time.	*1*	*2*	*3*	*4*	*5*
55. It is helpful to be able to talk with other people who have committed sex offenses.	*1*	*2*	*3*	*4*	*5*
56. I feel comfortable participating in my group.	*1*	*2*	*3*	*4*	*5*
57. I feel comfortable helping others in my group.	*1*	*2*	*3*	*4*	*5*
58. I trust the other members in my group.	*1*	*2*	*3*	*4*	*5*
Individual Therapy					
59. My individual therapy has been helpful.	*1*	*2*	*3*	*4*	*5*
60. I wish I could attend individual therapy more often.	*1*	*2*	*3*	*4*	*5*
61. The reason I don't attend individual therapy more often is because I don't request it.	*1*	*2*	*3*	*4*	*5*
62. I would rather attend individual therapy instead of group therapy.	*1*	*2*	*3*	*4*	*5*
63. I usually attend individual therapy about this often: (circle the answer that best applies to you)	*1 never*	*2 rarely*	*3 A Few Times Per year*	*4 1-2 times per month*	*5 once per week*
Please rate <u>your agreement</u> with the following statements about your group leaders (sometimes called therapists, counselors, or facilitators):	*Strongly Disagree*	*Disagree*	*Somewhat Agree*	*Agree*	*Strongly Agree*
	☹				☺
64. Usually, my group leaders make me feel comfortable and safe in therapy sessions.	*1*	*2*	*3*	*4*	*5*
65. I get along well with my group leaders.	*1*	*2*	*3*	*4*	*5*
66. I feel that my group leaders try to understand me.	*1*	*2*	*3*	*4*	*5*
67. My group leaders are pretty non-judgmental most of the time.	*1*	*2*	*3*	*4*	*5*
68. I usually feel comfortable sharing personal things with my group leaders.	*1*	*2*	*3*	*4*	*5*
69. I usually feel comfortable with the feedback or advice my group leaders offer to me.	*1*	*2*	*3*	*4*	*5*
70. My group leaders are good at bringing out important points during group therapy.	*1*	*2*	*3*	*4*	*5*
71. My group leaders deal with difficult moments well in group therapy.	*1*	*2*	*3*	*4*	*5*
72. I feel my group leader has a positive attitude toward the group members.	*1*	*2*	*3*	*4*	*5*
73. I trust my group leaders.	*1*	*2*	*3*	*4*	*5*

74. My current group leader is
    ☐ Male ☐ Female ☐ both

75. I am more comfortable with a group leader who is:
    ☐ Male ☐ Female ☐ no preference

REMINDER: Please do **NOT** write your name anywhere on this survey

Please rate <u>your agreement</u> with the following statements about Program Policies and Procedures:	*Strongly Disagree*	*Disagree*	*Somewhat Agree*	*Agree*	*Strongly Agree*
	☹				☺
76. The rules about attendance are fair.	*1*	*2*	*3*	*4*	*5*
77. The rules about lateness are fair.	*1*	*2*	*3*	*4*	*5*
78. My confidentiality is respected.	*1*	*2*	*3*	*4*	*5*
79. I agree with my treatment plan.	*1*	*2*	*3*	*4*	*5*
80. The expectations for successful completion and graduation are <u>clear</u>.	*1*	*2*	*3*	*4*	*5*
81. The expectations for successful completion and graduation are <u>fair</u>.	*1*	*2*	*3*	*4*	*5*
82. I am treated with respect by the staff.	*1*	*2*	*3*	*4*	*5*
83. I am given the right amount of homework and assignments.	*Too Little*		*Just Right*		*Too much*
84. The length of time of this program is fair to ensure that I will not reoffend.	*Too Short*		*Just Right*		*Too Long*
Please rate <u>your agreement</u> with the following statements about Your overall feelings about this treatment program:	*Strongly Disagree*	*Disagree*	*Somewhat Agree*	*Agree*	*Strongly Agree*
	☹				☺
85. I am here because I need to be here.	*1*	*2*	*3*	*4*	*5*
86. Now that I know what this program is like, I like it better than I thought I would.	*1*	*2*	*3*	*4*	*5*
87. Overall, my experience in this treatment program has been a positive one.	*1*	*2*	*3*	*4*	*5*
88. I have gained a great deal of understanding about my offenses from this program.	*1*	*2*	*3*	*4*	*5*
89. I have gained a great deal of understanding about preventing future offenses from this program.	*1*	*2*	*3*	*4*	*5*

90. Please use the space below to offer any comments you want to share about your personal experience in sex offender treatment.

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Basic information: Circle the choice that best applies to you.

1) What is your age?
- Under 25 years old 1
- 25 to 49 years old.....2
- 50 to 64 years old.....3
- 65 years old or more.....4

2) Which of the following best describes your current marital status?
- Never Married..... 1
- Married..... 2
- Divorced..... 3
- Separated..... 4
- Widowed..... 5

3) Which of the following best describes your racial background?
- White/Caucasian..... 1
- Minority 2

4) What is the number of years of school you completed?
- 8th grade or less..... 1
- Some high school..... 2
- High school graduate or GED.... 3
- College graduate..... 4

5) Which of the following categories best describes your household's total income before taxes last year? (or, in the last year that you earned income)
- Under $10,000..... 1
- $10,000 to $19,999..... 2
- $20,000 to $29,999..... 3
- $30,000 to $49,999..... 4
- $50,000 or more..... 5

6) How long have you been in this treatment program?
- Less than six months 1
- Six months – one years 2
- One year – two years 3
- More than two years 4

7) How long have you been in your current group?
- Less than six months 1
- Six months – one years 2
- One year – two years 3
- More than two years 4

8) How long have you been with your current facilitator or primary therapist?
- Less than six months 1
- Six months – one years 2
- One year – two years 3
- More than two years 4

9) In your <u>most recent</u> sex offense arrest, please circle the age of your victim(s) at the time of the offense.
- 5 years old or less..... 1
- 6 to 9 years old..... 2
- 10 to 12 years old..... 3
- 13 to 17 years old..... 4
- 18 years old or more.... 5

Please answer the following questions (#10-21) thinking about **ALL** your victims, even those you <u>haven't</u> been arrested for.

10) I have had female victims.

☐ NO ☐ YES

11) I have had male victims.

☐ NO ☐ YES

12) I have had family member victims.

☐ NO ☐ YES

13) I have had victims who I knew but was not related to.

☐ NO ☐ YES

14) I have had victims who were strangers.

☐ NO ☐ YES

15) How many times have you been <u>arrested</u> for a sex crime? _____

16) How many <u>TOTAL</u> victims do you think you have had (including those you were not arrested for)? _____

17) Have you ever used force or violence when committing a sex offense?

☐ NO ☐ YES

18) Have you ever used a weapon when committing a sex offense?

☐ NO ☐ YES

19) Have you ever physically injured a victim while committing a sex offense?

☐ NO ☐ YES

20) Have you ever been in sex offender treatment before entering this program?

☐ NO ☐ YES

21) If you answered yes to #20, where were you in treatment?

☐ In the community ☐ In prison ☐ both

Thank you for taking the time to answer this survey. Your responses will help researchers learn more about treating sex offenders and preventing sexual abuse.