

**INTERPERSONAL STYLE AND THE THERAPEUTIC ALLIANCE
IN SEXUAL OFFENDER TREATMENT**

Rachael Watson

B.App.Sc (Hons)

School of Psychological Sciences

Monash University

Submitted in partial fulfillment of the degree of

Doctor of Psychology (Clinical)

Forensic Specialisation

April 2016

Monash University

General Declaration

In accordance with Monash University Doctorate Regulation 17.2 Doctor of Philosophy and Master of Philosophy regulations the following declarations are made:

I, Rachael Watson, hereby declare that this thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

This thesis includes one original paper published in a peer-reviewed journal, one manuscript accepted for publication, and one manuscript under review. The main aim of the thesis was to explore the impact of clients' and therapists' interpersonal styles on therapeutic engagement, therapeutic alliance and treatment gain in sexual offenders. The ideas, development and writing up of all the papers in the thesis were the principal responsibility of myself, the candidate, working within the School of Psychological Sciences under the supervision of Professor Michael Daffern and Professor Stuart Thomas. The inclusion of co-authors reflects the fact that the work came from active collaboration between researchers and acknowledges input into team-based research.

In the case of Chapters 4, 5, and 6, my contribution to the work involved the following:

| Thesis chapter | Publication title | Publication status | Nature and extent of candidate's contribution |
|-----------------------|--|---------------------------|---|
| Chapter 4 | The Impact of Interpersonal Style and Interpersonal Complementarity on the Therapeutic Alliance between Therapists and Offenders in Sex Offender Treatment | Published | Review of relevant literature, study design, data collection and analysis, and write up. 80% |
| Chapter 5 | The Impact of Interpersonal Style on Ruptures and Repairs in the Therapeutic Alliance Between Offenders and Therapists in Sex Offender Treatment | Accepted for Publication | Review of relevant literature, study design, data collection and analysis, and write up. 80% |
| Chapter 6 | The Impact of Sex Offender's Interpersonal Style, Treatment Readiness and the Therapeutic Alliance on Treatment Gain | Submitted | Review of relevant literature, study design, data collection and analysis, and write up. 80% |

I have renumbered sections of submitted or published papers in order to generate a consistent presentation within the thesis.

Signed:



Date: 10/04/2016

Copyright Notices

Notice 1

Under the *Copyright Act 1968*, this thesis must be used only under the normal conditions of scholarly fair dealing. In particular no results or conclusions should be extracted from it, nor should it be copied or closely paraphrased in whole or in part without the written consent of the author. Proper written acknowledgement should be made for any assistance obtained from this thesis.

Notice 2

I certify that I have made all reasonable efforts to secure copyright permissions for third-party content included in this thesis and have not knowingly added copyright content to my work without the owner's permission.

Table of Contents

| | |
|---|------------|
| General Declaration..... | 2 |
| Copyright Notices | 4 |
| Table of Contents | 5 |
| List of Tables..... | 7 |
| Acknowledgements | 9 |
| Abstract..... | 11 |
| Manuscripts Produced During Candidature..... | 13 |
| Author’s Note | 14 |
| Chapter 1: Introduction and Thesis Overview..... | 15 |
| Introduction | 15 |
| Thesis Objectives | 18 |
| Thesis Overview..... | 19 |
| Chapter 2: Literature Review | 22 |
| Evidence-Based Rehabilitative Practice..... | 26 |
| Sexual Offender Treatment | 30 |
| Measuring Within-Treatment Change..... | 32 |
| Treatment Readiness | 35 |
| Treatment Engagement | 39 |
| Treatment Engagement within Offender Populations..... | 44 |
| From Treatment Engagement to the Therapeutic Alliance | 47 |
| The Therapeutic Alliance within Offender Populations | 51 |
| Ruptures in the Therapeutic Alliance..... | 54 |
| Therapist Characteristics | 58 |
| Therapeutic Alliance and Client Interpersonal Characteristics..... | 60 |
| Interpersonal Style, Engagement and Outcomes..... | 61 |
| Interpersonal Style within Offender Populations | 67 |
| Summary | 71 |
| Chapter 3: Extended Methodology..... | 74 |
| Ethical Approval | 74 |
| Method | 74 |
| Chapter 4: Interpersonal Style and the Therapeutic Alliance..... | 89 |
| Declaration for Chapter 4..... | 91 |
| Chapter 5: Interpersonal Style and Ruptures in the Therapeutic Alliance | 113 |
| Declaration for Chapter 5 | 115 |
| Chapter 6: Interpersonal Style, the Therapeutic Alliance, Readiness and Gain | 151 |
| Declaration for Chapter 6..... | 153 |
| Chapter 7: Integrated Discussion | 190 |
| Overview of Research Aims | 190 |
| Summary of Key Findings | 191 |
| Implications..... | 217 |
| Limitations | 219 |
| Future Research Directions | 221 |
| Conclusions | 223 |

| | |
|--|------------|
| Appendices | 259 |
| Appendix A - Ethics | 259 |
| Appendix B - Integrated Discussion Analyses..... | 261 |

List of Tables

Chapter 3

| | | |
|-----------|---|----|
| Table 3.1 | Offender Demographics: Age (Years) | 75 |
| Table 3.2 | Offender Demographics and Offence Variables | 76 |
| Table 3.3 | Data Completion Rates | 77 |
| Table 3.4 | Internal Consistency of CVTRQ Subscales | 82 |
| Table 3.5 | Internal Consistency of WAI-SF Subscales | 83 |
| Table 3.6 | Internal Consistency of IMI-C Subscales | 83 |

Chapter 4

| | | |
|-----------|--|-----|
| Table 4.1 | Correlations of Therapist 1 and Therapist 2 IMI and WAI-SF Ratings..... | 100 |
| Table 4.2 | WAI-SF: Offender and Therapist Ratings | 101 |
| Table 4.3 | WAI-SF: Mean Difference Between Current Study WAI-SF Ratings (Table 2) and Normative Samples | 101 |
| Table 4.4 | Mean and Standard Deviation of IMI Complementarity Scores..... | 102 |
| Table 4.5 | Preliminary Normative Data on IMI Complementarity Scores (Kiesler & Schmidt, 2006) and Mean Difference with Current Sample..... | 102 |
| Table 4.6 | Correlations of WAI and IMI scores..... | 104 |
| Table 4.7 | Regression Analysis of Therapist Rating of Offender Hostility and Dominance and the Related Offender Rating of Working Alliance | 105 |

Chapter 5

| | | |
|-----------|---|-----|
| Table 5.1 | Correlations of Therapist 1 and Therapist 2 Impact Message Inventory and Working Alliance Inventory – Short Form Ratings | 130 |
| Table 5.2 | Mean Change Over Time of Working Alliance Inventory – Short Form..... | 132 |
| Table 5.3 | Working Alliance Inventory – Short Form Total Ratings for No Rupture, Rupture/Repair, Rupture/No Repair Across Two Time Periods..... | 133 |
| Table 5.4 | ANOVA Difference Between No Rupture, Minor Rupture and Major Rupture Conditions | 133 |
| Table 5.5 | Mean and Standard Deviation of Offender Interpersonal Style and Age over Rupture Conditions | 134 |
| Table 5.6 | Logistic Regression Predicting Likelihood of Reporting Rupture Repair in the Therapeutic Alliance | 135 |

Chapter 6

| | | |
|-----------|--|-----|
| Table 6.1 | Offender Demographics and Offence Variables | 163 |
| Table 6.2 | Correlations of Therapist 1 and Therapist 2 Impact Message Inventory and Working Alliance Inventory – Short Form Ratings | 169 |
| Table 6.3 | Means and Standard Deviations of Treatment Gain, Offender IPS, Treatment Readiness and the Therapeutic Alliance..... | 171 |
| Table 6.4 | Correlations between Offender IPS, Treatment Readiness and Therapeutic Alliance Variables..... | 172 |
| Table 6.5 | Individual Regression Analyses of Offender IPS, Treatment Readiness and Therapeutic Alliance and the Related Offender Treatment Gain..... | 174 |

Appendix B

| | | |
|-----------|--|-----|
| Table B.1 | Early Therapist-Rated Therapeutic Alliance and Late Offender-Rated Therapeutic Alliance | 261 |
|-----------|--|-----|

| | | |
|-----------|--|-----|
| Table B.2 | Means and Standard Deviations of Therapist and Offender Impact Message Inventory-Control Axis | 262 |
| Table B.3 | Correlations between Treatment Readiness, Treatment Gain and Offenders' and Therapists' Ratings of the Therapeutic Alliance | 262 |

Acknowledgements

Firstly, I would like to express my appreciation to my supervisors, Professor Michael Daffern and Professor Stuart Thomas, as this thesis would not have been achievable without the benefit of their experiences, knowledge and positive guidance during this long journey. They have also provided me with great mentorship, and are two people I admire and respect, and have made the journey a much easier and more enjoyable one. I also acknowledge and thank my initial supervisor, Dr Stefan Luebbers, who set me on the path for my research topic, although it developed and changed over time. In addition I would like to thank Gabrielle Klepfisz for her help with data entry, which was really invaluable at the time. I wish her all the best for her research project.

I am grateful for all of the participants who took the time, with no compensation, to contribute to my research. In particular, I would like to thank the Sex Offender Program facilitators, who completed questionnaires for my study, I recognise that this was an addition to their already busy workload. There were people at Corrections Victoria without whom this project would not have been possible, I would like to give a special thanks to Chris Kozar, Melissa Braden, and Joseph Mollica for helping me organise the research project. In addition I would like to thank Michelle James, and Natasha Shott who took the time to familiarise me with the prison processes, and who were open to helping me with any concerns that arose. They definitely made the long data collection process much easier for me. And to Vivian Liu, for helping me manage the complex timetable in Community Corrections.

I am deeply grateful to have shared this postgraduate experience with my fellow doctoral students, in particular Ali, Brindha, Yvette, Belinda and Tegan. They gave me a chance to share and debrief, and provided distractions and a chance to relax and

switch off along the way. It has been invaluable having others who understand the challenges of undertaking (and finally completing!) a doctorate, as well as the challenges of being a psychologist new to the profession. These are definitely people who have kindness, insight and a great compassion for others.

On a personal note, I would like to express my appreciation for May and Kivu, who both strongly encouraged me to apply for the doctoral programme, which helped me to dream big. And to Mary, who paved the way for postgraduate studies, with her outstanding achievements through much adversity. To my sister Meagan, who has provided me with every possible support I could have needed, how can I thank you enough. Your ongoing pride in me has been a strong motivator, and I will never forget how excited you were at my undergraduate graduation, it was the best part of my night. Not to mention my graduation present to Bali, you have such a generous spirit. A special thanks to my mother, Jane, who has provided me with emotional support through every bump in the road, your support has been invaluable. And to my brother, Carl, who is now inspiring me with studies of his own, it is great to see you follow your passions.

And last, but definitely not least, I would like to express my extreme gratitude to my husband, who is in the unfortunate position of only ever knowing me as a postgraduate student. You have understood the pressures this entailed and provided me support and encouragement, particularly at those times when I struggled to continue. I appreciate all of those breakfasts in bed, and the opportunities to switch off and go camping, or just taking the dogs for a walk. You have given me a life away from study and work, which I value greatly.

Abstract

Offender rehabilitation has the potential to decrease criminal recidivism. However, many offenders do not benefit from rehabilitation efforts, with average reductions in recidivism rates approaching 20%; this gives scope for further room for improvement in rehabilitation efforts. Compared to risk assessment work and studies regarding treatment need, relatively little attention has been given to the process of treatment delivery, particularly as this may interplay between offender responsivity factors and the within-treatment change processes. The objective of the thesis was to examine the impact of sexual offender's interpersonal style on therapeutic engagement and therapeutic gain. Three inter-related empirical studies were conducted, separately aiming to: 1) explore the impact of offender and therapist interpersonal style, including interpersonal complementarity, on the therapeutic alliance; 2) explore the frequency of ruptures and rupture repairs in the therapeutic alliance between offenders and treatment providers and examine the relationship between offender interpersonal style and the occurrence of ruptures and repairs; and to 3) explore the relationship between various offender characteristics and treatment process variables and treatment gain. To achieve these aims, self-report data were collected from 75 sexual offenders undertaking treatment over three time points, prior to the commencement of group treatment, soon after group treatment began, and prior to completion of the group treatment programme. Group facilitators also completed self-report measures soon after group treatment began. Treatment gain was assessed post-treatment, based on treatment completion reports and clinical notes. Correlational analyses, analyses of variance and multiple regression analyses were used to explore the relationship between interpersonal style, the therapeutic alliance, ruptures in the therapeutic relationship and treatment gain.

Results showed that the interpersonal style of offenders and therapists impacted the treatment process via the therapeutic alliance. Offender interpersonal style and the therapeutic alliance were also associated with treatment gain. If either therapists or sexual offenders viewed the other as hostile or dominant, they were subsequently more likely to view the therapeutic alliance as weaker. The degree of complementarity between offenders' and therapists' interpersonal style, that is, whether their separate interpersonal styles matched (e.g., a dependent client was paired with a dominant therapist) did not improve the therapeutic alliance. Offender interpersonal style was also related to ruptures in the therapeutic relationship. Hostility and hostile-dominance in sexual offenders were related to the likelihood of a rupture occurring in the therapeutic relationship, however offender dominance was not. Offenders who did not experience a rupture in the therapeutic relationship had a stronger view of the therapeutic alliance than offenders who experienced a rupture in the therapeutic relationship that was not repaired.

The strength of the therapeutic alliance was related to treatment gain (as measured through within-treatment change). However, the stage of alliance development and consideration of who was rating the alliance were important factors to take into account when predicting therapeutic outcome. Offender dominance and hostile-dominance were both related to treatment gain, whereas offender hostility alone was not. Therefore, it appears that dominant interpersonal traits impact offenders' engagement in therapeutic change. In addition, sexual offenders with psychopathic personality traits were less likely to make treatment gain. These findings suggest that offender responsivity and treatment process are both important factors that should be taken into account when trying to understand treatment gain.

Manuscripts Produced During Candidature

Peer Review Publications

Watson, R., Daffern, M., & Thomas, S. (under review). The impact of sex offender's interpersonal style, treatment readiness and the therapeutic alliance on treatment gain. Manuscript submitted to *Sexual Abuse: A Journal of Research and Treatment* May 24, 2015.

Watson, R., Thomas, S., & Daffern, M. (accepted for publication). The impact of interpersonal style on ruptures and repairs in the therapeutic alliance between offenders and therapists in sex offender treatment. Manuscript accepted for publication with *Sexual Abuse: A Journal of Research and Treatment* September 02, 2015.

Watson, R., Daffern, M., & Thomas, S. (2015). The impact of interpersonal style and interpersonal complementarity on the therapeutic alliance between therapists and offenders in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment*. Published online 30 April 2015. doi:10.1177/1079063215580969

Author's Note

The following thesis is a thesis by publication, this design consists of core chapters, which comprise papers that have been published, or under review in peer-reviewed journals. It is not a different qualification, but rather, reflects a different format to a traditional thesis. The Monash University Faculty of Medicine, Nursing, and Health Sciences requires that papers “must have at least been submitted for publication, though not necessarily accepted”. In accordance with Monash University Institute of Graduate Research guidelines, both published and submitted papers are reproduced in their manuscript format within the main body of the current thesis.

A thesis by publication must retain a sustained and cohesive theme; thus, framing and linking text – in the form of preambles – are included in the current thesis to explain how the reported research fits within the overall thesis framework.

English spelling is used throughout the thesis, however US English spelling is used for the style of published manuscripts as they were published/ or submitted in an international journal where US spelling was required. While every effort has been made to minimise repetition of content, some overlap and/or repetition is inevitable. This is particularly evident when describing the general themes underlying each of the papers, and when describing research design and methodology.

Chapter 1: Introduction and Thesis Overview

Introduction

Offender rehabilitation is more effective at reducing criminal recidivism when compared to punishments; however, according to recent meta-analyses, rehabilitation only produces reductions in recidivism rates of approximately 20% (with a range from 10% to almost 40%; Lipsey & Cullen, 2007). These findings suggest that there is scope for further improvement. The base rate for sexual recidivism typically falls within 10% to 20%, assessed at follow-up periods between 6 months and 23 years (Hanson & Bussiere, 1998; Hanson et al., 2002). Hanson and colleagues (2002) have found that sexual offenders' recidivism is significantly reduced through treatment, 12.3% compared to a non-treated recidivism of 16.8%. CBT-based rehabilitation programmes have been found to have a greater impact on recidivism, with treated offenders recidivating at 9.9%, and non-treated sexual offenders recidivating at 17.4% (Hanson et al., 2002). The studies reviewed had follow-up periods between 12 months and 16 years.

Since the 1980s offender rehabilitation has shifted to a strong evidence-based approach (Andrews & Bonta, 2010). The major impetus behind this has been the development and adoption of the Risk-Need-Responsivity (RNR) model (Andrews et al., 1990). The RNR model guides rehabilitation programmes by directing services to those offenders with the highest risk of reoffending (risk), targeting dynamic or changeable risk factors (criminogenic needs), and focusing on the individual characteristics of offenders that are likely to impact their ability to benefit from treatment (responsivity; Andrews et al., 1990; Day et al., 2010). Programmes that more closely adhere to these RNR principles have been found to have the highest reductions in both violent (Dowden & Andrews, 2000) and sexual recidivism

(Hanson, Bourgon, Helmus, & Hodgson, 2009). Although the RNR model has strongly guided rehabilitation (assessment and management of risk, and tailoring content to dynamic risk factors), attention has begun to be focused on the process of delivering the treatment programme, particularly as this may interplay with offender responsivity and the within-treatment change process.

The treatment process includes a variety of factors beyond programme content, including therapist characteristics, client's perception of therapists, the therapeutic climate (including group climate) and the therapeutic alliance (Marshall & Burton, 2010). Treatment process variables account for a significant proportion of treatment outcomes, with the therapeutic relationship alone accounting for approximately 25% of the variance in treatment outcome in non-forensic populations (specifically within-treatment change; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). The therapeutic alliance is a theoretical conceptualisation of the therapeutic relationship, which is defined by the collaboration between therapists and clients on tasks and goals, as well as the therapeutic bond (Bordin, 1979; Martin, Garske, & Davis, 2000).

In offender research, a stronger therapeutic alliance has been found to be related to enhanced therapeutic outcomes (Frost & Connolly, 2004; Holdsworth, Bowen, Brown, & Howat, 2014), with a weaker therapeutic bond between sexual offenders and their therapists being shown to be related to increased sexual recidivism (Blasko & Jeglic, 2014). In addition, a weaker therapeutic alliance has also been shown to be related to increased treatment attrition (Holdsworth et al., 2014; Martin, Garske, & Davis, 2000), which is a significant problem in offender rehabilitation, as treatment dropout has been shown to be related to increased recidivism rates (Olver, Stockdale, & Wormith, 2011). Breakdowns, or ruptures in the therapeutic relationship have also

been suggested to impact therapeutic outcomes (Holdsworth et al., 2014; Martin, Garske, & Davis, 2000). However, there is little research on these potentially critical aspects of treatment with offenders, particularly with the sexual offender population. More specifically, there are no known published articles on ruptures in the therapeutic relationship in offender treatment, and the impact of ruptures on treatment outcomes.

Internal responsivity characteristics, those individual characteristics that impact offenders' ability to benefit from treatment, are a focus of the current study, as these are thought to interact with the treatment process to limit therapeutic gains. Another factor that has been the subject of recent attention is offender interpersonal style. Interpersonal style describes the characteristic way people see themselves and behave in interpersonal settings (Kiesler, 1987). Psychopathy, which remains of particular interest to forensic psychiatry and psychology, is characterised by a hostile and dominant interpersonal style. Offenders with higher levels of psychopathy are often found to have a poorer response to treatment (Hobson, Shine, & Roberts, 2000). It is also thought that psychopathic traits such as emotional shallowness, manipulativeness, dishonesty, and superficiality make developing a therapeutic alliance more difficult (Hemphill & Hart, 2002). Psychopathy has been the most commonly researched responsivity factor, conversely there is very limited research into the other characteristics that may enhance or interfere with sexual offender treatment gain.

One conceptualisation of interpersonal style that has received some focus (albeit limited) has been the interpersonal circumplex (Kiesler, 1987). This is a theoretical conceptualisation of interpersonal style. The two core dimensions of this model are power or control (ranging from dominance to submission) and affiliation (ranging

from hostility to friendliness; Blackburn & Renwick, 1996). Research has found that dominance is related to sexual offender treatment non-completion (Edens, 2006), with a lower level of affiliation being related to reduced benefit from the therapeutic process in non-offenders (Hardy et al., 2001). Further research is needed to determine the impact of interpersonal style on the therapeutic alliance between sexual offenders and their therapists, and the ability of people with particular interpersonal styles to make treatment gains. Additionally, there has been little research exploring the interaction between offender and therapist interpersonal styles, and the influence of this interaction on the strength of the therapeutic alliance. One measure of the interaction between offenders' and therapists' interpersonal styles is complementarity, which explores the degree to which the interpersonal style of offender and therapist match.

Thesis Objectives

The objective of the thesis is to explore the association between sexual offenders' characteristics, specifically their interpersonal style and level of psychopathy, and treatment process variables (i.e., the strength of the therapeutic alliance and whether ruptures were experienced during treatment) on treatment gain. This is an important field of research as it has the potential to elucidate those offender and therapist characteristics that may make it harder to establish and maintain a strong therapeutic alliance, and also explore the relative impact of offender and therapist factors and treatment process variables on treatment gain. The research aims for each study are outlined below.

Research Aims Study One. a) to describe and compare the nature of the therapeutic alliance from the perspective of therapists and offenders; (b) to determine the relationship between therapists' and offenders' interpersonal style and the

therapeutic alliance; (c) to explore whether offender hostility and dominance is related to the therapeutic alliance; and (d) to explore the level of complementarity in interpersonal style between therapists and offenders and determine whether complementarity is related to therapeutic alliance.

Research Aims Study Two. a) to describe the occurrence of ruptures in a sexual offender sample in treatment; b) to assess changes in offender rated therapeutic alliance from commencement to the end of treatment; c) to determine whether changes in therapeutic alliance over time differs for those who do not experience a rupture compared to those who experience a rupture that is repaired and those who experience a rupture that is not repaired; d) to determine whether interpersonal hostility, hostile-dominance, and psychopathy impact ratings of end-of-treatment therapeutic alliance for those offenders who report no rupture, a minor rupture or a major rupture; and e) to determine whether interpersonal or offence-specific factors affect the likelihood of a rupture being repaired.

Research Aims Study Three. a) to ascertain whether offender interpersonal style, treatment readiness or ratings of the therapeutic alliance predict treatment gain; and b) to determine whether the association between offender characteristics and treatment gain is moderated by the therapeutic alliance.

Thesis Overview

Chapter 2 comprises the literature review, which provides the background for the three studies; specifically it considers the history of offender rehabilitation. This includes a summary of the risk-needs-responsivity model (Andrews et al., 1990), the good-lives model (Ward, 2002) and theories of change (Prochaska, DiClemente, & Norcross, 1992). Treatment responsivity is further explored through the broader conceptualisation of treatment readiness, and the multifactor offender readiness

model (Ward, Day, Howells, & Birgden, 2004). The literature review then explores treatment engagement; both general and forensic research is reviewed, followed by a review of the literature pertaining to ruptures in the therapeutic relationship. Treatment responsiveness is then reviewed, with a particular emphasis on interpersonal style.

Chapter 3 provides an extended description of the methodology, to supplement those methodologies described in Studies 1, 2 and 3. This extended methodology describes the overall study design and provides details regarding participants, measures, the procedure and approach to analyses used in the subsequent studies.

Chapter 4 presents the first empirical study. This chapter begins with a summary of the literature regarding the therapeutic alliance and interpersonal style. Analysis of variance was used to determine the difference in offender-therapist ratings of the therapeutic alliance, with correlational analyses used to determine the association between interpersonal style (including complementarity) and the therapeutic alliance. Finally, regression analyses were used to determine whether offender interpersonal style would predict the strength of the therapeutic alliance.

Chapter 5 presents the second empirical study of the overall thesis. This chapter begins with a summary of the literature regarding the therapeutic alliance, ruptures in the therapeutic relationship and interpersonal style. Frequency analyses were run to determine the presence of ruptures and repairs in the therapeutic relationship, with analyses of variance being used to determine the difference of ratings of the alliance over the course of treatment, and whether offender interpersonal style differed for those who did not experience a rupture compared with those who experienced a minor or major rupture. Logistic regression analyses were run to determine the

impact of offender interpersonal style and offence-characteristics on the likelihood of a rupture being repaired.

Chapter 6 presents the third, and final, empirical study of the thesis. This chapter begins with a summary of the literature on the effectiveness of rehabilitation, offender responsivity and within-treatment change. Regression analyses were used to determine the impact of offender interpersonal style and the therapeutic alliance on treatment gain. Multiple regression analyses were also used to determine whether therapeutic alliance moderated the impact of offender interpersonal style (hostile-dominance and offender psychopathy) on treatment gain.

Chapter 7 presents the integrated discussion. This chapter presents an overview of the research aims of each empirical study, before providing a synthesis of each of the three studies' findings. An overview of the theoretical and clinical implications, suggestions for future research, a discussion of the overall study's limitations and a conclusion are offered.

Chapter 2: Literature Review

Rehabilitation programmes are promoted within prison and community settings to help reduce criminal recidivism (Lipsey & Cullen, 2007). These rehabilitation programmes aim to provide offenders with support and assistance to change their offending behaviours, or to change or otherwise manage the factors that contribute to their offending (Lipsey & Cullen, 2007). Andrews and Bonta (2010) report a change in attitude during the 1970s from a rehabilitative focus (which was argued at the time to be ineffective; Martinson, 1974), to one of punishment to deter and prevent further offending. Due to continued concerns about the perceived effectiveness of offender rehabilitation efforts, both in the USA and in Australia, there was an increased public focus on harsh penalties to deter criminal behaviours (Andrews & Bonta, 2010; Ross & Guarnieri, 1996). To counter the belief that rehabilitation was ineffective, rehabilitation efforts since the 1980s have focused on creating an evidence-based approach (Andrews & Bonta, 2010). For sexual offenders, pressures arising from community concerns about safety, victim advocacy agencies, and the introduction of dangerous offender and sexual offender specific legislation (such as Victoria, Australia's Serious Sex Offenders Monitoring Act, 2005) has led to an increased focus on the efficacy of sexual offender rehabilitation (Heseltine, Sarre, & Day, 2011; Sullivan, Mullen, & Pathé, 2005).

A review of meta-analyses conducted on the effectiveness of rehabilitative services on reducing recidivism rates has shown that, on average, rehabilitation leads to a 20% reduction in criminal reoffending across all offence types (with a range from 10% to almost 40% reduction in recidivism; Lipsey & Cullen, 2007). It has been shown that incarceration and sanctions within prison, without rehabilitation, can lead to increased rates of reoffending (Chen & Shapiro, 2007). Meta-analyses

exploring the effectiveness of punishment alone have shown that offenders who were incarcerated had higher recidivism rates than those who were placed on probation (Lipsey & Cullen, 2007); none of the meta-analytic studies reviewed by Lipsey and Cullen (2007) revealed a reduced rate of recidivism for correctional confinement.

Even though there is evidence of some success with rehabilitation efforts, there are still high levels of recidivism even for those who complete treatment programmes (Lipsey & Cullen, 2007), which suggests that rehabilitation efforts may still be improved. Research conducted by the Australian government showed that recidivism rates approximate 45% of all adult prisoners (all offence types combined), 2-years following release (Steering Committee for the Review of Government Services, 2006). An assessment of Australian prisoners by the Australian Bureau of Statistics (ABS) in 2011 showed that over half of all adult prisoners assessed at that time had been imprisoned previously (ABS, 2011). In Victoria, when analysing reconviction rates of prisoners (all offence types), as well as reimprisonment, it was found that within three months of release 24% of prisoners were reconvicted (Ross & Guarnieri, 1996). Further, within seven years of release, at least 74% of prisoners were reconvicted, and 54% had been reimprisoned. A study conducted on offending rates in 2002 found that 31% of New South Wales and Victorian male prisoners were reimprisoned within 9 months of release; with 51% of Indigenous prisoners being returned within that timeframe (Baldry, McDonnell, Maplestone, & Peeters, 2006), suggesting that recidivism occurring soon after release may be an increasing problem.

For sexual offenders specifically, approximately 10% to 20% will reoffend with a further sexual offence, with follow-up periods between 6 months and 23 years (Hanson & Bussiere, 1998; Hanson et al., 2002), which is relatively low compared to other offence types (Lievore, 2004). Lievore's (2004) review of sexual offender

recidivism found that different subtypes of sexual offenders recidivate at different rates, with incest offenders being least likely to reoffend, and extra-familial child sexual offenders being most likely to reoffend. Rapists are more likely to reoffend with a violent offence, and they typically have a larger general criminal history. Additionally, sexual offenders are most likely to reoffend within two to three years of release, however some will reoffend after this time. Sexual offender recidivism rates for all offence types (including non-sexual offences) have been found to be higher than sexual recidivism in isolation, with a 36.3% rate overall, and the highest recidivism rates being 46.2% for those previously convicted of a rape offence (Hanson & Bussiere, 1998). Even though rehabilitation provides the greatest recidivism reduction gains, many offenders still recidivate. The reasons why people reoffend despite completing treatment, and the intervention that produces the most effective reductions requires elucidation.

Attempts to understand the problems that can occur with rehabilitation in forensic settings require examination of issues arising from mandated treatment, including issues of social control and expectations of change from therapists and the prison system (Larke, 1985). Problems impacting the effectiveness of rehabilitation include difficulties with interpersonal relationships (which can be due to a lack of emotional awareness or control, as well as a lack of trust in others; Day, Casey, Ward, Howells, & Vess, 2010) and a lack of belief about the offending behaviour being problematic (Day, Bryan, Davey, & Casey, 2006; Day et al., 2010). These difficulties can lead to non-completion of the therapeutic programme. Our understanding of the rates of non-completion of treatment programmes, and the reasons that lead to this, remains limited in the Australian context. A recent meta-analysis of 114 studies of sexual offender and domestic violence interventions (Olver,

Stockdale, & Wormith, 2011) found an overall attrition rate of approximately 27% for all forensic therapeutic programmes, with 27% for sexual offender programmes and 37% for domestic violence programmes (Olver et al., 2011). Within the NSW Sex Offender Programme, a recent review reported a 33% attrition rate, with offenders dropping out of the programme due to behavioural problems such as aggression, unsatisfactory treatment progress or resistance to treatment (Ware & Bright, 2008).

Within a forensic setting, clients who drop out of treatment often show worse outcomes than those who complete treatment, and more importantly, than those who don't start treatment in the first place (McMurran & Theodosi, 2007; Olver et al., 2011). For sexual offenders, these outcomes include higher rates of both sexual and violent recidivism (Hanson & Bussiere, 1998; Hanson et al., 2002). McMurran and Theodosi (2007) surmised that the reason dropping out of treatment is worse than not beginning treatment could be due to: increased anti-authority attitudes, bringing up difficult personal issues that were not dealt with sufficiently, or increased sense of low self-worth or confidence from failing to finish the programme. A meta-analysis of offender treatment research has found that there are specific offender characteristics that are related to attrition, these include: psychopathy, greater criminal history, sexual deviance, higher score on risk assessment measures, treatment responsivity issues, problem attitudes/cognitions and denial or negative impression management (Olver et al., 2011). For sexual offenders specifically, denial and negative treatment attitudes also predict attrition, with higher levels of motivation and treatment engagement decreasing attrition rates (Olver et al., 2011).

This literature review aims to examine those factors that are thought to impact the effectiveness of rehabilitative services and in particular those factors that impact

sexual offenders' engagement in treatment programmes and treatment gain. This will be considered by exploring the broader non-forensic psychotherapy literature and where available, the findings from forensic literature, as well as specific sexual offender research. It is noted that while not always directly applicable, the non-forensic psychotherapy literature can be valuable in guiding the direction of further research into sexual offender rehabilitation. The areas of review include responsivity factors (e.g. matching content and pace of sessions to client attributes such as personality and cognitive ability, as well as staff and setting characteristics; Day, Casey, Ward, Howells, & Vess, 2010) pre-treatment measure of engagement, as conceptualised through treatment readiness (characteristics within the client or the therapeutic situation that support engagement in therapy, and are likely to promote therapeutic change; Howells & Day, 2003), expanding this readiness model to look at offender interpersonal style, and reviewing further therapeutic process factors including the therapeutic alliance and therapist characteristics. It will be argued that these factors impact upon sexual offenders' engagement in, and their derived benefit from therapeutic intervention.

Evidence-Based Rehabilitative Practice

The most critical impact on offender rehabilitation practices was the introduction of the Risk-Needs-Responsivity (RNR) model, first introduced by Andrews and colleagues in 1990. This is an evidence-based approach that informs practice in offender management, with evidence that interventions based on these principles can help reduce recidivism (Day et al., 2010). Risk assessment is a large part of the RNR approach, with treatment programmes being offered to those at higher risk of reoffending, allowing a targeted approach for resources to those most in need (Andrews et al., 1990; Day et al., 2010). A focus on dynamic or changeable risk

factors (or criminogenic needs, which fall under the ‘needs’ component of the RNR model) allow for a more targeted approach to treatment, promoting intervention on the dynamic risk factors that are associated with criminal offending (Andrews et al., 1990; Day et al., 2010). The responsivity component (including motivation, goals, problem awareness, personal identity and emotional capacity to engage) includes both general and specific elements: *general responsivity* suggests that cognitive behavioural treatment has been most effective for offenders in general (regardless of offender characteristics), whereas *specific responsivity* recognises that non-criminogenic factors that impact treatment response may need to be addressed to maximise treatment efficacy (Bonta & Andrews, 2007). These specific factors include individual characteristics of the offender that are likely to impact their ability to benefit from treatment, with one important part of this being motivation to change (Andrews et al., 1990; Day et al., 2010).

An influential meta-analysis of 45 studies on juvenile treatment programmes, and 35 studies on adult treatment programmes, ranging from the 1950s to 1989, showed that those rehabilitative programmes that most closely adhered to the RNR principles had more success in reducing recidivism, while programmes that did not follow RNR principles produced increased rates of recidivism (Andrews et al., 1990). The programmes that followed RNR principles included those that involved treatment for higher risk cases, and those that used structured intervention to target criminogenic needs. The success of the RNR approach appears to be generalisable across different types of offenders, as well as different forensic settings (Andrews & Bonta, 2010), including violent offenders (Dowden & Andrews, 2000) and sexual offenders (for needs and responsivity principles only; Hanson, Bourgon, Helmus, & Hodgson, 2009). For example, a meta-analysis of 23 studies, which had recidivism rates as the

outcome, found that programmes that more closely applied the RNR model had the highest reductions in general recidivism, and those that adhered to the needs and responsivity components of the RNR had higher reductions in sexual recidivism (Hanson et al., 2009). Although adherence to the risk principle was not significantly related to recidivism for sexual offenders, the direction of the effect was consistent with expectations (stronger treatment effects for higher risk offenders). Another meta-analysis, synthesising the results from 35 studies, found that those treatment programmes that most closely followed four RNR principles (1. human service, 2. risk, 3. criminogenic need, and 4. general responsivity, including modelling, role play and problem solving) had the greatest reductions in violent recidivism (Dowden & Andrews, 2000).

In addition to the RNR model, a Good Lives Model (GLM; first conceptualised by Ward in 2002) outlined a new approach to understanding offender rehabilitation. The GLM is an individually focused approach that seeks to enhance an offender's quality of life so that it is fulfilling and therefore less likely to lead to offending (Ward, 2002). The GLM assumes that an individual's general motivations or goals underlying their behaviour are seldom inherently bad (Day et al., 2010). But rather, people are motivated by 'primary human goods', which incorporates drives for: physical life needs, autonomy, inner peace, relatedness, community, happiness, excellence in play and work, spirituality and knowledge. According to the GLM, promoting better lives for offenders during rehabilitation can lead to a risk reduction. The GLM assumes that having an effective and pro-social way of achieving these primary human goods can reduce dynamic risk factors (Day et al., 2010). However, there has been criticism of the GLM, based on the belief that it takes away from the evidence-based assessment approach of the RNR model (Andrews, Bonta, &

Wormith, 2011). It has also been argued that the two can be combined, to allow for the dynamic risks to be lowered, while incorporating an individual focus on enhancing quality of life and achievement of the primary human goods (Ward, Yates, & Willis, 2012). Nevertheless, at this stage there is little published evidence for the impact of GLM on reoffending.

Although the RNR approach is highly regarded and widely used in selecting offenders for rehabilitation programmes, as well as being supported evidentially, a limitation of this approach is that it has limited focus on the process of therapy (Day et al., 2010). Offender responsivity is one area that is thought to impact the treatment process. More recently, researchers have attempted to expand the responsivity principle by broadening its conceptualisation, referring to the new, broader conceptualisation as readiness. A key aim of this new treatment readiness conceptualisation is to expand the limited progress made in the area of responsivity and to operationalise this concept in a way that allows for enhanced assessment and engagement (Day et al., 2010). To be treatment ready implies that the person is motivated to participate in the therapeutic programme, is able to respond to the therapist and the demands of the programme, and finds the treatment relevant (Ward, Day, Howells, & Birgden, 2004). It also means that the person has the skills and the capacity to enter and benefit from the therapeutic programme (Ward et al., 2004). This conceptualisation of treatment readiness also recognises that there are external factors, beyond offender (internal) responsivity factors, which may impact engagement in treatment (Ward et al., 2004). It may be that broader treatment process factors can be incorporated into this understanding of responsivity and readiness.

Looking beyond individual responsivity factors, broader treatment process factors have been found to relate to therapeutic gain, these include therapist

characteristics, client's perception of the therapist, the therapeutic climate of the group and the therapeutic alliance between treatment provider and client (Marshall & Burton, 2010). Treatment process variables may provide improvements to treatment outcomes. Process variables have been found to account for approximately 25% of variance in treatment outcome, in a non-forensic general psychotherapy sample (as measured through within-treatment change; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). Treatment process has commonly been examined in sexual offender research through analysing therapist characteristics that are likely to impact offender engagement and attrition, which will be addressed further in the literature review. It is thought that additional treatment process variables, such as the therapeutic alliance will impact upon sexual offender treatment gains, however this has received little empirical research to date.

Sexual Offender Treatment

Early sexual offender treatment was predominantly behavioural, with a focus on reducing deviant sexual arousal through aversion therapy and conditioning procedures (Laws & Marshall, 2003). This was based on the belief that deviant sexual arousal was causally linked to sexual offending. However, early reviews of sexual offender treatment suggested that behavioural intervention alone did not account for reduced recidivism rates (Hall, 1995; Rice, Quinsey, & Harris, 1991). Behavioural theories of sexual offending were therefore expanded throughout the 1970s and 1980s to incorporate cognitive processes (perceptions, memories, attitudes and beliefs) that directed behaviour (Marshall & Laws, 2003). The focus on developing healthy sexual interests (to contrast sexual deviance) was based on a belief that sexual offenders lacked the appropriate social skills to develop healthy, age appropriate sexual relationships (Becker, Abel, Blanchard, Murphy, & Coleman,

1978). This expanded to include the notion of cognitive distortions in helping to justify and maintain sexual violence (Marshall & Laws, 2003). As such, treatment programmes were developed to include reconditioning of appropriate sexual interests, social skills and assertiveness skills development, and challenging of cognitive distortions that were thought to increase propensity for sexual offending. In addition to this a relapse prevention approach was incorporated into sexual offender treatment programmes, which was largely drawn from a drug and alcohol treatment framework (Kirsch & Becker, 2006). It has since been suggested that sexual offending planning may additionally depend on positive mood and appetitive drives, which may not be adequately addressed by a traditional relapse prevention approach (Hudson, Ward, & McCormack, 1999). Additionally, Kirsch and Becker (2006) suggest that heterogeneous pathways to offending have yet to be incorporated into the current relapse prevention framework.

Further to the etiological understanding of sexual offending, evidence-based dynamic risk factors (e.g. sexually deviant interests/behaviours, antisocial orientation/criminality) based on the RNR model, have been used to guide programme content within sexual offender programmes (Olver, Wong, Nicholaichuk, & Gordon, 2007). The current CBT-based approach to sexual offender rehabilitation has been found to reduce recidivism by as much as 40%, with Hanson and colleagues (2002) noting a reduction in recidivism from 17.4% in untreated sexual offenders to 9.9% in treated sexual offenders. However, a significant number of sexual offenders do not respond to treatment, thus there remains a demand for the further refinement of treatment programming efforts. Against this background it is possible that responsivity and treatment process factors may be investigated to assist improvement in treatment.

Measuring Within-Treatment Change

Treatment outcome research in offender populations has almost exclusively focused on the distal outcome of recidivism rates; individually based within-treatment change has not received much attention (Beggs, 2010). Within-treatment outcomes are those gains or changes that occur as a result of treatment, and can be measured directly after treatment completion, whereas recidivism post discharge (for incarcerated offenders) is a longer-term measure of treatment gain, which may be influenced by numerous post treatment factors (e.g., loss of a relationship or accommodation; Beggs, 2010). Within-treatment change presents as a potentially important outcome measure because it facilitates exploration of the change process, and ascertains how these changes are related to recidivism (Kirsch & Becker, 2006). Within-treatment change analyses allow for examination of the effectiveness of the procedures used to ameliorate risk factors, or enhance GLM goods. It also allows us to understand which components of the treatment programme are most effective at reducing recidivism (Kirsch & Becker, 2006), as changes in specific dynamic risk factors, responsivity or treatment process issues may differentially relate to offender change.

There are three types of within-treatment change measurements: measuring dynamic risk factors pre-post treatment, risk assessment tools measuring within-treatment outcome, and clinically rated post-treatment gain (can include treatment gain factors and behavioural conduct in treatment; Beggs, 2010). To date, findings on change during treatment and subsequent impact on recidivism rates within sexual offender treatment have been inconsistent. However, regardless of measurement type, the studies reviewed by Beggs (2010) either showed no relationship between within-treatment change and recidivism, or a negative relationship, with increased gain

being associated with decreased recidivism. Most studies exploring treatment-related change have used a clinical post-treatment measurement of within-treatment change. Although, Beggs and Grace (2011) found that both a pre-post treatment measure of change and clinical post-treatment rating were positively correlated with each other; higher ratings of both predicted a reduction in sexual recidivism.

When measuring whether pre-post changes in specific treatment targets (including dynamic risk factors) impact on recidivism rates, study results have been inconsistent. Wakeling, Beech, and Fremantle (2013) found that treatment change, with 'improved' ratings (an increase) of sexual obsessions, rumination, impulsivity, empathy, perspective taking, or self-esteem being related to higher rates of recidivism, compared to those who 'deteriorated' or were 'already okay'. In addition, other research on sexual offenders has found that positive treatment changes in self-esteem were associated with a reduction in sexual recidivism, and reductions in anger and hostility were associated with reductions in violence recidivism (Olver, Nicholaichuk, & Wong, 2014a). A reduction in a combined dynamic needs score (drawn from the Violence Risk Scale – Sexual Offender Version) was also associated with reductions in both violent and sexual recidivism (Olver et al., 2014a). Treatment change in the areas of sexual deviance, and responsivity were related to reductions in general, sexual and violent recidivism (Olver, Beggs, Christofferson, Grace, & Wong, 2014b). However change in pro-offending attitudes and cognitions were not related to reduced recidivism (Beggs & Grace, 2011; Olver et al., 2014a).

Barnett, Wakeling, Mandeville-Norden, and Rakestrow (2013) found that in sexual offenders undergoing community-based treatment (n = 3,402) there was no relationship between treatment change and recidivism once pre-treatment risk level had been taken into account. Measures of change included: self-esteem, locus of

control, emotional loneliness, victim empathy distortion, cognitive distortions, under-assertiveness and emotional distress. However, Beech and Ford (2006) looked at a sample of 51 sexual offenders, and found the opposite, none of the offenders who had shown within-treatment change reoffended, whereas 14% of offenders who did not show within-treatment change went on to reoffend. The change assessed was a shift in sexual offenders' attitudes across eight measures: self-esteem, emotional loneliness, under-assertiveness/over-assertiveness, victim empathy distortions, personal distress, locus of control, emotional identification with children and sexual interest in children. Olver, Kingston, Nicholaichuk, and Wong (2014c) found small to moderate pretreatment to post-treatment changes on measures of sexual offenders' cognitive distortions, aggression/hostility, empathy, loneliness, social intimacy and acceptance of responsibility, however, scores on these measures frequently demonstrated a weak and /or inconsistent relationship to sexual, violent and general recidivism. Due to these inconsistencies, Olver and colleagues (2014c) suggested that these findings do not support the use of self-report measures when analysing offender change. Although Olver and colleagues also noted that the correlation between self-report change scores and recidivism increased after partialling for pre-treatment scores (potentially removing variance associated with impression management), which suggests that self-report measures may provide a useful measure of treatment change. Overall, the findings also suggest that all targeted treatment areas may not equally contribute to reductions in recidivism. Beggs (2010) notes that beyond risk specific within-treatment outcomes, responsivity factors are a potentially important area of research and clinical work and that enhancing responsivity would allow clinicians' to maximise offenders' ability to engage in and benefit from treatment.

Treatment Readiness

Treatment readiness concerns the factors that influence whether an offender enters, remains in, or engages in therapy (McMurrin & Ward, 2010). Assessment of treatment readiness can be used to identify aspects of a person that influences their engagement with treatment, and therefore, with proper intervention when readiness is low, can increase treatment success (McMurrin & Ward, 2010). Originally, the understanding of treatment readiness stemmed from an understanding of motivation to change, and understanding the cycle of change and a person's preparedness to make change (Serin & Kennedy, 1997; Serin & Lloyd, 2009). This has since been expanded to include both internal responsivity factors and external factors, such as the type of program, access to services and situational factors (Ward et al., 2004).

When looking at how people change in general, and also through the therapeutic process, the mostly commonly used model of change is the transtheoretical model of change (TTM), which consists of five stages of change: 1) Precontemplation (there is no intention to change), 2) Contemplation (awareness that the problem exists and some desire to change it, but no action plan), 3) Preparation (intention to take action, and some previous attempts at change), 4) Action (behaviour, experience or environment is modified to make the change and overcome the problem) and, 5) Maintenance (prevention of relapse; Prochaska, DiClemente, & Norcross, 1992). These stages are often cycled through as the person desiring change either makes progress or experiences a relapse (Prochaska et al., 1992). This model has typically been used for guiding treatment of people with addictions, however a more recent overview of the use of the TTM in forensic populations has been compiled (Casey, Day, & Howells, 2005). For sexual offender treatment, it has been suggested that addressing cognitive distortions and victim empathy early in treatment can increase

awareness and allow for a re-evaluation (potentially increasing problem awareness, leading to a shift from the pre-contemplation, to contemplation or action stages of change). It was noted by Casey and colleagues that sexual offenders might find it difficult to develop the therapeutic relationship, which is believed to be critical to the action and maintenance stages, due to the social stigma attached to child sexual offending. Overall, the TTM relates to readiness because individuals who are in the pretreatment, or contemplation stages, are not likely to want to be engaged in a therapeutic programme that is based on action (i.e., change). This has implications for treatment readiness, as those who are not aware that they have a problem that needs changing, or are unwilling to take action to change, may not be ready to engage in treatment.

There has been criticism of the TTM, with a critique of the model being conducted on 87 studies, showing that the stages of change are often not discrete, with there being overlap between non-adjacent stages, for example the precontemplation and action stages (Littrell & Girvin, 2002). This suggests that people can have components of different stages simultaneously, which may be problematic for those measures that use the TTM to assess within-treatment change, such as the Violence Risk Scale – Sexual Offender Version, as measures that use the TTM conceptualisation may not adequately represent an offender's level of change. Another critique of the TTM is that it fails to take into account all of the internal and external contributors to motivation (Drieschner, Lammers, & van der Staak, 2004). Drieschner and colleagues (2004) noted that motivation can often be multidimensional and can shift based on internal and external factors, including perceived external pressures, outcome expectancies, self-efficacy and perceived suitability of the treatment.

Serin and Kennedy (1997) explored treatment readiness, as well as responsivity, within an offender population, with treatment readiness being conceptualised as one aspect of treatment responsivity (which also included the offender's motivation to make change). They defined responsivity as being related to response to treatment, compliance and amenability, and treatment gain (Serin & Kennedy, 1997). The treatment gain aspect incorporates the degree of change the offender has made. At this conceptualisation of treatment readiness, it was understood that the TTM provided some basis for understanding change, however in offender populations, rather than those with addictions only, the TTM did not look enough at individual differences that can lead to and sustain change (Serin & Lloyd, 2009). It was also limited in the lack of focus on the prosocial aspects that are needed to support a life of non-offending (Serin & Lloyd, 2009).

Following Serin and Kennedy's (1997) elucidation of treatment readiness, Ward and colleagues (2004) created a model that incorporated both internal responsivity factors (including motivation, goals, problem awareness, personal identity and emotional capacity to engage), and external factors, such as access to services, type of programme and general environmental/situational factors. This is known as the Multifactor Offender Readiness Model (MORM; Casey, Day, Howells, & Ward, 2007). According to the MORM, readiness encompasses cognitive (beliefs, cognitive strategies), affective (emotions), volitional (goals, wants or desires), and behavioural (skills and competencies) domains and factors related to identity (Casey et al., 2007). Specifically, treatment readiness can be defined as "the presence of characteristics (states or dispositions) within either the client or the therapeutic situation, which are likely to promote engagement in therapy and which, thereby, are likely to enhance therapeutic change" (Day et al., 2010, p. 6). Within the MORM, treatment readiness

is seen as a broader construct that encompasses both motivation and responsibility (Day et al., 2010). Therefore, when someone is ready for treatment, they are motivated to be in treatment, able to respond to the treatment, able to engage in treatment, and also, they have the capacity to do so (Day et al., 2010).

The MORM has demonstrated validity for use with violent offenders in Australia (Day et al., 2009). When using the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ; a measure of treatment readiness based on the internal aspects of the MORM; Casey et al., 2007), readiness was found to accurately predict treatment engagement with offenders undertaking the violent offender treatment programme. Additionally, researchers have used the MORM to investigate the affective aspect of readiness in violent offenders, and how this impacted engagement in the treatment programme (Howells & Day, 2006). Howells and Day (2006) proposed that accessibility to emotion, and the ability to express this emotion, may impact treatment readiness and engagement. However, this has not yet been supported empirically. Ward, Day, Howells, and Birgden (2004) noted that sexual offender treatment readiness might be particularly impacted by offenders' affective responses, specifically the emotions of shame and guilt. A preoccupation with concerns about negative self-evaluation may prevent sexual offenders from engaging in therapy. However, it is thought that guilt can motivate therapeutic engagement and behaviour change, as levels of shame are reduced. As with other offender types, Ward and colleagues (2004) noted that having adequate cognitive abilities and interpersonal skills enables sexual offenders to participate more effectively in the therapeutic programme, and to engage in a therapeutic relationship with their facilitators.

Although relatively new, the MORM provides a conceptualisation of treatment readiness, which allows for a range of both internal and external factors to be researched and incorporated into the one model. The internal factors allow for an expansion of the current understanding of responsivity that is incorporated in the RNR. Although the current measure of the MORM (the CVTRQ) does not incorporate a measure of external factors, it may be that therapeutic process factors (such as therapist characteristics and group climate) can add to the understanding of offender treatment readiness, as these factors are likely to impact offender engagement.

Treatment Engagement

Treatment readiness is a pretreatment measure of factors that may impact treatment engagement. Treatment engagement incorporates multiple constructs, including the level of therapeutic alliance between the client and the therapist and the client's engagement with the actual therapeutic process, including engaging in therapeutic tasks (Elkin et al., 1999; Simpson & Joe, 2004). When someone is not engaged in the therapeutic process it can be seen through poor attendance, clients dropping out of therapy or a poor relationship between the therapist and client (Howells, 2004). Another way a lack of treatment engagement can present is through the client's reluctance or unwillingness to completely participate in therapy or with therapeutic tasks (Howells, 2004). When someone is well engaged in treatment there is an improved treatment process (which includes the client engaging in the specific treatment programme tasks, as well as in the therapeutic relationship; Serin, Kennedy, Mailloux, & Hanby, 2007), and there is a higher likelihood of treatment retention, thus leading to better therapeutic outcomes (Garner, Godley, & Funk, 2008).

Research into treatment engagement has revealed various reasons why people don't engage in therapy. One study has found that a client's cognitive ability may impact their level of engagement, with higher cognitive ability being predictive of higher levels of engagement (Katz et al., 2005). In this study treatment engagement was measured through treatment motivation (incorporating: problem recognition, desire for help, and treatment readiness) as well as a measure of treatment retention (how long they participated in the outpatient drug treatment programme). It was also shown that those with lower cognitive abilities showed higher levels of hopelessness regarding their future. Another study found that clients who were more autonomous in their motivation towards treatment (those that believed they were initiating and in control of their own actions towards change) were more likely to engage in the therapeutic process (Klag, Creed, & O'Callaghan, 2010). In this study treatment engagement was measured based on the level of self-reported 'involvement' in the therapeutic community for substance users.

A review of programmes seeking to enhance treatment engagement has found that (with a depressed elderly population) using an individualised programme, such as removing barriers to treatment access and shared-decision making about which treatment option to use, increased the level of treatment engagement (Raue & Sirey, 2011). Psychiatric clients who were more introspective, and were able to accept personal responsibility for their problems, were also more likely to have higher treatment engagement (Loeffler-Stastka & Blueml, 2010). This was true also for those that had less dysfunctional personality styles, enabling them to engage more with the therapeutic process.

An analysis of feedback themes from eight psychiatric wards, chosen for their high levels of treatment engagement, found that treatment engagement can be

enhanced through: improving respect and empowerment of patients, making sure staff are available for patients to access when needed (including a sense that the staff are approachable), making observations of the patients more interactive, and increasing the amount of therapeutic programmes on the ward (Pereira & Woollaston, 2007). It was also found that, on a psychiatric ward, the atmosphere on the ward influenced the patient's motivation, as well as levels of depression, and therefore their treatment engagement (Beazley & Gudjonsson, 2011). Perceiving the psychiatric ward to have a poor atmosphere was related to higher levels of depression and lower motivation to engage in treatment.

Disengagement has been shown to be problematic, with one-third of people with serious mental health issues being found to be disengaged from mental health services (Kreyenbuhl, Nossel, & Dixon, 2009). It was found that younger males, people with low social functioning, and people from an ethnic minority background, were more likely to disengage from mental health treatment services. A further risk of problematic engagement was with people with early onset psychosis, or with comorbid psychiatric and substance use disorders. Difficulties occurred with treatment engagement for the early psychosis population (who only had symptoms for the first time within the previous 2 years), with those who had been physically abused as a child, or had low levels of neuroticism and high agreeableness (Lecomte et al., 2008). In this study engagement was reported by the therapist, and looked at how available the client was for treatment, their level of collaboration and help-seeking behaviours, as well as their adherence to treatment. Having only the therapist's report of disengagement is somewhat problematic because it doesn't explore the client's view of engagement, which may give further explanation into why engagement was not attained.

Treatment disengagement can occur because of a lack of collaboration in the therapeutic relationship, and can also occur if the client doesn't believe that the treatment is necessary or is meeting their needs (Kreyenbuhl et al., 2009). Another factor associated with early disengagement from treatment (as measured by dropping-out after the first session) was having a lower socioeconomic status, which was assessed through educational level (Rossi et al., 2008). It has also been found that patients disengage from treatment due to external demands, such as having difficulty taking time off work to attend sessions, or being in a time constraining caring role (Ruggeri et al., 2007).

The implications for treatment disengagement were investigated by Rossi and colleagues (2008), who found that psychiatric patients who dropped out of treatment after the first session were more likely to be unwell, as measured by a general health questionnaire, compared to those that were discharged after one session. It was also found that patients that dropped out rated their initial contact as unsatisfying. This suggests that the disengagement from the service due to dissatisfaction may be negatively associated with patient outcomes, more so than the amount of time participating with the service. Even though it was found that patients that were dissatisfied with the service dropped out quickly, it was noted that some of these people self-referred to other services, which means that they could potentially find another service that was more suitable. Another study, however, found that only 30% of people who dropped out of community mental health services followed up with other health professionals; including general practitioners and private psychologists or psychiatrists (Ruggeri et al., 2007). It was also shown that patients who dropped out of the service were unwell more frequently (as rated by higher levels of

psychopathology, higher disability ratings and lower general functioning) than those who left treatment with the mutual agreement of the therapist.

In summary, in a non-forensic, psychotherapy setting, locus of control and self-efficacy have been found to be important for client engagement, as those who believe they are initiating and in control of their own change process (Klag et al., 2010), including having a shared decision-making process (Raue & Sirey, 2011), showed higher levels of engagement. Although not researched within a sex offender population, increasing a sense of self-efficacy and locus of control may increase offender change, however this is likely to remain a challenge with mandated treatment.

Specific client attributes, such as higher cognitive ability (Katz et al., 2005), being able to take personal responsibility for problems and less dysfunctional personality functioning (Loeffler-Stastka & Blueml, 2010) improved engagement in treatment. Environmental factors were also associated with engagement, including changing how staff engaged with clients (improving respect and empowerment), the availability of programs (Pereira & Woollaston, 2007) and ratings of the ward atmosphere (Beazley & Gudjonsson, 2011), which is consistent with the MORM conceptualisation of offender treatment readiness. Clients who disengage from treatment are at risk of poorer outcomes (Ruggeri et al., 2007), therefore further understanding how people engage in treatment, and who is likely to struggle to maintain engagement in an important area of research, particularly in forensic settings, given the potential of poorer outcomes being associated with increased recidivism.

Treatment Engagement within Offender Populations

Treatment engagement is particularly important in offender populations because of the negative association between offender attrition and recidivism, including for sexual offenders (Hanson & Bussiere, 1998; McMurrin & Theodosi, 2007; Olver et al., 2011). A lack of engagement in the therapeutic process can be directly related to both poor attendance, and dropping out of treatment early (Howells, 2004; Olver et al., 2011). It is therefore important to understand and improve treatment engagement for offenders in order to enhance the possible outcomes and to ultimately reduce recidivism rates.

Within a sexual offender population, engagement in group treatment, as well as motivation, are seen to be important factors that facilitate successful treatment (Barrett, Wilson, & Long, 2003). It is noted that sexual offender engagement in group treatment has been found to be associated with lower levels of denial and with increased treatment progress (Levenson & Macgowan, 2004). In addition, group cohesion has been shown to be associated with a reduction in pro-offending attitudes over the course of treatment (Beech & Hamilton-Giachritsis, 2005). Levenson, Prescott, and D'Amora (2010) suggest that a positive therapeutic environment helps to foster offender engagement, with positive views of both the therapist and fellow group members enhancing engagement in treatment and investment in intervention goals. They also noted the benefits of sexual offender engagement, stating that when engaged in the therapeutic process, offenders were able to develop and practice intimacy skills, which may help reduce recidivism risk. Research on sexual offender treatment engagement remains limited, however research on general offender engagement may address issues relevant to the sexual offender population.

Violent or drug offenders who had difficulty with behavioural inhibition were more likely to drop out of treatment and were less likely to report improvements in reducing aggressive responses (Fishbein et al., 2009). It was suggested that these behavioural inhibition problems might impact engagement and persistence in the treatment programme. In this case, a lack of engagement was assumed by the fact that the client dropped out of treatment and showed a limited change in behaviours. Within substance-abuse programmes in prison settings it has been found that female offenders were more likely to have higher levels of treatment engagement than male offenders (Staton-Tindall et al., 2007). For male offenders, but not females, it was found that a general lack of emotional involvement with others was also associated with lower engagement with treatment. Engagement was measured by the offender's report of rapport with the counsellor, as well as by their willingness to participate in the treatment process.

A 'criminal thinking style' is also related to lower levels of treatment engagement (Best, Day, Campbell, Flynn, & Simpson, 2009). A criminal thinking style includes attitudes of entitlement, justification or rationalisation of crimes, and cold heartedness towards others. Importantly, research within a correctional setting has found that low treatment engagement may lead to higher rates of treatment non-completion, which also influenced treatment outcomes, as measured by risk reduction (Drieschner & Boomsma, 2008). Low engagement was also found to be related to higher rates of expulsion from treatment programmes, specifically for sexual offenders (Drieschner & Boomsma, 2008). In this study the relationship between treatment engagement and the outcome of lowered recidivism was not explored.

When looking at improving treatment engagement, it was found that offenders in mandated substance abuse programmes were more likely to have higher levels of

treatment engagement if they had high levels of treatment motivation (Hiller, Knight, Leukefeld, & Simpson, 2002). Having a desire for help and high levels of treatment readiness (as measured by a TCU Motivation scale; Simpson & Joe, 1993) was also associated with more personal involvement in the treatment process (Hiller et al., 2002). Another study of prison-based substance abuse programmes also found that offender motivation was an important contributor to treatment engagement (Welsh & McGrain, 2008). Additionally, it was found that the level of counsellor competence (as rated by the inmate), rapport with the counsellor, level of support experienced by peers, and programme structure were all predictive of treatment engagement. The programme structure, which was assessed by the offender, was rated on whether it was organised, whether the rules and work assignments were seen as fair, and how satisfied they were with both the group and individual programmes.

Although a direct comparison between treatment engagement of offenders and non-offenders has not been conducted, it is noted that issues of motivation and problems with accepting personal responsibility for problems are common amongst sexual offenders (Schneider & Wright, 2004). It is also important to note that respect, empowerment, collaboration and ability to make decisions are all factors that contribute to treatment engagement in the general population that may be problematic in a prison setting (Ross, Polaschek, & Ward, 2008). One common theme that emerges within both populations is the lack of consistent measurement of engagement. The current approach to conceptualising engagement in treatment readiness research has been through looking at the therapeutic alliance, which gives a consistent theoretical understanding and measurement approach in which to compare study results. Therapeutic alliance is most commonly understood through Bordin's (1979) Pantheoretical Model of Therapeutic Alliance framework.

From Treatment Engagement to the Therapeutic Alliance

The therapeutic alliance (also called the working alliance, therapeutic bond or helping alliance) can be broadly defined as “the collaborative and affective bond between client and therapist”; research has shown that the quality of the therapeutic alliance influences therapeutic outcomes (Martin, Garske, & Davis, 2000, p.438). Therapeutic alliance comprises three components, which look at both the engagement between the therapist and client, as well as the client’s engagement in the therapeutic process. The therapeutic alliance includes: 1) a collaborative client/therapist relationship; 2) an affective bond present between the client and therapist; and 3) the ability for the client and therapist to agree on treatment goals or tasks (Bordin, 1979). Collaboration between the client and therapist is an important part of therapeutic alliance, with agreement and willingness to work together viewed as critical to a good alliance (Bordin, 1979). The alliance between therapist and client itself facilitates the therapeutic intervention; therefore it is relevant to all therapies, and a requirement for the therapeutic process in general (Bordin, 1979; Martin et al., 2000). Based on Bordin’s conceptualisation, the therapeutic alliance is typically measured through three components, the collaboration on *tasks*, *goals*, and the therapeutic *bond* (Horvath & Greenberg, 1989).

A review of therapeutic alliance research has found a moderate, and reliable, relationship between the therapeutic alliance and the outcomes of therapy, with an average effect size of $r = .275$ (Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin et al., 2000). These findings indicate that the strength of the therapeutic alliance itself can predict positive therapeutic outcomes. Within specific populations the relationship between the therapeutic alliance and treatment outcomes has further been supported, with research showing that higher levels of therapeutic alliance

between patients with schizophrenia and their therapists lead to better rehabilitation outcomes (Davis & Lysaker, 2007), including better quality of work with the vocational rehabilitation, as well as better personal presentation.

Research into opioid-abusing pain patients found that the therapeutic alliance increased significantly over the course of therapy (Bethea, Acosta, & Haller, 2008). Therapists who didn't label the patient as an addict, and who focused on the pain the patient was experiencing, had more positive responses from the patient in terms of the therapeutic alliance. However, it was noted that there was no relationship between the therapeutic alliance (as viewed by the patient) and behaviour change (with either medication adherence or decreased drug use). This finding was inconsistent with previous research into opiate abusers and it was suggested by the authors that the self-reported alliance might have focused on the therapeutic bond, rather than the collaborative tasks and goals. It was indicated that this bond aspect may be less connected with outcomes, however the study did not look at the breakdown of the three components of therapeutic alliance to test this hypothesis.

Contradicting the previous finding was a study that found that a patient's self-reported strength of the alliance was significantly related to the patient's drug and alcohol use the following week (Crits-Christoph et al., 2011). This was further supported by a study into drug abusers that found that the client's report of alliance strength was significantly related to treatment drop-out (Meier, Donmall, McElduff, Barrowclough, & Heller, 2006). This measure of the therapeutic alliance looked at Bordin's three aspects of the alliance and explored the predictive value of the alliance within the early stage of treatment.

A meta-analysis of studies investigating the strength of the therapeutic alliance and therapy drop-out showed that a poorer therapeutic alliance was related to higher

rates of drop-out (Sharf, Primavera, & Diener, 2010). This research was based on psychotherapy patients, and the strength of the relationship was moderately strong, at $d = .55$. These findings strongly suggest that having a poor therapeutic alliance can lead to clients disengaging from the therapeutic process, lessening their potential therapeutic gains. The relationship between therapeutic alliance and treatment drop-out was slightly lessened by the client's educational level, with a higher level of education reducing the strength of the relationship (Sharf et al., 2010). It was suggested that clients with a higher educational level were more likely to complete treatment in general, regardless of the alliance; therefore the impact of the alliance on client drop-out was weaker. Alternatively it was suggested that highly educated clients may have a greater convergence of expectations with their educated therapists. In addition, Sharf and colleagues (2010) found that inpatient clients were more sensitive to the effect of a problematic therapeutic alliance, with there being a greater likelihood of drop-out.

A meta-analysis reported by Diener and Monroe (2011) also found that the higher a client's attachment insecurity the poorer the quality of the therapeutic alliance, which suggests that the ability of the client to form ongoing, trusting relationships likely impacts the therapeutic relationship. The quality of the therapeutic alliance has also been shown to predict future violence within a psychiatric inpatient setting, with lower therapeutic alliance between staff and patients being more problematic (Beauford, McNiel, & Binder, 1997).

Tichenor and Hill (1989) found that clients, therapists and third-party observers did not agree on ratings of working alliance, noting that findings from different perspectives were not necessarily interchangeable. In an adolescent substance-abuse treatment programme, Auerbach, May, Stevens, and Kiesler (2008) found a

significant difference between client and therapist ratings of the therapeutic alliance, with clients' perceptions of the alliance being significantly higher than their therapists' ratings, on all aspects except collaboration on tasks, where there was no significant difference. There was also no correlation found between client-therapist therapeutic alliance ratings. By contrast, Belding and colleagues (1997) found a low correlation between client and therapists perceptions of the therapeutic alliance. Meier and Donmall (2006) found that the association between therapist and client ratings became weaker over the course of treatment. Horvath (2000) explains that therapists and clients may see the therapeutic alliance differently due to the differing filter through which each may see the relationship. Horvath (2000) goes on to suggest that therapists may be influenced by their training to see the therapeutic alliance through a theoretical lens, whereas clients would assess the alliance based on their past relationship experiences. However, it is noted that the clients' perceptions of the therapeutic alliance are thought to be more predictive of outcomes than the rating of therapists or third parties (Horvath, 2000). This is consistent with a review conducted by Horvath and Symonds (1991), which found a reliable and moderate relationship between the therapeutic alliance and therapeutic outcome, with client ratings of the alliance being most predictive of outcomes (and third-party observer ratings being least predictive).

It is not known whether a greater difference in therapist-client ratings of the therapeutic alliance has a negative impact on outcomes, as the extant research has produced inconsistent findings. Meier and Donmall (2006) found that differences in therapeutic alliance ratings did not impact whether drug treatment clients remained in treatment, however Auerbach and colleagues (2008) found that a greater discrepancy in alliance ratings was associated with poorer behavioural functioning for adolescents

involved in a drug treatment programme. It is noted that the outcomes being measured in these studies are different; therefore discrepancies in therapeutic alliance ratings may have an impact on different aspects of treatment outcome (whether it be participation, attrition, compliance or behaviour change).

The Therapeutic Alliance within Offender Populations

Ross, Polaschek, and Ward (2008) have proposed a Revised Theory of the Therapeutic Alliance for consideration of offender-therapist relationships. They note that the therapeutic alliance is a dynamic process and can be influenced by therapist characteristics (including personality, interpersonal style, attachment style), therapist professional skills, therapist therapeutic goals and expectations, and client characteristics, treatment readiness, and client therapeutic goals and expectations. It is proposed that all of these components interact with the therapeutic alliance model, impacting upon the collaborative relationship (goals, task and bond). Additionally, Ross and colleagues (2008) propose that therapist and client factors also interact, impacting their behaviours towards each other, which also impacts the quality of the alliance.

Amongst offenders, it has been found that those who have difficulty forming a therapeutic alliance are more likely to have low levels of treatment readiness, which some have argued can be identified and addressed by the treatment facilitator to help prevent poor treatment outcomes (Kozar, 2010). Research looking at violent psychopathic prisoners found that when there was an increase in the therapeutic alliance over the course of the therapeutic programme, the offender changed most (as measured by the Violence Risk Scale; Polaschek & Ross, 2010). However, it was also found that therapist's ratings of the therapeutic alliance taken at the beginning of the therapeutic programme were not predictive of outcomes. Given that the change

over time of the alliance was predictive of change, it appears that the development of the therapeutic alliance over the course of therapy may be more important to therapeutic gain than the level of therapeutic alliance early in treatment.

With the sexual offender population it has been suggested that the therapeutic alliance is important, as it is thought to provide the offender with a safe environment in which the therapist can engage the offender about their crime minimisation or denial, to gain better outcomes (Serran, Fernandez, Marshall, & Mann, 2003). The therapist displaying positive features, such as warmth or empathy, creates a stronger alliance, whereas confrontational approaches lead to poorer outcomes (Serran et al., 2003). The therapeutic bond has been found to be important in sexual offender treatment, as a weaker bond has been found to be related to increased sexual recidivism (Blasko & Jeglic, 2014). A review of the literature for those in treatment for violence against their partners has shown that the therapeutic alliance (called the working alliance in this study) was related to outcome (Taft & Murphy, 2007). This review further supports the research done with sexual offenders, as it is inferred that a confrontational therapeutic approach is likely to negatively impact the alliance and impair outcomes. In one study into spousal abuse treatment it was found that the strength of the alliance between the therapist and male perpetrator (as measured at session 1) was associated with treatment outcome (Brown & O'Leary, 2000). The treatment outcome in this study was a decrease in psychological and physical aggression; no relationship was found between the therapeutic alliance and completion of treatment.

An important area to explore when understanding the therapeutic alliance in forensic contexts is the existence of dual roles of the therapist and the impact this has on the therapeutic relationship (Skeem, Loudon, Polaschek, & Camp, 2007). With

mandated treatments, there may also be an issue of power imbalance and an attempt by therapists to control the behaviour of the offender; in these situations the offender may face consequences for not following through on a particular treatment programme, or for exhibiting challenging or offending risk-related behaviours (Ross et al., 2008; Skeem et al., 2007). Offenders can also be influenced by the prison environment they live in, with uncaring and hostile conditions potentially impacting the trust and engagement in the therapeutic alliance (Ross et al., 2008). It has been found that, within mandated populations, the therapist being caring, fair, gaining the offender's trust, and being authoritative rather than authoritarian in their approach improves the therapeutic relationship (Skeem et al., 2007). It is important to note that the dual-roles that therapists have when engaging in therapy with offenders may not be fully articulated by Bordin's understanding of the therapeutic alliance. Future research needs to determine whether Bordin's model is appropriate for offender populations. Ross and colleagues' (2008) Revised Model of the Therapeutic Alliance may be more applicable to offender populations, although this has yet to be tested.

The therapeutic alliance is important for improving engagement and therapeutic outcomes in both psychiatric and forensic settings. It has been shown that the quality of the therapeutic relationship can lead to improved outcomes, and also that the patient's ability to form relationships impacts this therapeutic alliance. Both the patient/offender and the therapist contribute to the development and maintenance of this alliance, which has the ability to change over the course of the therapeutic sessions. In forensic settings it is important to note that there may be extra dimensions of the therapeutic relationship, (e.g. impact of challenging offender interpersonal behaviours, breakdowns in the therapeutic alliance, external rather than internal motivations to change, or impact of the therapeutic environment and therapist

characteristics) including those that are unique to sexual offenders, which are not currently being accounted for in the research.

Ruptures in the Therapeutic Alliance

A rupture describes a breakdown in collaboration between therapist and client; this can occur with the therapeutic bond, or with the agreement of tasks or goals (Safran & Muran, 2006). Signs of an alliance rupture can include either withdrawal or confrontation by the client (Westra, Constantino, & Aviram, 2011). Ruptures can vary in their intensity, with some being minor tensions, through to more major breakdowns in relationships; and can occur at any stage during the therapeutic process (Safran, Muran, & Eubanks-Carter, 2011). They are believed to occur when the therapeutic relationship represents, or fails to follow, the patient's usual pattern of maladaptive interpersonal functioning (Ackerman & Hilsenroth, 2001). Ruptures can be assessed from three different perspectives: the client, the therapist, or a third-party observer (Safran et al., 2011). There are two ways a client can deal with the breakdown in the therapeutic alliance, through confrontation or through avoidance (Ackerman & Hilsenroth, 2001). A client can directly confront the therapist with their negative views towards the therapist or the therapeutic process, or they can avoid this confrontation and instead withdraw and become distant and avoidant. In order for the ruptures to be addressed, they need to be recognised by the therapist and resolved through the therapeutic process. This can be difficult for the therapist when being directly confronted by the client, or potentially be difficult to recognise if the client withdraws. It is noted that ruptures can occur at different stages in the therapeutic process, however the pattern of these ruptures have been disputed by different researchers (see below).

It has been suggested that the development of the therapeutic alliance typically passes through three distinct stages; in the initial stage there is generally higher levels of optimism for the therapeutic process, leading to an easier development of the alliance (Mann, 1973). This alliance can then be tested when these high expectations are not met during the middle stage of the therapy and reduced alliance can also occur due to the demands of the therapeutic tasks. In the final stage, alliance can be strengthened through successful treatment, or by the client gaining a more realistic understanding of the therapeutic process. This is called the high-low-high pattern of alliance. According to Horvath and Luborsky (1993), the first stage of this alliance development takes place over the first five sessions, peaking at session three, with alliance breakdowns during this early stage being a predictor of therapy non-completion. A second critical stage in the development/maintenance of the therapeutic alliance is when the therapist starts challenging the client's dysfunctional patterns or beliefs, potentially leading to alliance ruptures (Horvath & Luborsky, 1993). Understanding when ruptures are likely to take place, and when pressures are placed on the client leading to a breakdown in the therapeutic relationship can enable therapists to be more aware of this process, potentially limiting the negative effects and also enabling repairs in the relationship.

Having an alliance rupture leads to a reduction in a client's belief about a positive therapy outcome, this can create a sense of demoralisation in the client, as they have less hope about gaining some improvement in their symptoms (Westra et al., 2011). Of note, clients who have a lower belief in a positive therapeutic outcome tend to have higher levels of hostility and less affiliation (Westra et al., 2011). Research into the therapeutic alliance with patients with obsessive-compulsive personality disorder or avoidant personality disorder found that a stronger early

alliance (session 2 to session 5) led to more improved symptoms of both the personality disorder and depression (Strauss et al., 2006). It was also found that having a rupture, which was then repaired, also predicted positive treatment gains. In this study, major fluctuations in the reported alliance were used as a measure of a rupture; in which they predicted there would be a high-low-high pattern of alliance, with the low level of alliance (occurring during the middle stage of therapy) being a stage of rupture.

Further investigation into ruptures in the therapeutic alliance (measured after each of the first 6 sessions) found that low intensity ruptures, with higher rupture resolution, lead to higher alliance ratings and reported session quality (Muran et al., 2009). Ruptures that were lower in intensity were found to predict better interpersonal functioning, whereas higher ratings of rupture resolution were related to higher rates of treatment retention (compared to those with lower resolution of ruptures). It was also found that there were differences in how patients and therapists viewed the therapeutic relationships, with patients being less likely to view a rupture in the therapeutic alliance than therapists. This suggests that even if the therapist views the therapeutic relationship to be breaking down, the client might not view it this way. This potentially may be due to the expectations clients have in interpersonal relationships in general, as they may be more willing to tolerate relationship difficulties. There may also be an opportunity here for the therapist to intervene before the relationship deteriorates to the point that the client finds it problematic and unilaterally terminates therapy.

There has been a lack of consensus about the high-low-high pattern of ruptures and repairs mentioned previously. One study has instead proposed a linear increase of therapeutic alliance (Stevens, Muran, Safran, Gorman, & Winston, 2007), showing

that the therapeutic alliance gradually increased in strength over the course of a therapeutic programme (30 sessions in length). It was also reported that 50% of the cases showed a more localised rupture-repair process, which were those that were resolved within 3-5 sessions of the initial rupture event. In this study, the presence of ruptures and repairs were not related to therapeutic outcomes. Another study also supported the more localised rupture-repair events, with the ruptures occurring randomly and thus not relating to a specific session number, or stage of the therapy (Stiles et al., 2004). The authors explained that these were V-shaped rupture-repair events, as the clients had a sudden, sharp downward spike of therapeutic alliance rating, followed by a quick return to either the previous level, or higher level of reported alliance. Those clients that experienced ruptures in the therapeutic relationship, but then had those ruptures repaired, had better outcomes (in levels of depression or ratings of interpersonal problems). These findings, as well as those by Strauss and colleagues (2006) suggest that having ruptures in the therapeutic alliance may allow clients to learn about relational problems they may have with others, and improve their skills at overcoming these problems.

In offender populations, issues of autonomy and control may impact the strength of the therapeutic alliance, particularly as the mandated setting can cause a power imbalance, and may lead to clients feeling that they are being controlled by their therapist. In some settings, where therapists also have the power to impact a client's liberty, this 'sense of being controlled' may actually be tied to real implications for mandated clients (Skeem et al., 2007). Within a sexual offender population, it has been found that child sexual offenders sometimes compare therapists to parental figures (Drapeau, 2005), which may lead to triggers of childhood dysfunctional interpersonal patterns resulting in a therapeutic rupture (Safran, Crocker, McMMain, &

Murray, 1990; Safran & Kraus, 2014). Although research into sexual offender alliance and ruptures in the therapeutic relationship is limited, it is thought that confrontational reactions by therapists to offenders' denial and minimisation (Serran, Fernandez, Marshall, & Mann, 2003) may increase the likelihood of a rupture occurring. If an offender-client values status and respect, they may perceive a therapist who takes a dominant or overly directive position as disrespectful (Holtforth & Castonguay, 2005). This has been supported by child sexual offender research, as it has been found that those offenders who have an interpersonal preference for autonomy or control, may be resistant to a therapist being overly dominant or controlling (Drapeau, 2005).

Research into patterns of ruptures and repairs in the therapeutic relationship, and whether there is an optimal pattern to predict positive therapeutic outcome reveals inconsistent findings. However, it is noted that recovery from a rupture generally has a positive impact on therapeutic outcomes. One major limitation in the therapeutic alliance research is the lack of investigation into the rupture and repair events in forensic populations and in particular, in research with sexual offenders. Offenders may show a different pattern of difficulties with interpersonal functioning, which may make the therapeutic relationship uniquely challenging. Further, the nature of mandated treatment and the dual-role of therapists might impact these alliance ruptures in different ways than the alliance ruptures in non-forensic populations.

Therapist Characteristics

Certain characteristics of the therapist have been shown to influence the strength of the therapeutic alliance, including the ability of the therapist to have close and supportive interpersonal relationships. In one study, therapists' level of self-directed hostility, their perceived current level of social support, and their level of comfort

with closeness in interpersonal relationships, significantly predicted the strength of the bond in the therapeutic alliance (Dunkle, 1996). Those with less hostility towards themselves, higher levels of support and greater comfort with closeness were more likely to report a strong emotional bond early in therapy. This study also found that a therapist's level of experience did not predict the alliance ratings with the goal and task aspects of the therapeutic alliance. Another study also found that attachment style predicted problems with the alliance, with anxiously attached therapists having a weaker therapeutic alliance (Black, Hardy, Turpin, & Parry, 2005). Those therapists with anxious-attachment styles also had higher levels of self-reported problems in therapy. In addition to the general literature on therapist characteristics, there are some findings, albeit limited, on the impact on therapist characteristics in sexual offender treatment.

With sexual offender treatment, therapist warmth, empathy, asking open-ended questions, being directive and rewarding have all been found to significantly relate to treatment gain (Marshall et al., 2003). It is important, in a sexual offender population, for therapists to be supportive when they are challenging the offender, and to not be overly confrontational (Drapeau, 2005; Marshall et al., 2002; Marshall et al., 2003). Being seen to be challenging in an aggressive way, or being overly critical, hostile or sarcastic had a negative impact on within-treatment change and offender participation in treatment (Drapeau, 2005; Marshall et al., 2003). This is particularly relevant for sexual offender treatment, as high levels of denial and minimisation may lead to higher levels of confrontation by therapists (Serran et al., 2003).

These findings suggest that within general and forensic settings, problems within therapeutic relationships may not completely lie with the patient/offender, but with both interactants in the relationship. Therapist characteristics may be an important

external factor for the MORM conceptualisation of readiness, as it has been shown to impact offender engagement.

Therapeutic Alliance and Client Interpersonal Characteristics

Within the general psychotherapy literature, client characteristics have also been found to be important to the development of the therapeutic alliance and treatment outcomes. The client's attachment style has been found to impact the therapeutic alliance; when a client has the ability to form secure attachments their relationship with their therapist was also more likely to be securely attached (Mallinckrodt, Porter, & Kivlighan, 2005). A securely attached therapeutic relationship would allow a client to feel encouraged to explore troubling experiences, whilst feeling that the therapist is responsive, sensitive and emotionally available to them. When this secure attachment occurred the therapeutic session was more likely to show characteristics of 'depth' and 'smoothness'. A deeper session allows for more intensive investigation of inner states and a smooth running session would be when the client feels safe and comforted in that therapeutic environment. Clients who had good social support were shown to be more likely to have a better therapeutic alliance (called working alliance in this study), as rated by the client (Mallinckrodt, 1991).

Eames and Roth (2000) also found that a secure attachment was related to higher levels of therapeutic alliance, and fearful attachment (anxious about abandonment and avoidant of intimacy) being related to lower alliance. It was also shown that both preoccupied (feeling anxious about closeness with others, and also having a strong desire for intimacy) and dismissively (avoiding intimacy and not feeling anxiety about being abandoned) attached clients had a gradual increase in therapeutic alliance over time. Those clients who had a preoccupied attachment were more likely to

experience ruptures in the therapeutic alliance, and those with dismissive attachment having less ruptures.

Research has also found that having a higher readiness to change was predictive of a stronger therapeutic alliance (called working alliance) and that psychopathic traits were a strong negative predictor of the alliance (Taft, Murphy, Musser, & Remington, 2004). Furthermore, clients with lower levels of borderline personality traits and lower hostile-dominant interpersonal problems had higher levels of therapeutic alliance. These interpersonal findings were consistent with a study exploring the impact of interpersonal style and the forming of the therapeutic alliance in psychiatric patients, which found that clients with a friendly-submissive interpersonal style were more likely to develop a stronger alliance (Muran, Segal, Samstag, & Crawford, 1994). Clients who had a hostile-dominant interpersonal style had greater problems with developing a therapeutic alliance. In addition, Joe, Simpson, and Broome (1998) found that the strongest client predictor of therapeutic engagement was pre-treatment motivation and treatment readiness. These factors were found to be more important than socio-demographics, drug use, criminality and psychiatric history.

Interpersonal Style, Engagement and Outcomes

To further understand the impact of people's relationship styles and the therapeutic alliance, interpersonal style will now be explored in more detail. This is an important component that has not been incorporated into the current measurement of treatment readiness (under the MORM model). Interpersonal style describes the characteristic pattern of interpersonal behaviours that a person brings to different interpersonal situations (Kiesler, 1987). These interpersonal responses may be overt and involve actions (behavioural reactions), or covert and private (cognitive –

including fantasies and perceived evoking messages, direct emotional responses, and action tendencies; Schmidt, Wagner, & Kiesler, 1999). According to Leary (1957) the aim of interpersonal behaviour is to either reduce anxiety in interpersonal interactions, or to increase or maintain self-esteem. There are two core dimensions of interpersonal behaviour and these can be explained in terms of the interpersonal circumplex (Kiesler, 1987; Leary, 1957), which is an empirically derived conceptualisation of the two key interpersonal dimensions: power/control (or agency, one person's influence over another) and affiliation (or communion, the connection between people; Blackburn & Renwick; 1996; Horowitz et al., 2006). According to interpersonal theory the power/control dimension ranges from dominance to submission and the affiliation dimension ranges from hostility to friendliness. Interpersonal style is closely related to attachment style, with anxious and avoidant attachment styles being related to the hostile and submissive interpersonal style, and attachment security being associated with a warm and dominant interpersonal style (Gallo, Smith, & Ruiz, 2003).

There can be complementarity between interpersonal styles; this is where a person's interpersonal style results in interpersonal behaviour that evokes reactions in other people, or their interpersonal behaviour (Kiesler, 1987). With the affiliation dimension a *corresponding* response is generally elicited (hostility evoking hostility and friendliness evoking friendliness), whereas with the power/control dimension a *reciprocal* response is generally elicited (dominance evokes submission and submission evokes dominance; Lillie, 2007). The complementarity of the interpersonal behavioural response is not always corresponding or reciprocal, with a person's *preferred* interpersonal style also influencing their response, as well as situational factors (Kiesler & Auerbach, 2003). Therefore, someone's interpersonal

response may be influenced by either his or her preferred approach, and by the particular situational circumstances. Alternatives to the complementary interpersonal behavioural response (correspondence on the affiliation dimension and reciprocation on the power/control dimension) are acomplementary responses and anticomplementary responses. An acomplementary response is one that either corresponds on the affiliation dimension, or is reciprocal on the power/control dimension, but is not complementary on both dimensions (Lillie, 2007). An anticomplementary response is one that neither corresponds with affiliation, nor reciprocal on power/control (Lillie, 2007).

Horowitz and colleagues (2006) proposed a revised circumplex model, noting four main differences. They stated that the negative pole to the communion axis is indifference, rather than hostility (as this was noted to be the opposite of love, or the desire for connection with others). The second change suggested was the notion that a behaviour invites, rather than evokes, a desired reaction from others, as ambiguity in the behaviour, or the motive from the responder would also help determine the response. The third change suggested was the complement of an action would be the reaction that would actually satisfy the motive behind the behaviour, rather than merely the action itself. And lastly, they suggested that noncomplementary reactions provoke a negative affect. Horowitz and colleagues (2006) noted that miscommunications occur when the motives behind behaviours are unclear; therefore the meaning of the behaviour is seen as ambiguous. It was also noted that reactions that are complementary for one person, might not be complementary for another person.

Interpersonal complementarity within dyadic interactions may influence the satisfaction of those involved with the therapeutic relationship, potentially impacting

engagement (Dryer & Horowitz, 1997). A noncomplementary response may result in less productivity with tasks and a sense of dissatisfaction with the interaction (Estroff & Nowicki, 1992; Horowitz et al., 1991; Kiesler, 1983). Research has shown that in a dyadic relationship where the interpersonal goal of one person (i.e. to dominate) was complementary to the behaviour of their partner there was more satisfaction in the interpersonal interaction (Dryer & Horowitz, 1997). It was further shown that a dominant participant who interacted with a submissive participant was more satisfied with the interaction (Dryer & Horowitz, 1997). Therefore, understanding the interpersonal style of both participants in the dyadic interaction is important to determine the overall satisfaction with those interactions for both people.

When looking specifically at practitioner/patient relationships, patients have shown higher levels of satisfaction when both the practitioner and patient viewed each other as affiliative (i.e., friendly; Kiesler & Auerbach, 2003). Alternatively, when the practitioner viewed the patient as being more dominant and hostile, patients were less satisfied and their adjustment was worse (Kiesler & Auerbach, 2003). Having complementary practitioner affiliation is also positively related to patient compliance with treatment programmes (Kiesler & Auerbach, 2003). However with the control dimension, when the practitioner is either less controlling, or more controlling, there are reports of greater compliance (Kiesler & Auerbach, 2003). This difference between higher or lower levels of the interpersonal dimension of control would depend on the need of the patient. This is an important aspect of the interpersonal relationship, as a poor fit between interpersonal styles can lead to poorer alliance and poorer outcomes (Kiesler & Auerbach, 2003).

Prior research into interpersonal styles has shown that when assessing how the interpersonal style of depressed patients influences outcomes of cognitive therapy,

participants who had an under-involved (low affiliation) interpersonal style had less improvement in their symptoms after treatment (Hardy et al., 2001). This suggests that patients who do not have a friendly interpersonal approach with others are less likely to benefit from the therapeutic process. However, this relationship was mediated by the therapeutic alliance, suggesting that if the therapist can, despite the low levels of affiliation, still build a relationship with an under-involved client, that these negative impacts can be overcome. A study on the interpersonal style of people with agoraphobia found that people with submissive, deferent, inhibited and mistrusting interpersonal styles had higher levels of anxiety (Shean & Uchenwa, 1990). This shows that a person's way of relating to others can actually influence the way they experience the world, which can lead to anxiety. Gaining an understanding into a client's general relationship approach may provide a way to conceptualise how they see the world, and give areas to target interventions.

Research looking into the relationship between personality disorders and interpersonal style found that people with narcissistic personality disorder had higher domineering and vindictive interpersonal approaches (Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009). This included being aggressive and controlling towards others, as well as showing an inability to be supportive of others. When looking at the relationship between borderline personality traits and interpersonal problems (as rated by the inventory of interpersonal problems), it was found that those with borderline personality were more likely to be overly accommodating, self-sacrificing and intrusive/needy when relating to others (Hilsenroth, Menaker, Peters, & Pincus, 2007). This suggests that people with borderline personality disorder are more likely to want to have affiliation with others, and to be submissive in their interpersonal relationships. However, borderline personality disorder is a disorder of instability and

the interpersonal style of these patients is inconsistent, and correspondingly their interpersonal behaviour can be irregular.

Daffern, Duggan, Huband, and Thomas (2010) found that patients with severe personality disorder were more likely to have greater variability in how they viewed the interpersonal style of the nurses they interacted with, viewing them as either more dominant or more submissive. It has also been shown that a discrepancy between a person's self-perceived interpersonal style and their interpersonal style as perceived by others is related to higher levels of psychological distress (Van Buren & Nowicki, 1997). More specifically, higher levels of distress were present if participants perceived themselves as less dominant than others perceived them. So even beyond the complementarity of the two interactants, issues can occur if someone perceives himself or herself as being less dominant than they actually present to others. This suggests that the level of awareness of one's own interpersonal style is important to psychological wellbeing and is something that can be addressed during the therapeutic process.

Another study investigating inpatients with personality disorders found that patients who exhibited aggressive behaviours were more likely to have hostile and dominant interpersonal styles (Daffern, Duggan, Huband, & Thomas, 2008). A nurturing and help-seeking interpersonal style was more likely to be found in people who completed treatment (Daffern et al., 2008). Further research into psychiatric inpatients supported these previous findings, with a hostile-dominant interpersonal style being related to physical aggression during hospitalisation (Daffern et al., 2010). This need for dominance can potentially create problems with collaboration or compliance with tasks and goals, which is needed to create a strong therapeutic alliance.

The interpersonal styles of both interactants in a working relationship are important, with research showing that within psychiatric hospitals the interpersonal style of nursing staff was related to physical assaults by patients (Bilgin, 2009). Nurses that were less social and less tolerant experienced more physical assaults by the psychiatric patients. It was also found that nurses who had a more help-seeking interpersonal style were exposed to more verbal assaults, and also had a greater concern for the occurrence of physical assaults. Another study has found that therapists alter their therapeutic approach based on their clients' interpersonal styles, even when that interpersonal style is not explicitly known (Hardy, Stiles, Barkham, & Startup, 1998). When clients had an overinvolved interpersonal style, therapists tended to use relationship-orientated approaches, or ones that focused on affect. When clients were under-involved, therapists used more cognitive-based approaches. The outcomes of the therapy for both over and under-involved clients did not differ, suggesting that tailoring a therapeutic approach to the specific interpersonal needs of the client may not be problematic to therapeutic outcomes.

Interpersonal Style within Offender Populations

When assessing forensic inpatients to see whether interpersonal style was linked to violent actions, as well as threats to commit violent actions, it was found that offenders with a dominant, coercive (hostile and dominant), and hostile interpersonal style were more likely to be violent (Doyle & Dolan, 2006). Offenders with dominant and hostile interpersonal styles may have difficulty engaging in a collaborative therapeutic relationship with a therapist who is not submissive. This was supported by Simpson and colleagues (2012), who found that offenders with higher levels of hostility who were participating in a substance abuse programme showed poorer treatment engagement. Ongoing hostility would likely make a therapeutic alliance

difficult to establish and maintain. These difficulties with engagement and the therapeutic alliance would reduce the likelihood of effective rehabilitation, and with this type of interpersonal style, suggests that the offender may not be ready to engage in treatment.

When looking at the interpersonal style of forensic psychiatric patients (the sample in this case was a combination of general, violent and sexual offenders), it was found that those with mental illness were more likely to have a submissive interpersonal style than those without mental illness (Blackburn, 1998). However, it was also found that, regardless of the presence of a mental illness, those offenders with higher levels of criminal convictions were more likely to have a dominant interpersonal style. Another study, which looked at the interpersonal style of male general and sexual offenders, found that a high level of interpersonal dominance, as well as low levels of warmth, was related to aggressive behaviours within prison (Edens, 2009). Both high levels of dominance and low warmth were also found to be associated with antisocial and paranoid traits, while only high levels of dominance was related to treatment noncompliance. In addition, clients who have hostile and dominant interpersonal styles are also likely to have difficulty in developing a strong therapeutic alliance (Muran, Segal, Samstag, & Crawford, 1994). Although research into the impact of interpersonal style on the therapeutic alliance and within-treatment changes in a sexual offender population is limited, it is thought that challenging offender interpersonal behaviours make the development of a strong therapeutic relationship difficult (Bender, 2005), and therefore may reduce therapeutic gains.

One area of research into offender interpersonal style that has received the majority of focus is psychopathy. Research has found an association between psychopathy and hostile-dominant interpersonal behaviours (Blackburn, 1998). When

looking at adolescents with psychopathic traits, it was found that psychopathic traits and hostile and dominant interpersonal styles were associated (Hillege, Das, & de Ruiter, 2010). For male adolescents, it was the grandiose and manipulative psychopathic traits that were correlated with dominant interpersonal behaviour, and for female adolescents it was the impulsive and irresponsible psychopathic traits. Psychopathy includes personality traits, such as glibness/superficiality, grandiosity and shallowness of emotions, as well as behavioural traits, such as manipulation, lying and having a parasitic and antisocial lifestyle (Hare, 1991; Hare, 2003). Psychopathy has been shown to impact an offender's engagement in treatment (Ross et al., 2008), and their rate of recidivism (Looman, Abracen, Serin, & Marquis, 2005). For sexual offenders specifically, high rates of psychopathy have been shown to interact with sexual deviance, to increase rates of sexual recidivism (Olver & Wong, 2006). Hobson, Shine, and Roberts (2000) found that psychopaths were less likely to actively participate in treatment, and were more likely to present with disruptive behaviours during treatment.

Early research on psychopathy and offender rehabilitation raised concerns about the effectiveness of treating those with high psychopathic traits (Hare, Clark, Grann, & Thornton, 2000; Hobson et al., 2000). It was shown that treating psychopathic offenders actually increased rates of violent recidivism (Rice, Harris, & Cormier, 1992; Seto & Barbaree, 1999), although these findings are inconsistent (Gretton, McBride, Hare, O'Shaughnessy, & Kumka, 2001; Skeem et al., 2002). Hare and colleagues (2000) explain that insight-oriented programmes may give the psychopathic offender an opportunity to develop ways of manipulating and deceiving people, which they then apply whilst in the community. They also note that it is possible that psychopathic offenders manipulate staff into thinking they have made

progress during treatment, in order to increase their chance of release from prison. Hare and colleagues (2000) reported that those psychopaths who had higher levels of personal/affective traits of psychopathy were more likely to have a higher risk of recidivism when treated compared to untreated psychopaths, whereas those treated offenders with low personal/affective psychopathic traits had no difference in recidivism rates compared to untreated psychopaths. Those offenders with high levels of personal/affective psychopathy traits were also more likely to have negative treatment-related attitudes and disruptive behaviours within the group (Hobson et al., 2000). Although there is a history of negative perceptions about the efficacy of treating psychopaths, in a recent review, Polaschek and Daly (2013) note that newer studies, incorporating programs designed for high-risk offenders, showed some positive outcomes for the treatment of psychopaths. However, they also note that it is not yet known whether the psychopathic personality traits should be a treatment target, or whether the challenging behaviours are something the therapists have to 'work around'.

The body of general and forensic research strongly suggests that a person's interpersonal style can greatly impact the therapeutic alliance and treatment gain. Furthermore, the more extreme or abnormal the patient's interpersonal behaviour, particularly in relation to the dimensions of hostility and dominance, the greater the perceived impact on the therapeutic alliance, making the alliance be perceived as less positive (Kiesler & Watkins, 1989). Research also reveals a positive relationship between the complementarity of interpersonal style between therapists and clients and perceptions of the alliance (Kiesler & Watkins, 1989), suggesting that the interpersonal style of both clients and therapists, as well as interpersonal complementarity between the therapist and client, may be crucial to the client's

engagement in the therapeutic process and the therapeutic relationship. Most of the research into the interpersonal style of offenders relates to being able to predict aggression or recidivism rates, with few studies focusing on engagement and the impact of client interpersonal style on within-treatment change. There is also limited information about the degree of complementarity between therapists and offenders (including sexual offenders), and how this impacts the therapeutic relationship. To further enhance rehabilitation efforts, a greater understanding of interpersonal factors that influence treatment engagement (and therefore outcomes) requires exploration. This could give further knowledge into how to enhance the therapeutic relationship, improving collaboration, and ultimately reducing recidivism rates.

Summary

Although empirically-based offender rehabilitation has been shown to be the most successful way to decrease recidivism, reductions remain modest, which leaves scope for further work to create reduction in recidivism rates. Understanding the factors that adversely impact therapeutic engagement within sexual offender treatment, as well as reduced within-treatment change, may provide an avenue to improve rehabilitation services and therefore treatment outcomes, with the ultimate aim being a reduction in sexual and violent offending. Reference to treatment readiness, through the MORM conceptualisation, may assist understanding of offender engagement, and how engagement can be maximised through the selection of appropriate therapeutic activity. The therapeutic alliance is used for this understanding, however the therapeutic relationship within offender populations, especially the likelihood and role of ruptures and repairs, needs critical research attention. As relationship functioning is an important part of the therapeutic alliance, understanding an offender's interpersonal style is crucial in understanding how well

they will engage in the therapy itself, and to build the therapeutic alliance. This literature review provides the foundation of the research aims for the overall thesis. The research aims and hypotheses for the three empirical studies are presented below.

Study One.

Research aims: a) to describe and compare the nature of the therapeutic alliance from the perspective of therapists and offenders: (b) to determine the relationship between therapists' and offenders' interpersonal style and the therapeutic alliance; (c) to explore whether offender hostility and dominance is related to the therapeutic alliance; and (d) to explore the level of complementarity in interpersonal style between therapists and offenders and determine whether complementarity is related to therapeutic alliance.

Hypotheses: (1) it was hypothesised that both hostile and dominant therapist and offender interpersonal styles would be negatively associated with the therapeutic alliance; and (2) it was hypothesised that complementarity between therapists and offenders would be positively associated with the therapeutic alliance.

Study Two.

Research aims: a) to describe the occurrence of ruptures in a sexual offender sample in treatment; b) to assess changes in offender-rated therapeutic alliance from commencement to end of treatment; c) to determine whether change in therapeutic alliance over time differs for those who do not experience a rupture compared to those who experience a rupture that is repaired and those who experience a rupture that is not repaired; d) to determine whether interpersonal hostility, hostile-dominance, and psychopathy impact ratings of end-of-treatment therapeutic alliance for those offenders who reported no rupture, a minor rupture or a major rupture; and

e) to determine whether interpersonal or offence-specific factors affect the likelihood of a rupture being repaired.

Hypotheses: (1) it was hypothesised that offenders who experienced a rupture that was not repaired would rate the therapeutic alliance at the end of treatment as poorer compared to offenders who did not experience a rupture in the alliance; (2) it was hypothesised that those offenders who experienced a rupture that was repaired would rate the therapeutic alliance more strongly at the end of treatment than those offenders who reported a rupture that was not repaired; and (3) it was hypothesised that offenders who reported a major rupture would have higher ratings of psychopathy, hostility and dominance than those who reported no rupture and a minor rupture.

Study Three.

Research aims: a) to ascertain whether offender psychopathy, interpersonal style, treatment readiness or ratings of the therapeutic alliance predict treatment gain; and b) to determine whether the association between offender characteristics and treatment gain is moderated by the therapeutic alliance.

Hypotheses: (1) it was hypothesised that offender hostility, dominance, hostile-dominance and psychopathy would impact on treatment gains; (2) it was hypothesised that treatment readiness would positively impact treatment gains; (3) it was hypothesised that offender ratings of therapeutic alliance would predict treatment gain, and that the presence of a therapeutic rupture would be negatively related to treatment gain; (4) it was hypothesised that the difference in offender-therapist therapeutic alliance ratings would be negatively related to treatment gain; and (5) it was hypothesised that the relationship between offender characteristics and treatment gain would be moderated by the therapeutic alliance.

Chapter 3: Extended Methodology

The current research examined sexual offender interpersonal style, the therapeutic alliance and treatment gain in clients participating in a sexual offender treatment programme. The research methodology relevant to each empirical study is outlined in the three manuscripts presented in Chapters 4, 5 and 6; however due to space constraints imposed by the respective journals, and to provide a detailed overview of the study, this chapter provides additional methodological detail for the overall research study.

Ethical Approval

Ethical approval for the current study was obtained from Victoria, Australia's Department of Justice Human Research Ethics Committee (JHREC) on 5 June 2012 (see Appendix A). Ethics approval was also obtained from Monash University Human Research Ethics Committee (MUHREC) on 21 June 2012. A core ethical issue in the current study was recruiting participants from a mandated treatment programme. Participants may have felt that participation would be viewed positively by the parole board, or by programme facilitators. To counter this, participants were clearly informed that participation was voluntary and was not associated with the requirements of their treatment programme. Furthermore, a unique code was allocated to each participant to enable matching of data from each time point, while maintaining participant confidentiality. Participants were also informed that they could withdraw from the study at any time, without penalty.

Method

Research design. The overall thesis is comprised of three empirical studies. The thesis had a longitudinal design with data being collected over four time points (*Stage One* = prior to treatment, *Stage Two* = three-four weeks into treatment, *Stage Three* =

towards the end of treatment and *Stage Four* = after treatment was completed). Total hours in the programme ranged from 72 to 150 hours, between 3 and 8 months, depending of level of risk and treatment needs. Due to the variation in treatment length, the time of data collection for the third stage of the study was determined in consultation with therapists. The empirical study described in Chapter 4 (Study One) was based on data drawn from the second time point, consisting of data from therapists and offenders. The empirical study described in Chapter 5 (Study Two) was based on data drawn from the second and third time points, consisting of data from therapists and offenders at *Stage Two*, and from offenders at *Stage Three*. Both of these studies also had information supplemented from the file review at the fourth time point. The empirical study described in Chapter 6 (Study Three) was based on data drawn from the first, second, third and fourth time points, consisting of data attained from therapists and offenders. Additionally, file review information was used to supplement data analysis in Study Three. Post-hoc analyses were conducted to inform the integrated discussion, these results can be found in Appendix B.

Participants. Participants were recruited through the Corrections Victoria Sexual Offenders Programme at Marngoneet Correctional Centre (a medium security prison in Victoria, Australia) and Victoria’s Community Corrections services. Offender age-related demographics are outlined in Table 1, and offender demographics and offence-related variables are outlined in Table 2.

Table 1

Offender Demographics: Age (Years)

| | <i>n</i> | M | SD | Range |
|---|----------|-------|-------|-------------|
| Age at start of programme | 75 | 44.97 | 15.15 | 21-73 years |
| Age of first sexual offence conviction | 75 | 30.45 | 13.49 | 14-70 years |
| Age of first general offence conviction (violent and non-violent) | 49 | 22.39 | 10.12 | 11-53 years |

Table 2
Offender Demographics and Offence Variables

| | | <i>n</i> |
|------------------------------|--|------------|
| <i>Country of Birth</i> | Australia | 61 (81.3%) |
| | Other | 13 (17.4%) |
| | Unspecified | 1 (1.3%) |
| <i>Education Level</i> | Less than Yr 10 | 27 (36%) |
| | Less than Yr 12 | 30 (40%) |
| | Completed Yr 12 | 8 (10.7%) |
| | Tertiary (complete or incomplete) | 10 (13.3%) |
| <i>Marital Status</i> | Single | 28 (37.3%) |
| | Divorced/Separated | 22 (29.3%) |
| | Partner | 12 (16%) |
| | Married/Defacto | 12 (16%) |
| | Unspecified | 1 (1.3%) |
| <i>Location</i> | Marngoneet | 60 (80%) |
| | Community Corrections | 15 (20%) |
| <i>Programme Completion</i> | Completers | 67 (89.3%) |
| | Non-completers | 5 (6.7%) |
| | Ongoing at time of research completion | 3 (4%) |
| <i>PCL-SV Rating</i> | Above cut-off (18) | 5 (8.7%) |
| | Below cut-off | 69 (92%) |
| | Unspecified | 1 (1.3%) |
| <i>Static-99 Rating</i> | High | 26 (34.7%) |
| | Mod-High | 28 (37.3%) |
| | Mod, Mod-Low, Low | 18 (24%) |
| | Not specified | 3 (4%) |
| | Unspecified | 1 (1.4%) |
| <i>Victim Age</i> | Adult only | 12 (16%) |
| | Child only | 42 (56%) |
| | Adult and Child | 20 (26.7%) |
| | Unspecified | 1 (1.4%) |
| <i>Victim Gender</i> | Male | 9 (12%) |
| | Female | 57 (76%) |
| | Male and Female | 8 (10.7%) |
| | Unspecified | 1 (1.4%) |
| <i>Victim Relationship</i> | Extrafamilial | 49 (65.3%) |
| | Intrafamilial | 8 (10.7%) |
| | Extrafamilial and Intrafamilial | 17 (22.7%) |
| | Unspecified | 1 (1.4%) |
| | Unspecified | 1 (1.4%) |
| <i>Prior Sexual Offences</i> | None | 27 (36%) |
| | One | 28 (37.3%) |
| | Two or more | 19 (25.4%) |
| | Unspecified | 1 (1.3%) |

The rates of data completion for each questionnaire are noted in Table 3. Non-completion by incarcerated participants was due to the removal of offenders from the programme (5 offenders were removed from the programme due to reoffending while undertaking the programme, hostile and aggressive behaviour towards therapists, or mental health issues – active symptoms of psychosis); data non-completion largely stemmed from non-return of questionnaires by community participants (procedurally participants were provided with the questionnaires in paid return-addressed envelopes). There was no significant difference in interpersonal style, therapeutic alliance or Static-99 scores between those who did not complete all stages of the study, and those who did complete all stages of the study. There were 17 therapists recruited to the programme based on their role as facilitator of an offender-participant. There was a 77% therapist data completion rate for the Impact Message Inventory (IMI-C) and 80% therapist data completion rate for the Working Alliance Inventory – Short Form (WAI-SF).

Table 3

Data Completion Rates

| | <i>n</i> |
|--|----------|
| Corrections Victoria Treatment Readiness Questionnaire | 72 (96%) |
| Early offender-rated Working Alliance Inventory | 64 (85%) |
| Offender-rated Impact Message Inventory | 65 (87%) |
| Postsession Questionnaire + late offender-rated Working Alliance Inventory | 54 (72%) |
| Early therapist-rated Working Alliance Inventory | 60 (80%) |
| Therapist-rated Impact Message Inventory | 58 (77%) |

Measures. *Corrections Victoria Treatment Readiness Questionnaire (CVTRQ).*

The Corrections Victoria Treatment Readiness Questionnaire (CVTRQ) is a 20-item self-report measure, which provides a total readiness score, with high scores (greater than 72) indicative of greater treatment readiness (Casey, Day, Howells, & Ward, 2007). There are four subscales: 1) attitudes and motivation, 2) emotional reactions,

3) offending beliefs, and 4) efficacy. CVTRQ items represent aspects of the MORM that can be reliably assessed through a brief self-report measure. The attitudes and motivation subscale includes questions on beliefs about treatment programmes, willingness to change, self-efficacy, and desire to stop offending. The emotional reactions subscale includes questions on self-directed anger, as well as guilt, regret and shame about the offending behaviour. The offending beliefs subscale includes questions that relate to willingness to take responsibility for offending, and directing blame towards others. The efficacy subscale includes questions on an offender's ability to trust others, a pattern of recent non-offending, and ability to be directed by others. These subscales can be used to direct interventions if the readiness score is low.

The CVTRQ was normed on 177 convicted male offenders participating in a mandated cognitive skills programme, which was delivered both within the community and within prisons in Victoria (Casey et al., 2007). The four-factor structure (attitudes and motivation, emotional reactions, offending beliefs and efficacy) was established through principal components analysis (PCA). The CVTRQ was found to be significantly correlated with the convergent measures analysed. When using the CVTRQ on a violent offender population, there were adequate levels of convergent validity with measures on self-efficacy (Loza-Fanous Self-Efficacy Questionnaire), readiness (Serin Treatment Readiness Scale) and the process of change (Processes of Change Questionnaire). The CVTRQ was also found to accurately predict treatment engagement with offenders undertaking the violent offender treatment programme within the prison system. The CVTRQ has good internal consistency and shows high levels of discriminant and convergent validity (Casey et al., 2007). Cronbach's alpha scores for the current sample are shown in

Table 4. The scores on the CVTRQ are positively correlated with therapeutic engagement, as measured at the midpoint of the therapeutic programme (Casey et al., 2007). Casey et al. (2007) found the CVTRQ predicted treatment engagement, with the Attitudes and Motivations scale being the most strongly related to treatment engagement.

The Impact Message Inventory (IMI-C). The Impact Message Inventory (IMI-C) is a revised 8-scale version of the IMI (Schmidt, Wagner, & Kiesler, 1999). It is a 56-item inventory that looks at the more covert emotional impacts of interpersonal behaviours or interactions (Kiesler & Auerbach, 2003); these interactions are based on the interpersonal circle (Schmidt et al., 1999) originally outlined by Leary (1957) and Kiesler (1983). It is completed after a therapeutic consultation and can be done by either one or both client or therapist, with the aim to be to measure their emotional experience of the interaction (Kiesler & Auerbach, 2003). It assesses one person's target behaviour as assessed by the 'pull' on the other person's behaviour (Schmidt et al., 1999). The IMI-C consists of an octant scale that follows the traditional interpersonal circle format: Dominant, Hostile-Dominant, Hostile, Hostile-Submissive, Submissive, Friendly-Submissive, Friendly and Friendly-Dominant (Schmidt et al., 1999). Each octant scale is comprised of seven items, using a 4-point rating scale (Schmidt et al., 1999). The internal consistency of the IMI-C is acceptable, with the Cronbach's Alphas ranging from .69 to .89 on the eight subscales (Schmidt et al., 1999). Cronbach's alpha scores for the current sample are shown in Table 6.

The IMI-C uses the therapist's elicited response of the client to measure their interpersonal style (Kiesler & Auerbach, 2003). The 'impact message' is the covert affective, cognitive and behavioural pulls that the therapist feels in response to the

interpersonal interaction with the client (Kiesler & Auerbach, 2003). The IMI-C is designed specifically to measure the nature of the dyadic interaction (Kiesler & Auerbach, 2003) and has been used to measure the impact of certain clients on their therapists (Schmidt et al., 1999). The IMI has also been used with treatment planning, helping the therapist to understand the client's potential self-defeating interpersonal style, as well as improving the therapists understanding of the clients' nonverbal relationship messages (Kiesler & Auerbach, 2003).

The Working Alliance Inventory (WAI). The Working Alliance Inventory (WAI) was developed by Horvath and Greenberg in 1989, and is based on Bordin's (1979) conceptualisation of alliance (bonds, goals, and tasks). The WAI is a self-report measure using a 7-point likert scale for both the client and counsellor versions, with each having a total of 36 items (12 for each of the alliance dimensions). Participants are asked to rate a series of statements, which indicate their opinion about the therapist or the therapy session. The WAI has 3 subscale scores (bond, goals, and tasks) and an overall alliance score and has good reliability and validity, with a Cronbach's alpha of .93 for the client version and .87 for the therapist version (Horvath & Greenberg, 1989). Research has found a reliable relationship between early (3rd session) working alliance measures (using the WAI) and the outcome measures of satisfaction and change (Horvath & Greenberg, 1989).

The short-form version of the WAI (WAI-SF) was adapted from the WAI by Tracey and Kokotovic (1989), and was constructed through factor analysis with the four highest-loading items from each subscale being included to form the new WAI-Short Form. This short form version consists of 12 items, with the primary measure being the general alliance score, with the three subscale scores being secondary. The WAI-SF also showed acceptable internal consistency, with a Cronbach's alpha of .98

(client's form) and .95 (therapist's form; Tracey & Kokotovic, 1989). All subscales have a score ranging from .83 to .92, with the client form showing better internal consistency (Tracey & Kokotovic, 1989). Cronbach's alpha scores for the current sample are shown in Table 5.

The Postsession Questionnaire (PSQ). The Postsession Questionnaire (PSQ; Muran, Safran, Samstag, & Winston, 1992) consists of self-report measures of the therapeutic alliance (WAI; Horvath & Greenberg; 1989), as well as a self-report measure that asks direct questions about the occurrence of ruptures, the intensity of the ruptures and whether the ruptures were resolved, these are measured on a 5-point likert scale. There is also allowance for an open-ended description of the rupture/repair situation, this allows for further understanding of the context of the ruptures and repairs as well as process issues that may have contributed to the ruptures and/or repairs. The current study utilised the self-report measures of rupture occurrences and resolution of ruptures, as well as the incorporated therapeutic alliance measure (WAI).

The Psychopathy Checklist (PCL). The Psychopathy Checklist (PCL) is a rating scale design to measure psychopathic traits (Cooke, Michie, Hart, & Hare, 1999). The Psychopathy Checklist Screening Version (PCL-SV) is a screening measure of the Psychopathy Checklist (PCL), which takes less time to administer and requires less case note information (Cooke et al., 1999). It has a 12-item rating scale, which is taken directly from the PCL; items have been made shorter and have been simplified, although the core meaning of each item remains the same (Cooke et al., 1999). Items are rated on a 3-point scale, with scores over 18 being indicative of psychopathy (Cooke et al., 1999). The PCL-SV can be scored from file information and takes approximately 30 minutes to complete.

Treatment Readiness Responsivity Gain Scale: Short Version (TRRG:SV). The TRRG:SV is a measure of treatment readiness, responsivity and treatment gain (Serin, Kennedy, & Mailloux, 2005). These three domains can be assessed independently. Only the Treatment Gain domain was used for the purposes of this study. The Treatment Gain Scale is a clinical rating scale that is measured post-treatment, and assesses a combination of knowledge, competencies and participation. The purpose of the Treatment Gain domain is to provide an overall estimate of an offender's performance, rather than specific programme target gains (Serin et al., 2005). The Treatment Gain Scale consists of eight items, rated on a scale of 0 (poor) to 3 (very good), with descriptions provided to assist scoring. Higher scores are indicative of higher treatment gain. The eight items include: 1) evidence of increased skills from programme, 2) disclosure in programme, 3) application of knowledge, 4) application of skills, 5) depth of emotional understanding of programme content, 6) appropriateness of behaviour in group, 7) participation, and 8) therapeutic alliance. Data on predictive validity were not available on this measure at the time of writing.

Table 4

Internal Consistency of CVTRQ Subscales

| | Cronbach's Alpha |
|--------------------------|------------------|
| Attitudes and Motivation | .685 |
| Emotional Reactions | .692 |
| Offending Beliefs | .791 |
| Efficacy | .416 |

Table 5

Internal Consistency of WAI-SF Subscales

| | Cronbach's Alpha |
|--------------------------|------------------|
| <i>Therapist ratings</i> | |
| Task | .947 |
| Bond | .807 |
| Goals | .835 |
| <i>Offender ratings</i> | |
| Task | .868 |
| Bond | .869 |
| Goals | .594 |

Table 6

Internal Consistency of IMI-C Subscales

| | Cronbach's Alpha |
|---------------------------------------|------------------|
| <i>Therapist ratings of offenders</i> | |
| Dominance | .866 |
| Hostile-Dominance | .865 |
| Hostility | .880 |
| Hostile-Submission | .856 |
| Submission | .829 |
| Friendly-Submission | .808 |
| Friendly | .843 |
| Friendly-Dominance | .584 |
| <i>Offender ratings of therapists</i> | |
| Dominance | .586 |
| Hostile-Dominance | .737 |
| Hostility | .447 |
| Hostile-Submission | .646 |
| Submission | .437 |
| Friendly-Submission | .685 |
| Friendly | .784 |
| Friendly-Dominance | .153 |

Recruitment and procedure. Participants were recruited through Corrections Victoria's Sexual Offenders Programme at Marngoneet Correctional Centre (a medium security prison in Victoria, Australia) and through Victorian Community Corrections services. Sexual offender rehabilitation programs in Victoria, Australia, adhere to a cognitive-behavioural treatment approach, and are delivered predominantly in a group therapy format (Gelb, 2007). Core programme modules

include: commencement (introductory module); offence cycle (aim to identify and restructure offence-related cognitive distortions); victim empathy (aim to understand the impact of the offending on the victim); and self-management (the development of a relapse prevention plan; Gelb, 2007). There are five additional modules available that address: motivation/denial, fantasy reconditioning, emotion management, intimacy and social competencies, and maintaining change.

Sexual offenders and their therapists were invited to participate in the study. All sexual offenders recruited were participating in a group treatment programme, with the prison programme comprising 2 weekly 3-hour sessions, and the community programme comprising a 3-hour programme once a week. Total hours in the programme ranged from 72 to 150 hours (between 3 to 8 months), depending on level of risk and treatment need. Participants were clearly informed that participation was voluntary and was not a requirement of their treatment programme or parole conditions. Within prison, participants were recruited outside of standard group time. Within the community participants were recruited pre or post group, or prior to completing psychometrics required for the sexual offender programme. Upon recruitment participants signed consent forms, and were assigned unique study identification codes to help maintain confidentiality. These codes were used to align data at different stages of data collection. Participants in prison completed the questionnaires while the researcher was present, whereas participants within the community were supplied with return addressed envelopes and were asked to complete the questionnaires outside of group time. Participants received no remuneration for their time.

Stage One: Before entering the group programme, each incarcerated participant completed the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ) to

determine their level of treatment readiness. Within the community setting this took place after the first week of the group (but before the third week), when offenders attended Carlton Community Corrections outside of group time to complete their Sex Offender Programme psychometrics. Due to this difference in timing for the first stage of data collection, a one-way analysis of variance (ANOVA) was conducted to determine whether there was any difference in CVTRQ scores for community versus incarcerated participants. There was no significant difference between the groups, $F(1, 70) = 0.17, p = .69$.

Stage Two: After three weeks of treatment offender participants completed the Working Alliance Inventory Short Form (WAI-SF) to measure treatment engagement, and the Impact Message Inventory (IMI-C) on their two group facilitators. At this same time point group facilitators completed the WAI-SF, to measure the facilitators' views of the treatment engagement of the participant, and the IMI-C to ascertain the offenders' perceived interpersonal styles. Therapists were allocated at random as Therapist 1 or Therapist 2 to reduce biases in the data upon future consolidation. This is further discussed in the Data preparation section below.

Stage Three: After the three quarter point of the treatment programme (based on the standard length of treatment) participants completed the Post-Session Questionnaire (PSQ), which included the Working Alliance Inventory (WAI), to assess ruptures and repairs in the therapeutic relationship, as well as treatment engagement. This was conducted prior to treatment completion to enable offenders to reflect on their current, as well as past treatment experiences. It also enabled access to participants due to their continued attendance at Community Corrections, and prior to being released on parole at Marngoneet Correctional Centre.

Stage Four: Case file reviews were conducted after the participants had completed treatment using the Psychopathy Checklist Screening Version (PCL-SV) to assess for levels of psychopathy, the Treatment Gain Scale to measure within-treatment change, as well as to determine previous psychiatric history, previous treatment involvement and criminal history. The PCL-SV was scored on pre-treatment data only, and the Treatment Gain Scale was scored on the Treatment Completion Reports and treatment notes completed by facilitators during the course of the Sexual Offender Programme only.

Data preparation. Overall, missing data were found to be missing at random. Cases were excluded if they had more than 10% missing data, with five cases being excluded. Cases with less than 10% missing data had their item scores prorated based on mean subscale scores. Missing data were analysed prior to consolidation of Therapist 1 and Therapist 2 data. On the IMI-C (offenders' ratings) there were eight cases with one missing item (1.8%) and one case of two missing items (3.6%). On the IMI-C (therapists' ratings) ten cases had one missing item (1.8%), four cases had two missing items (3.6%) and three cases had three missing items (5.4%), three cases were excluded. On the WAI-SF (early offenders' ratings) there were seven cases with one missing item (8.3%). On the WAI-SF (early therapists' ratings) one case had one missing item (8.3%) and one case was excluded. On the CVRTQ, four cases had one missing item (5%), and one case was excluded. No items were prorated on the PSQ or late ratings of the WAI-SF.

Two therapists ran each group programme, as such data was collected on offenders' views of both therapists and both therapists were requested to complete questionnaires on their views of offenders' interpersonal style and the therapeutic alliance. In order to keep the data analyses independent, the data set was consolidated

to include only one offender-therapist response. Data were first eliminated if there was no therapist or offender response, if both full sets of responses were available then Therapist 1 data was used. This data was random due to the random allocation of therapists to 'Therapist 1' and 'Therapist 2' conditions at data collection stage. Prior to consolidation, Therapist 1 and Therapist 2 data sets were analysed to determine their relationship. It was found that all data was correlated except for therapists' ratings of WAI-SF *Bond*. Therefore, some variance may have been lost in the consolidation process. The reason for the differences in bond ratings are unknown, however it has been proposed by Kozar and Day (2012) that within a forensic setting the therapeutic bond may be seen by some therapists as an avenue through which they can be exploited or manipulated by offenders. Therefore some therapists may instead focus on appearing distant and professional, focusing more on therapeutic tasks and goals. It is noted that the correlations are outlined in Study One (Chapter 4) and Study Two (Chapter 5).

Data analysis. Detailed information about data analyses used in each empirical study is outlined in the following chapters. Therefore, the following section will provide a brief summary of the analyses used.

Study One aimed to examine the nature of the therapeutic alliance in a sexual offender population, and the impact of interpersonal style (including offender and therapist interpersonal complementarity) on the alliance. The interpersonal axes and complementarity were calculated based on the IMI-C Manual (Kiesler & Schmidt, 2006). A one-way between-subjects analysis of variance (ANOVA) was conducted to analyse the difference in offender-therapist views of the therapeutic alliance, with correlational analyses being run to explore the relationship between the therapeutic alliance and offender-therapist interpersonal style, including interpersonal

complementarity. Finally, regression analyses were run to determine whether offender interpersonal style would predict the therapeutic alliance.

Study Two aimed to explore the occurrences of rupture in the therapeutic relationship in sexual offender treatment, including the impact of ruptures on the therapeutic alliance. It also aimed to explore the difference in offenders' interpersonal styles for those that experienced ruptures or had ruptures that are repaired. ANOVAs were conducted to determine the impact of ruptures on the ratings of the therapeutic alliance over time, as well as to determine the difference in interpersonal style ratings for those offenders who experience no rupture, minor rupture or major rupture in the therapeutic relationship. Finally, regression analyses were run to determine the impact of interpersonal style, and offence-specific factors on the likelihood of a rupture being repaired.

Study Three aimed to examine the impact of offender interpersonal style, the therapeutic alliance and treatment readiness on offender treatment gain. Regression analyses were conducted to determine whether these factors were predictive of gain. Multiple regression analyses were conducted to determine whether the relationship between offender interpersonal style and treatment gain was moderated by the therapeutic alliance. To run these analyses both offender interpersonal style variables and therapeutic alliance ratings were centered (Mean – X) and an interaction variable was created (IPS x TA).

Chapter 4: Interpersonal Style and the Therapeutic Alliance

The Impact of Interpersonal Style and Interpersonal Complementarity on the Therapeutic Alliance between Therapists and Offenders in Sex Offender Treatment

Preamble for Chapter 4. The literature review presented in Chapter 1 of the thesis outlined the current limits in offender rehabilitation, particularly in regards to recidivism outcomes. Much has been gained in treatment effectiveness with an evidence-based RNR approach to rehabilitation, however further gains can potentially be made in regards to offender responsivity and engagement in the treatment process.

Chapter 4 consists of the first empirical study of the thesis. Study One aimed to explore the nature of the therapeutic alliance in a sexual offender treatment programme, and to determine the impact of both offenders' and therapists' interpersonal styles on this alliance. Study One further aimed to determine whether complementarity in offenders' and therapists' interpersonal styles would impact the therapeutic alliance.

Published as:

Watson, R., Daffern, M., & Thomas, S. (2015). The impact of interpersonal style and interpersonal complementarity on the therapeutic alliance between therapists and offenders in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment*. Published online 30 April 2015. Impact factor: 2.113; 5 year impact

factor: 1.85; Ranking: Criminology and Penology 9 out of 55; Psychology, Clinical 40 out of 119.

Erratum: Table 2 (pg. 101), symbol should be *F*.

Participants (pg. 97), should be ‘...with 61 (81.3%) offenders born in Australia, 13 (17.3%) overseas, and 1 (1.3%) unspecified. Twenty-seven (36%) offenders completed lower than Year 10 level of schooling, 30 (40%) completed lower than Year 12, 8 (10.7%) completed schooling to Year 12 level, with 10 (13.3%) offenders having engaged in tertiary education to a complete or incomplete level.’ ‘...with 28 (37.3%) offenders rated as moderate-high and 26 (34.7%) rated as high. Eighteen (24%) fell within the low, moderate-low, or moderate risk of reoffending (with 3 [4%] not specified...’.

Declaration for Chapter 4

Declaration by Candidate

In the case of Chapter 4, the nature and extent of my contribution to the work was the following:

| Nature of contribution | Extent of contribution (%) |
|---|----------------------------|
| Generation of ideas, data collection and analysis, and write up | 80% |

The following co-authors contributed to the work. If co-authors are students at Monash University, the extent of their contribution in percentage terms must be stated:

| | Nature of contribution | Extent of contribution (%) for student co-authors only |
|----------------------------------|---------------------------------|---|
| Professor Michael Daffern | Critical revision of manuscript | N/A |
| Professor Stuart Thomas | Critical revision of manuscript | N/A |

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate and co-authors' contributions to this work.

| Candidate | | Date |
|----------------|------------|------------|
| Rachael Watson | [REDACTED] | 10/04/2016 |

| Main Supervisor | | Date |
|---------------------------|------------|------------|
| Professor Michael Daffern | [REDACTED] | 10/04/2016 |

The Impact of Interpersonal Style and Interpersonal Complementarity on the Therapeutic Alliance Between Therapists and Offenders in Sex Offender Treatment

Sexual Abuse: A Journal of
Research and Treatment
1–21

© The Author(s) 2015

Reprints and permissions:

sagepub.com/journalsPermissions.nav

DOI: 10.1177/1079063215580969

sax.sagepub.com



Rachael Watson¹, Michael Daffern^{2,3},
and Stuart Thomas⁴

Abstract

Therapist and treatment process variables affect the effectiveness of offender rehabilitation programs. This study examined the influence of therapists' and offenders' interpersonal styles (IPSs) and interpersonal complementarity on therapeutic alliance (TA). Seventy-five sex offenders and their therapists evaluated each other's IPSs and the TA after 3 weeks of treatment. Offenders evaluated the TA more positively than therapists. Regarding the impact of IPS, therapist affiliation was positively correlated and therapist control was negatively correlated with offenders' ratings of the TA; in other words, offenders evaluated the TA more strongly when therapists were perceived as affiliative, and weaker when therapists were viewed as controlling. Offender affiliation was positively correlated with therapists' ratings of TA; in other words, therapists evaluated the TA more strongly when offenders were viewed as more affiliative; perceptions of offender control were unrelated to offenders' ratings of TA. Complementarity in IPS between offenders and therapists did not affect TA.

¹Monash University, Melbourne, Australia

²Swinburne University of Technology, Melbourne, Australia

³Victorian Institute of Forensic Mental Health, Melbourne, Australia

⁴University of Wollongong, Sydney, Australia

Corresponding Author:

Rachael Watson, Centre for Forensic Behavioural Science, Swinburne University of Technology, 505 Hoddle St., Clifton Hill, Melbourne, Victoria 3068, Australia.

Keywords

therapeutic alliance, interpersonal style, complementarity, sexual offender, treatment process

Treatment process variables affect therapeutic change, with the therapeutic relationship accounting for approximately 25% variance in treatment outcomes in non-forensic populations (Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). The therapeutic relationship is also important for offenders' engagement in treatment (Holdsworth, Bowen, Brown, & Howat, 2014), including sexual offender treatment (Frost & Connolly, 2004; Levenson, Macgowan, Morin, & Cotter, 2009). The treatment process includes factors such as therapist characteristics and clients' perception of therapists, the therapeutic climate (group climate), and the therapeutic alliance (TA; Marshall & Burton, 2010). Compared with interrogation of treatment content, research into process-related issues in sex offender treatment programs is limited (Serran, Fernandez, Marshall, & Mann, 2003). However, there is evidence that a positive therapeutic relationship facilitates a safe environment in which therapists can engage the sexual offender about crime minimization/denial and potentially improve outcomes (Serran et al., 2003). Marshall and Burton (2010) suggested that treatment process may be more important for offender populations than non-offender populations because offenders typically have a higher base rate of interpersonal difficulties. Furthermore, the influence of hostile, uncaring prison environments has been shown to negatively affect the development of trust and offender engagement (Ross, Polascheck, & Ward, 2008); such difficulties in treatment processes can lead to treatment non-completion or reductions in treatment gain (Holdsworth et al., 2014; Martin, Garske, & Davis, 2000). This is significant for offender populations as treatment non-completion is associated with an increased likelihood of recidivism (Olver, Stockdale, & Wormith, 2011).

The TA

One important treatment process factor that has attracted substantial research focus is the TA (also called the working alliance, therapeutic bond, or helping alliance). The TA involves the collaborative and affective bond between therapists and their clients (Martin et al., 2000), with a positive TA having been found to be associated with better treatment outcomes (Martin et al., 2000). TA is most commonly understood through Bordin's (1979) Pantheoretical Model, which articulates three core components: collaboration on tasks, goals, and the affective bond (Bordin, 1979).

Meta-analysis has shown an overall positive relationship between TA and therapy outcomes (Horvath & Symonds, 1991). Although the TA typically fluctuates over time, TA measured early in treatment is significantly associated with treatment outcomes ($r = .31$), consistent with TA measured later in treatment ($r = .30$; Horvath & Symonds, 1991). The available evidence suggests there is typically a lack of agreement between how clients, therapists, or third-party observers view the working alliance (Tichenor & Hill, 1989). Therapists often rate the TA more poorly than clients

(Auerbach, May, Stevens, & Kiesler, 2008; Belding, Iguchi, Morral, & McLellan, 1997), with one study finding a similarity in ratings (Johansen, Melle, Iversen, & Hestad, 2013). It has been suggested that therapists and clients may have different ideas about the nature of the TA, with therapists placing greater importance on tasks and goals (Hatcher, Barends, Hansell, & Gutfreund, 1995). Few studies have examined whether this discrepancy is related to poorer outcomes; extant research includes one study that found no relationship between client–therapist discrepancy and treatment retention (Meier & Donmall, 2006), whereas Auerbach and colleagues (2008) found that a larger discrepancy between raters was associated with poorer behavioral functioning for adolescents during substance abuse treatment.

Beyond Bordin's conceptualization of the TA, research has increasingly expanded to incorporate an understanding of other features of therapy, such as therapist and client characteristics, and their impact on therapeutic engagement. Ross and colleagues (2008) proposed a *Revised Theory of the TA* specifically for the forensic context, extending Bordin's Pantheoretical Model, incorporating greater focus on both therapist and client characteristics (including their interpersonal style [IPS], attachment style, professional and personal skills, treatment readiness, and how these variables affect the core TA factors: goals, task, and bond). They also proposed that the interaction between clients and therapists is crucial to understanding the TA, including their behavior, and emotional and cognitive responses toward each other. Of note, they suggest this interaction is a dynamic one that can change over time.

IPS

IPS describes the consistent pattern of interpersonal behaviors that a person brings to different interpersonal situations (Kiesler, 1987). There are two core dimensions of interpersonal behavior (Kiesler, 1987; Leary, 1957): (a) power/control (ranging from dominance to submission) and (b) affiliation (ranging from hostility to friendliness/warmth; Blackburn & Renwick, 1996). People typically have a preferred pattern of interpersonal behaviors; however, adaptive interpersonal functioning is marked by flexibility in response to situational demands (Kiesler & Auerbach, 2003). A revised model of the circumplex, suggested by Horowitz and colleagues (2006), proposed that interpersonal responses are not automatically evoked but provide an invitation for someone to respond. They note that interpreting the motive behind the interpersonal behavior is important and that ambiguous behaviors can be interpreted differently.

Within offender populations, interpersonal difficulties are prominent, with higher levels of hostility, self-centeredness, irritability, callousness, self-defeating behaviors, and anxiety (Ross et al., 2008). More extreme, pervasive, and inflexible interpersonal behaviors are associated with personality disorder (American Psychiatric Association, 2013). For example, offenders with personality disorder have been found to be non-compliant, dominant, and coercive in their IPS (Blackburn, 1998). Furthermore, offenders are higher in interpersonal dominance than community samples (Edens, 2009). Edens (2009) noted that dominance is related to sex offender treatment non-compliance (Edens, 2009). High levels of dominance (high control/power) and low

warmth (low affiliation) are also related to antisocial traits, as are aggressive behaviors within prison (Edens, 2009). Daffern and colleagues have shown that interpersonal dominance and hostile-dominance in particular (elevations on both dominance and hostility) are associated with aggression and violence in mental health units (Daffern, Duggan, Huband, & Thomas, 2010; Daffern, Thomas, et al., 2010; Daffern, Tonkin, et al., 2010). It is unknown what the optimal levels of dominance/submission is for offenders to build a strong TA, or whether complementarity with therapists (a matching between therapists' and clients' IPS) is important. Interpersonal complementarity may be particularly important in treatment. For example, submissive clients may prefer dominant therapists and vice versa (reflecting complementarity between the IPSs of the two interactants).

Offender characteristics also affect treatment engagement and the TA (Holdsworth et al., 2014). Holdsworth and colleagues reported that higher levels of hostility were related to an increased likelihood of treatment dropout, reduced participation in treatment, reduced rapport with therapist, reduced treatment satisfaction, and reduced peer support. Offenders who complete treatment have been found to have lower levels of hostility (Derks, 1996), psychopathy (McCarthy & Duggan, 2010), and impulsivity (McCarthy & Duggan, 2010; McMurrin, Huband, & Duggan, 2008). A low-level of friendliness (low affiliation) is also related to reduced benefit from the therapeutic process in non-offenders (Hardy et al., 2001). However, if a TA was established despite this low affiliation, the negative impacts were ameliorated. It should be noted that there is limited published research that has explored the impact of offenders' IPS on the TA task, goals, and bond, although Cookson, Daffern, and Foley (2012) found that hostile-dominance was negatively correlated with TA in a sample of mental health patients.

Therapist Characteristics

Therapist characteristics affect treatment outcomes with sex offenders (Marshall et al., 2002). Therapist empathy and warmth are significantly related to treatment benefit, as are asking open-ended questions, and being directive and rewarding (verbal encouragements; Marshall et al., 2003). Challenging by therapists that is firm but supportive has also been shown to be related to a reduction in victim blaming by sex offenders (Marshall et al., 2002); however, Karver, Handelsman, Fields, and Bickman (2005) warned that too much directiveness (in a non-offender population) can lead clients to view therapists as less warm and empathic, negatively influencing the TA. With a sex offender population, it has been found that a confrontational therapeutic style (aggressive and/or derogatory challenging, critical, hostile, sarcastic) negatively affects treatment-induced change and participation (Drapeau, 2005; Marshall et al., 2003). A controlling and aggressive therapeutic style can also lead to lowered group cohesiveness, which may affect therapeutic quality for sex offender group programs (Beech & Fordham, 1997). However, with sex offenders, high levels of denial and minimization may encourage a confrontational approach by therapists (Serran et al., 2003).

Therapists are often required to change their interpersonal approach in different settings as well as in response to the different IPSs of clients. Flexibility is an important feature for effective therapy, which includes being able to adapt to the clients' interpersonal behavior and emotional needs (Marshall, 2005). Marshall and colleagues (2003) noted that therapists' ability to move between a directive and non-directive style was an important feature in adjusting to a clients' interpersonal approach, and it has been suggested that a reflective style is more effective with aggressive or defensive clients (Ashby, Ford, Guernsey, & Guernsey, 1957). However, if therapists deem that a supportive approach with offenders is ineffective, they could quickly change to a more confrontational approach (Marshall et al., 2002), which is likely to reduce the TA.

Therapy-Related Interactions

Although much of the previous research looks at either therapist or offender characteristics in isolation, Ross and colleagues (2008) proposed that therapist and client characteristics are not static, isolated factors, but rather lead to cognitive processes and emotional responses affecting the clients' and therapists' behaviors toward each other. They note that these processes affect the task, bond, and goal components of the TA. However, research in this field remains limited.

Interpersonal theory explores the interaction between the IPS of therapists and clients by way of measurement of interpersonal complementarity. Complementarity is a core principle of interpersonal theory and relates to covert transactional interactions designed to evoke overt behaviors from others (Kiesler & Schmidt, 2006). When an interaction is complementary, interactants have either a corresponding (friendliness evoking friendliness) or reciprocal (dominance evoking submission) response (Lillie, 2007). Research shows that interpersonal complementarity affects satisfaction with the therapeutic process and engagement (Dryer & Horowitz, 1997). Within a medical setting, complementary affiliation between doctors and patients has been shown to lead to greater treatment compliance (Kiesler & Auerbach, 2003). Greater complementarity is also related to a higher bond rating of the working alliance (Kiesler & Watkins, 1989). However, findings are inconsistent, with more recent research finding no relationship between complementarity and the working alliance in an adolescent substance treatment population (Auerbach et al., 2008). Research has shown that therapists are more likely to show complementarity in their IPS when patients are friendly, with complementarity potentially increasing patients' self-esteem and self-evaluation (Caspar, Grossmann, Unmüßig, & Schramm, 2005). There is no research on the impact of interpersonal complementarity in offender population treatment studies.

Current Study

It is known that therapeutic process variables account for a significant proportion of treatment outcome; however, more research needs to be conducted to determine the impact of therapists' and clients' characteristics on the therapeutic relationship in

offender populations. Understanding the TA in this population is important due to the increased level of interpersonal difficulties in those offenders and the increased risk of recidivism associated with disengagement from or non-completion of treatment.

This study has four aims: (a) to describe and compare the nature of the TA from the perspective of therapists and offenders, (b) to determine the relationship between therapists' and offenders' IPS and the TA, (c) to explore whether offender hostility and dominance is related to assessments of the TA, and (d) to explore the level of complementarity in IPS between therapists and offenders and determine whether complementarity is related to TA. It was hypothesized that both hostile and dominant therapist and offender IPSs would be negatively associated with the TA. It was further hypothesized that complementarity between therapists and offenders would be positively associated with TA.

Method

Participants

All participants were male, above the age of 18 years, and recruited from the Sex Offender Program run by the Department of Justice (Corrections Victoria is part of the Department of Justice). All participants were assessed as moderate-low to high risk of sexual reoffending (Australian Institute of Criminology, 2011) according to STATIC-99 assessment (with some participants' risk rating increased from low risk due to clinical over-ride despite STATIC-99 assessment). The treatment program targets dynamic risk factors related to sexual offending, with the community-based Program comprising a 3-hr session once a week and the prison-based program consisting of 2 weekly 3-hr sessions. Total hours in the program range from 72 to 150 hr, between 3 and 8 months, depending on level of risk posed by the offender and their treatment needs.

The sample comprised 75 participants, with 60 recruited from Marngoneet Correctional Centre and 15 from Community Corrections; in the community, the offenders were either on a community order or parole. Those offenders recruited from Marngoneet Correctional Centre started the program toward the end of their sentences, whereas community-based offenders started the program near the beginning of their community or parole orders. Offenders ranged in age from 21 to 73 years ($M = 44.97$, $SD = 15.15$), with 61 (53%) offenders born in Australia, 13 (11.3%) overseas, and 1 (0.9%) unspecified. Twenty-seven (23.5%) offenders completed lower than Year 10 level of schooling, 30 (26.1%) completed lower than Year 12, 8 (7%) completed schooling to Year 12 level, with 10 (8.7%) offenders having engaged in tertiary education to a complete or incomplete level. Sixty-seven offenders completed the treatment program, 5 were non-completers, and 3 were ongoing at the time of the study. Reasons for non-completion were (a) re-offense while undertaking the program, (b) offenders withdrawing after hostile and aggressive behavior toward therapists, and (c) mental health issues (active symptoms of psychosis). Most offenders were classified as moderate-high or high risk of reoffending (based on the Static-99), with 28 (24.3%) offenders rated as moderate-high and 26 (22.6%) rated as high. Eighteen (15.7%) offenders

fell within the low, moderate-low, or moderate risk of reoffending (with 3 [2.6%] not specified although regarded as moderate to high risk given their inclusion in the treatment program). A one-way between-subjects ANOVA was conducted to compare the effect of risk level on TA, with no significant difference found, $F(2, 61) = 0.29, p = .75$.

Measures

The Impact Message Inventory (IMI). The Impact Message Inventory–Circumplex (IMI-C; Schmidt, Wagner, & Kiesler, 1999) is a 56-item inventory that assesses the covert emotional experience of interpersonal behaviors or interactions (Kiesler & Auerbach, 2003). The IMI-C was designed to measure the nature of the dyadic interaction (Kiesler & Auerbach, 2003) and has been used to measure the impact of clients' interpersonal behaviors on their therapists (Schmidt et al., 1999). The IMI-C consists of an octant scale that follows the traditional interpersonal circle format, consisting of 7 items per subscale: *Dominant* (e.g., “when I am with this person he makes me feel bossed around”), *Hostile-Dominant* (e.g., “when I am with this person he makes me feel that I want to get away from him”), *Hostile* (e.g., “when I am with this person he makes me feel like an intruder”), *Hostile-Submissive* (e.g., “when I am with this person it appears to me that he thinks he's inadequate”), *Submissive* (e.g., “when I am with this person it appears to me that he sees me as superior”), *Friendly-Submissive* (e.g., “when I am with this person he makes me feel that I could ask him to do anything”), *Friendly* (e.g., “when I am with this person he makes me feel that I could lean on him for support”), and *Friendly-Dominant* (e.g., “when I am with this person it appears to me that he wants to be the charming one”). Each octant scale is rated on a 4-point rating scale (ranging from *not at all* to *very much so*). The IMI-C has shown acceptable internal consistency, with Cronbach's alpha ranging from .69 to .89 across the eight subscales (Schmidt et al., 1999).

The Working Alliance Inventory–Short Form (WAI-SF). The WAI-SF (Tracey & Kokotovic, 1989) is a self-report measure of the TA between therapist and client. The short-form version consists of 12 items and can be completed by the client or the therapist. The WAI has three subscale scores, consisting of 4 items per subscale; *Bond* (“[therapist] and I trust one another”), *Goal* (“[therapist] and I have different ideas on what my problems are”), and *Task* (e.g., “I believe the way we are working with my problem is correct”), all measured on a 7-point Likert-type scale (ranging from *never* to *always*). The WAI-SF has good internal consistency, with a Cronbach's alpha of .98 (client's form) and .95 (therapist's form; Tracey & Kokotovic, 1989).

Procedure

The study was approved by the Monash University Human Research Ethics Committee (MUHREC) and the Department of Justice Human Research Ethics Committee (JHREC). Sexual offenders participating in sex offender treatment through Corrections Victoria (the state of Victoria, Australia corrections department) and their therapists were invited to

participate in the study. Participation was voluntary and the study was not associated with the requirements of their program. In June 2012, permission was received to begin recruitment and data collection at Marngoneet Correctional Centre (a medium security prison in Victoria, Australia) and through Victorian Community Corrections services. Questionnaires were administered 3 to 4 weeks after the commencement of treatment. Participants at Marngoneet Correctional Centre completed the IMI-C and WAI-SF while the researcher was present, outside of treatment program time. Community participants were given the IMI-C and WAI-SF, with return paid and addressed envelopes, to complete outside of the treatment program time. At this time, treatment therapists were also given the IMI-C and WAI-SF to be completed about the participants within their treatment group. There were two therapists per group, with each offender being asked to complete questionnaires based on their perception of IPS and TA on both therapists. Therapists were randomly allocated as Therapist 1 or Therapist 2 for each participant.

Data Preparation

Missing data were determined to be random, and four cases were discarded due to having more than 10% missing data. Of the remaining cases, 18 had 1.8% missing, 5 had 3.6% missing, and 8 had 8.3% missing; in these cases, the participant's mean response for the specific subscale was used. To keep data independent, data were consolidated to use only one offender–therapist response. Data were eliminated first if there was no offender or therapist response; if both full sets were available, “Therapist 1” was chosen. All Therapist 1 and Therapist 2 data sets were correlated except the therapists' view of the *Bond* aspect of the TA (see Table 1). This suggests that there was no difference in the way the two therapists viewed the TA with the offender except for therapists' assessment of the bond; the two therapists' perceptions of the bond differed. The reason for this difference is unclear. It may be because forensic therapists have different ideas about the importance of the bond, whereas they may agree more readily on the tasks and goals; the therapeutic bond may be seen by some therapists as means through which they can be exploited or manipulated by offenders (Kozar & Day, 2012). It may be that some therapists are reluctant to acknowledge a strong bond because they want to appear distant and professional and focused on goals and tasks. It may also be that within a therapeutic relationship, the bond that is shared with the two therapists is different, that participants share a stronger bond with one therapist compared with another. As therapists' perceptions were correlated, with the exception of assessment of bond, to aid data analysis, the data were consolidated, although some loss of variance in terms of the *WAI-Bond* was lost in this process.

Approach to Analysis

A one-way between-subjects ANOVA was conducted to analyze the difference between therapists' and offenders' ratings of the TA. Independent-samples *t* tests were run to compare WAI-SF normative samples with the current WAI-SF findings, and to compare IMI Complementarity normative samples with the current IMI Complementarity

Table 1. Correlations of Therapist 1 and Therapist 2 IMI and WAI-SF Ratings.

| | <i>Therapist 1</i> |
|-------------------------|--------------------|
| Therapist 2 | |
| WAI-Goal | .33* |
| WAI-Task | .35* |
| WAI-Bond | .24 |
| WAI-Total | .33* |
| IMI Dominant | .76** |
| IMI Hostile-Dominant | .71** |
| IMI Hostile | .71** |
| IMI Hostile-Submissive | .53** |
| IMI Submissive | .55** |
| IMI Friendly-Submissive | .87** |
| IMI Friendly | .72** |
| IMI Friendly-Dominant | .42** |
| IMI Control | .62** |
| IMI Affiliation | .74** |

Note. IMI = Impact Message Inventory; WAI-SF = Working Alliance Inventory–Short Form.

* $p < .05$ (two-tailed). ** $p < .01$ (two-tailed).

findings. Correlations were computed to explore the relationship between therapists' and offenders' ratings of the TA and IPS. The following IPS calculations were conducted based on instructions from the IMI-C manual (Kiesler & Schmidt, 2006). The *Affiliation* axis was calculated by combining the dimensions of hostility and friendliness. The *Control* axis was calculated by combining the dimensions of dominance and submission. Complementarity along the *Control* axis was computed using the formula: ABS (offender control axis + therapist control axis). Complementarity along the *Affiliation* axis was computed using the formula: ABS (offender affiliation axis – therapist affiliation axis). A score of 0 equals perfect complementarity, with a score of 6 being perfect non-complementarity. Overall complementarity was computed by summing the two axes' complementarity scores. A score of 0 equals perfect complementarity, with a score of 12 equating perfect non-complementarity on the total complementarity score. Regression analysis was used to explore whether a hostile or dominant IPS would predict ratings of the working alliance for sex offenders undergoing treatment.

Results

Therapists' and Offenders' Ratings of the (WAI-SF)

Offenders' ratings of the TA *Goal*, *Task*, and *Total* alliance score were all significantly higher than therapists' ratings. There was no significant difference between offenders' and therapists' ratings on the TA *Bond* (Table 2). Table 3 shows normative samples of clients' and therapists' ratings on the WAI-SF. A significant difference was found between

Table 2. WAI-SF: Offender and Therapist Ratings.

| | Offender | | | Therapist | | | t(122) |
|-----------|----------|-------|-------|-----------|-------|-------|---------|
| | n | M | SD | n | M | SD | |
| WAI-Goal | 64 | 21.06 | 4.12 | 60 | 17.40 | 3.89 | 25.83** |
| WAI-Task | 64 | 22.02 | 4.80 | 60 | 16.10 | 4.59 | 49.18** |
| WAI-Bond | 64 | 19.44 | 5.21 | 60 | 17.92 | 3.73 | 3.46 |
| WAI-Total | 64 | 62.52 | 12.74 | 60 | 51.42 | 10.96 | 26.91** |

Note. WAI-SF score range: Subscales = 4-28, total = 12-84. WAI-SF = Working Alliance Inventory–Short Form.

*p < .05 (two-tailed). **p < .01 (two-tailed).

Table 3. WAI-SF: Mean Difference Between Current Study WAI-SF Ratings (Table 2) and Normative Samples.

| | Adolescent sample (Auerbach, May, Stevens, & Kiesler, 2008) | | | | Schizophrenia sample (Johansen, Melle, Iversen, & Hestad, 2013) | | | |
|-------------------|---|-------|------|--------|---|------|------|--------|
| | n | M | SD | t(101) | n | M | SD | t(104) |
| Client ratings | | | | | | | | |
| WAI-Goal | 39 | 21.23 | 6.24 | 0.17 | 42 | 20.9 | 3.8 | 0.20 |
| WAI-Task | 39 | 21.92 | 5.93 | 0.09 | 42 | 20.4 | 4.1 | 1.80 |
| WAI-Bond | 39 | 20.61 | 6.01 | 1.04 | 42 | 20.3 | 4.9 | 0.85 |
| WAI-Total | 39 | 63.76 | 16.4 | 0.43 | 42 | 61.6 | 11.1 | 0.38 |
| Therapist ratings | | | | | | | | |
| WAI-Goal | 39 | 20.38 | 4.42 | 3.53** | 42 | 20.6 | 3.0 | 4.48** |
| WAI-Task | 39 | 19.43 | 4.34 | 3.60** | 42 | 20.4 | 3.4 | 5.16** |
| WAI-Bond | 39 | 19.48 | 4.24 | 1.93 | 42 | 21.5 | 2.6 | 5.37** |
| WAI-Total | 39 | 59.28 | 12.1 | 3.35** | 42 | 62.4 | 7.7 | 5.59** |

Note. WAI-SF score range: Subscales = 4-28, total = 12-84. WAI-SF = Working Alliance Inventory–Short Form.

*p < .05 (two-tailed). **p < .01 (two-tailed).

therapists' ratings of the TA in the current sample and the schizophrenia spectrum sample. A significant difference was found between therapists' ratings of the TA *Goal*, *Task*, and *Total* alliance in the current sample and the adolescent substance treatment sample; however, no difference was found in therapists' TA *Bond* ratings. There was no difference found between offenders' ratings of the TA and clients' ratings in the two samples.

Therapists' and Offenders' Ratings of the IMI-C

The covert impacts of the IPS of offenders and group therapists were evaluated using four scales (*Dominance*, *Submission*, *Friendliness*, *Hostility*); Table 4 shows mean

Table 4. Mean and Standard Deviation of IMI Complementarity Scores.

| | <i>n</i> | <i>M</i> | <i>SD</i> |
|-----------------------------|----------|----------|-----------|
| Complementarity Control | 56 | 2.48 | 1.44 |
| Complementarity Affiliation | 56 | 1.82 | 1.26 |
| Complementarity Total | 56 | 4.29 | 2.06 |

Note. IMI complementarity score range: Axes = 0 (perfect complementarity) to 6 (perfect non-complementarity), total = 0 (perfect complementarity) to 12 (perfect non-complementarity). IMI = Impact Message Inventory.

Table 5. Preliminary Normative Data on IMI Complementarity Scores (Kiesler & Schmidt, 2006) and Mean Difference With Current Sample (Table 4).

| | <i>n</i> | <i>M</i> | <i>SD</i> | <i>t</i> (102, 103) |
|------------------------------------|----------|----------|-----------|---------------------|
| Diabetic patients and physicians | | | | |
| Complementarity Control | 48 | 1.23 | 0.76 | 5.40** |
| Complementarity Affiliation | 49 | 1.38 | 0.80 | 2.10* |
| Complementarity Total | 48 | 2.61 | 0.76 | 5.34** |
| TBI-Patient/Intervention–Admission | | | | <i>t</i> (82) |
| Complementarity Control | 28 | 1.34 | 1.12 | 3.67** |
| Complementarity Affiliation | 28 | 2.53 | 1.80 | 2.10* |
| Complementarity Total | 28 | 3.86 | 2.33 | 0.86 |
| TBI-Patient/Intervention–Discharge | | | | <i>t</i> (82) |
| Complementarity Control | 28 | 1.62 | 1.00 | 2.83** |
| Complementarity Affiliation | 28 | 2.61 | 1.46 | 2.57* |
| Complementarity Total | 28 | 4.24 | 1.82 | 0.11 |

Note. IMI complementarity score range: Axes = 0 (perfect complementarity) to 6 (perfect non-complementarity), total = 0 (perfect complementarity) to 12 (perfect non-complementarity). IMI = Impact Message Inventory; TBI = Traumatic Brain Injury.

* $p < .05$ (two-tailed). ** $p < .01$ (two-tailed).

complementarity scores, with normative data (Kiesler & Schmidt, 2006) shown in Table 5. The therapist/offender population showed a lower level of *Control Complementarity* compared with *Affiliation Complementarity*, and showed a lower level of *Control Complementarity* than the normative samples.

Intercorrelations Between Therapists' and Offenders' Ratings of the TA and IPS

Offenders' perception of therapist *Affiliation* was positively correlated ($r = .57$) with the offenders' rating of the TA (including *Total TA* and *Goal, Task, and Bond* subscales). There was also a significant negative correlation between offenders' perception of therapist *Control* ($r = -.39$) and the offenders' rating of the TA, (including *Total*

TA and *Goal, Task, and Bond* subscales). Therapists' perceptions of offender *Affiliation* was positively correlated ($r = .61$) with the therapists' rating of the TA (including *Total TA* and *Goal, Task, and Bond* subscales). There was also a significant negative correlation between therapists' perception of offender *Control* ($r = -.45$) and the therapists' rating of the TA (including *Total TA* and *Goal, Task, and Bond* subscales; Table 6).

There was no statistically significant association between *Complementarity* of IPS and the ratings of TA for therapists or offenders. There was, however, a significant association between *Complementarity* on the *Control* axis (*dominance* and *submission*) and differences in therapist-offender ratings on the TA *Bond* ($r = .29$). An increase in non-complementarity on the *Control* axis was associated with an increase in difference in bond ratings between therapists and offenders.

Hostility, Dominance, and the TA

Therapists' ratings of offender *hostility* were associated with lower offenders' rating of the TA (see Table 7). However, therapists' ratings of offender *dominance* were not significantly associated with the offenders' rating of the TA (Table 7).

Discussion

The TA

The first aim of this study was to explore and compare the nature of the TA from therapists' and offenders' perspectives. Results revealed a significant difference between therapists' and offenders' assessments of the *Task* and *Goals* elements of the TA, as well as overall TA. In general, offenders rated the TA higher than therapists, except for the *Bond* component, where there was no statistically significant difference between offenders' and therapists' assessments. This difference may be due to offenders feeling less comfortable about the process or connection with therapists when compared with the more practical goal/task components of the therapeutic relationship; this may be due to the fact that there were two therapists and the treatment was provided in a group format so the strength of the bond may have been dispersed as offenders connected emotionally with two therapists rather than one. The discrepancy between ratings of TA by offenders and therapists is consistent with a study of therapists and adolescents in substance abuse treatment, and a study of short-term psychotherapy with non-offenders (Auerbach et al., 2008; Tichenor & Hill, 1989). It has been suggested that therapists and offenders see the TA differently due to the differing filter through which each may see the relationship (Horvath, 2000). Horvath (2000) suggested that therapists would potentially be influenced by their training to see the TA through a theoretical lens, whereas clients would assess the TA based on their past relationship experiences.

The TA alliance ratings were compared with two normative samples (Auerbach et al., 2008; Johansen et al., 2013), with offender ratings of the TA being consistent with both adolescents in substance abuse treatment (Auerbach et al., 2008) and clients on the

Table 6. Correlations of WAI and IMI Scores.

| | Therapist affiliation (rated by client) | Therapist control (rated by client) | Client affiliation (rated by therapist) | Client control (rated by therapist) | Affiliation complementarity | Control complementarity | Total complementarity |
|--|---|---|---|---|--------------------------------|----------------------------|--------------------------|
| WAI-Client | | | | | | | |
| Goal | .43** | -.37** | .32* | -.05 | -.09 | -.21 | -.20 |
| Task | .47** | -.25* | .22 | -.02 | .14 | -.10 | .02 |
| Bond | .62** | -.41** | .39** | -.14 | .19 | -.04 | .09 |
| Total | .57** | -.39** | .35** | -.08 | .10 | -.12 | -.02 |
| WAI-Therapist | | | | | | | |
| Goal | .09 | -.26 | .55** | -.39** | -.17 | .04 | -.07 |
| Task | .02 | -.26 | .50** | -.29* | -.23 | .00 | -.14 |
| Bond | .07 | -.22 | .63** | -.55** | -.17 | .03 | -.08 |
| Total | .06 | -.28* | .61** | -.45** | -.21 | .03 | -.11 |
| WAI-Client/Therapist Difference | | | | | | | |
| Goal | .17 | .20 | -.24 | .11 | .09 | .10 | .12 |
| Task | .25 | .17 | -.16 | .09 | .10 | -.06 | .02 |
| Bond | -.09 | -.01 | -.11 | -.05 | -.17 | .29* | .10 |
| Total | .17 | .12 | -.21 | .03 | -.01 | .13 | .08 |

Note. WAI = Working Alliance Inventory; IMI = Impact Message Inventory.
*p < .05 (two-tailed). **p < .01 (two-tailed).

Table 7. Regression Analysis of Therapist Rating of Offender Hostility and Dominance and the Related Offender Rating of Working Alliance.

| | Standardized B | T |
|---|----------------|---------|
| Constant | | 15.41** |
| Therapist rating of offender <i>hostility</i> | -.40 | -3.16** |
| Adjusted R ² | | .14 |
| n | | 54 |
| Constant | | 14.85 |
| Therapist rating of offender <i>dominance</i> | -.17 | -1.28 |
| Adjusted R ² | | .01 |
| n | | 54 |

Note. Dependent variable: Client-rated working alliance total.

* $p < .05$ (two-tailed). ** $p < .01$ (two-tailed).

schizophrenia spectrum undergoing treatment (Johansen et al., 2013). However, therapists' ratings of TA with sex offenders in this study were significantly lower than therapists' ratings of the TA in the two normative samples. This may be due to the challenges of working in a forensic setting, with therapists potentially dealing with more difficult IPSs, or due to the challenges associated with exploring sexual offenses. The bond ratings of therapists treating adolescent substance abusers was similar to the bond ratings of therapists treating sex offenders, suggesting there may be similar challenges with developing, or a reluctance to develop, a therapeutic bond in these populations.

IPS and the TA

The second aim was to determine the relationship between therapists' and offenders' IPSs and the TA. There was a positive association between therapists' perception of offender *Affiliation* and their rating of the TA. In addition, therapists' perception of offender *Control/Dominance* was associated with poor TA; that is, therapists who assessed their offender clients as friendly rather than hostile reported higher TA, and therapists who assessed their offender clients as more dominant reported a lower TA. This is consistent with previous research suggesting that offender hostility and dominance negatively affect rapport and engagement (Edens, 2009; Holdsworth et al., 2014). There was also a positive association between offenders' perception of therapist *Affiliation* and all aspects of the TA. However, if offenders assessed therapists as being more *Controlling*, then this negatively affected their perception of the TA. This suggests that therapist hostility and dominance both negatively affect the TA. This is consistent with previous research showing that therapist characteristics can affect offender engagement and the quality of the working relationship (Beech & Fordham, 1997; Drapeau, 2005; Marshall et al., 2002, 2003).

Therapists may be perceived as hostile if they are overly confrontational, use aggressive and/or derogatory challenging, and/or are overly critical or sarcastic

(Drapeau, 2005, Marshall et al., 2003). An overly dominant therapist is controlling and/or overly directive; he or she has an authoritarian rather than an authoritative IPS. When dealing with offenders with a hostile IPS, therapists may benefit from seeking an understanding of the function of the offenders' hostility and its developmental origins. It is the offenders' past relational experiences that likely lead to current interpersonal difficulties, with offenders' early life experiences affecting how they view current relationships. Hostility will likely stem from relational schemas (expectations regarding relational interactions, including cognitions, emotions, and strategies/procedures for negotiating relationships; Safran et al., 2000). Therefore, if therapists can understand the nature of offenders' maladaptive relational patterns, they may be able to understand the function the hostility serves for offenders and its developmental origins, and seek to address the problematic (albeit seemingly acceptable and familiar) interpersonal behavior collaboratively, rather than simply reacting to hostility with hostility or control. Naturally, when therapists and other offender clients are unsafe, controlling tactics are required, but if there is no imminent risk of harm, therapists should work collaboratively and directly with hostility and offender control, and attempt to exercise other, more functional interpersonal behaviors.

Hostility, Dominance, and the TA

The third aim of this study was to determine whether offender hostility or dominance affected their own assessment of the TA. It is important to note that client-rated TA has been shown to have a greater relationship with therapy outcome (Horvath, 2000). It was hypothesized that offenders who were higher in hostility and dominance would have worse ratings of the TA; this hypothesis received partial support. Offender *Hostility* was associated with the TA as perceived by offenders, whereas *Dominance* was not. The first finding is consistent with research that has shown higher levels of offender hostility is related to reduced participation in treatment and rapport with therapists (Holdsworth et al., 2014). Conversely, the finding that dominance was not associated with the TA is somewhat dissimilar to the findings reported by Edens (2009). In Edens (2009), sex offenders who had higher levels of dominance showed greater non-compliance of treatment, as rated by staff. That study used an offender reported measure of dominance and looked at aspects of attendance, assignment completion, and within group behavior as their outcome. This study may also have had an overlap of participants who were dominant, but also hostile, whereas the current study included only those who were perceived as dominant or hostile, not an overlap of both hostile-dominance. Based on the current findings, therapists perceiving hostility in sex offenders within their group program should be aware that this may be associated with offenders having a more negative view of the TA. However, this may not be the case with those who are displaying dominant, yet friendly, behaviors. These findings suggest that within the sex offender population, hostile IPS rather than dominance is more important to TA, with dominant presentations in this population less likely to affect the development of the TA. With hostile sex offenders it is particularly important for therapists to be flexible in their interpersonal approaches and

to maintain awareness of their own interpersonal behaviors (Marshall et al., 2003). Ideally a warm, empathic approach is recommended, with flexibility to move from directive (but non-confrontational) to non-directive (using open-ended questions) interactions (Marshall et al., 2003).

Complementarity and the TA

The fourth aim was to determine whether complementarity in IPS was related to TA. Therapists' and offenders' complementarity for *Control* was lower than complementarity for *Control* in the normative data, reported by Kiesler and Schmidt (2006). This suggested that the degree of match or complementarity between offenders and therapists was less than that observed in a non-forensic setting; this may be because forensic therapists are reluctant to relinquish control for fear of collusion or manipulation, whereas non-forensic practitioners may be more comfortable negotiating issues of control. It was hypothesized that greater complementarity between therapists and offenders would be positively related to TA. This hypothesis was not supported; *Complementarity* in IPS was unrelated to the *Goal, Task, Bond*, or overall TA. These results suggest that interpersonal complementarity between sex offenders and therapists within a group program does not affect TA. This finding is inconsistent with previous findings by Dryer and Horowitz (1997; regarding satisfaction of interactions) and Kiesler and Watkins (1989), however both these studies were with non-forensic populations. The current finding is consistent with findings from an adolescent substance abuse program (Auerbach et al., 2008), where complementarity was also unrelated to TA. It may therefore be that offender clients who have high levels of dominance are more familiar with non-complementary interactions (having their dominant actions met by dominant reactions, particularly from authority figures). In addition, given the mandated forensic population, offenders may have also been more inclined to be overly compliant or to endorse responses consistent with positive impression management. Finally, it is possible that therapists' and client offenders' IPS characteristics have greater impact on TA than complementarity.

An increase in *Control* non-complementarity was related to a greater difference in the ratings of the TA *Bond* by offenders and therapists, but not with the ratings of *Goal* and *Task*. Although it is not uncommon to have a discrepancy in perceptions of the TA (Tichenor & Hill, 1989), the current sample had no statistically significant difference in perceptions of the TA *Bond*. Potentially, an increase in difference in bond rating could be due to a lack of reciprocation on the *Control* axis. If one interactant responded to a dominant approach with dominance, or a submissive approach with submission, this may influence one of the parties to rate the bond lower. Therefore, responding to a dominant action with an attempt to control or challenge may, although necessary, be problematic with regard to TA, and effort will be required to acknowledge the underlying reasons for the rupture in the alliance and attempts will need to be made to repair the relationship. Alternatively, these results imply that therapists may be able to use a non-directive approach with those with a dominant IPS, with use of reflection and open-ended questions, to preserve the TA bond.

Limitations/Future Research

There are several limitations which should be considered when interpreting the results presented here. The first limitation was the measurement of the TA and IPS at Week 3 of the treatment program. Although this is when TA is commonly measured, in a group setting, the TA may not have been fully developed at this point in time. Further to this, the context of a group program, with the presence of other group members and two therapists, may have influenced perceptions of the TA. This may make the findings difficult to apply to one-therapist relationships due to the coexisting, and potentially overlapping, therapeutic relationships. Furthermore, the use of data from one of the two therapists may have affected the findings due to reducing the variability within the data; however, our use of random allocation as Therapist 1 or 2 will help ameliorate such differences. Another limitation was that social desirability was not assessed; it may also be that offenders in this population are inclined to be overly compliant or use impression management, thus potentially affecting the accuracy of the findings. However, it is noted that the WAI is a commonly used tool in offender research. Another limitation was the small sample size; although smaller sample sizes are not uncommon in forensic settings, this may have affected statistical power and therefore, our ability to detect significant findings; generalizability is also affected. Furthermore, some of the data were incomplete due to non-responses by therapists and by offenders within the Community Corrections setting. Although specific reasons for non-completion were not gathered, this may potentially be associated with participants' IPS and TA.

Future research could expand the current findings by exploring the link between sex offenders' IPS and treatment outcomes (completion and treatment gain), as well as their impact on recidivism. The current study used a short-form version of the WAI; future research might incorporate the full version to increase validity and further explore TA. The TA has been found to change over the course of treatment (Horvath & Symonds, 1991), therefore looking at whether IPS impacts on the TA changes over time may also be informative for treatment providers. People with different interpersonal presentations may also respond differently to any ruptures in the TA, or reduce their ability to repair the relationship. It may be at this stage that complementarity can be beneficial; however, this proposition would require further empirical investigation.

Conclusion

The current study explored the impact of IPS on the TA between therapists and offenders in a sex offender treatment program. The results expand our current understanding of the TA to incorporate interpersonal characteristics of those involved in the working relationship. Offenders viewed the TA more positively than therapists on all aspects except *Bond*. In addition, when therapists or offenders assessed the other as more *Affiliative*, then they also viewed the TA more positively, whereas viewing the other as being more *Controlling* had a negative impact on how that interactant (therapists or offenders) perceived the TA. This suggests that the perception of the interpersonal behaviors of others is important, and that friendliness/affiliation is conducive to a

more positive TA; interpersonal dominance worsens perceptions of the therapeutic relationship. Complementarity in IPS was not found to affect the TA, which suggests that choosing therapists to match offenders' IPS in an attempt to increase complementarity is unnecessary. It was further found that offender hostility was associated with a more negative perception of the TA.

Therapists should keep in mind that a dominant/overly directive approach may create compliance but potentially impair the TA. Therapists should aim to lessen engagement in offenders' dysfunctional interpersonal patterns, to be aware of their own hostile and dominant behaviors, and to be flexible in their responses to offenders; making sarcastic, critical or hostile comments; or having a hostile tone or body language in response to offenders' hostility will negatively affect the TA. Rather, warmth, empathy, using a reflective style with verbal encouragements and having the capacity and preparedness to shift from a non-directive (using open-ended questions) to a directive approach (but non-confrontational) is important for building and maintaining beneficial therapeutic relationships. This approach may be easier to maintain if therapists can understand the underlying function of offenders' behaviors and to recognize that dysfunctional interpersonal patterns stem from earlier adverse life experiences.

Due to the higher prevalence of difficult interpersonal functioning in forensic populations, support and supervision for therapists who are working with hostile and domineering sexual offenders is critical. Supervision and support may help minimize frustration and hostile responses, while maximizing opportunities for working effectively with this challenging offender population. It is recommended that in addition to gaining knowledge and skills concerning program content and facilitation, a higher focus needs to be placed on training therapists to deal with responsivity factors, such as offender dominance and hostility, and managing ruptures which occur in the therapeutic relationship as a consequence of problems within the relationship.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Ashby, J. D., Ford, D. H., Guernsey, B. G., & Guernsey, L. F. (1957). Effects on clients of a reflective and leading type of psychotherapy. *Psychological Monographs*, *71*, 1-32. doi:10.1037/h0093778
- Auerbach, S. M., May, J. C., Stevens, M., & Kiesler, D. J. (2008). The interactive role of working alliance and counselor-client interpersonal behaviors in adolescent substance abuse

- treatment. *International Journal of Clinical and Health Psychology*, 8, 617-629. Retrieved from <http://www.redalyc.org/pdf/337/33712016001.pdf>
- Australian Institute of Criminology (2011). Prison-based correctional rehabilitation: An overview of intensive interventions for moderate to high-risk offenders. *Trends & Issues in Crime and Criminal Justice*, 412, 1-6. Retrieved from http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi412.pdf
- Beech, A., & Fordham, A. S. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment*, 9, 219-237. doi:10.1177/107906329700900306
- Belding, M. A., Iguchi, M. Y., Morral, A. R., & McLellan, A. T. (1997). Assessing the helping alliance and its impact in the treatment of opiate dependence. *Drug and Alcohol Dependence*, 48, 51-59. Retrieved from [http://dx.doi.org/10.1016/S0376-8716\(97\)00103-8](http://dx.doi.org/10.1016/S0376-8716(97)00103-8)
- Blackburn, R. (1998). Relationship of personality disorders to observer ratings of interpersonal style in forensic psychiatric patients. *Journal of Personality Disorders*, 12, 77-85. doi:10.1521/pedi.1998.12.1.77
- Blackburn, R., & Renwick, S. J. (1996). Rating scales for measuring the interpersonal circle in forensic psychiatric patients. *Psychological Assessment*, 8, 76-84. doi:10.1037/1040-3590.8.1.76
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, 16, 252-260. doi:10.1037/h0085885
- Caspar, F., Grossmann, C., Unmüssig, C., & Schramm, E. (2005). Complementary therapeutic relationship: Therapist behavior, interpersonal patterns and therapeutic effects. *Psychotherapy Research*, 15, 91-102. doi:10.1080/10503300512331327074
- Cookson, A., Daffern, M., & Foley, F. (2012). The relationship between aggression, interpersonal style and therapeutic alliance during short-term psychiatric hospitalization. *International Journal of Mental Health Nursing*, 21, 20-29. doi:10.1111/j.1447-0349.2011.00764.x
- Daffern, M., Duggan, C., Huband, N., & Thomas, S. (2010). Staff and patient's perceptions of each other's interpersonal style: Relationship with severity of personality disorder. *International Journal of Offender Therapy and Comparative Criminology*, 54, 611-624. doi:10.1177/0306624X09335111
- Daffern, M., Thomas, S., Ferguson, M., Podubinski, P., Hollander, Y., Kulkarni, J., . . . Foley, F. (2010). The impact of psychiatric symptoms, interpersonal style and coercion on aggression during psychiatric hospitalization. *Psychiatry and Biological Processes*, 73, 365-382. Retrieved from <http://dx.doi.org/10.1521/psyc.2010.73.4.365>
- Daffern, M., Tonkin, M., Howells, K., Krishnan, G., Ijomah, G., & Milton, J. (2010). The impact of interpersonal style and perceived coercion on aggression and self-harm in personality-disordered patients admitted to a secure psychiatric hospital. *Journal of Forensic Psychiatry & Psychology*, 21, 426-445. doi:10.1080/14789940903505951
- Derks, F. C. H. (1996). A forensic day treatment program for personality disordered criminal offenders. *International Journal of Offender Therapy and Comparative Criminology*, 40, 123-134. doi:10.1177/0306624X96402005
- Drapeau, M. (2005). Research on the processes involved in treating sexual offenders. *Sexual Abuse: Journal of Research and Treatment*, 17, 117-125. doi:10.1177/107906320501700203
- Dryer, D., & Horowitz, L. M. (1997). When do opposites attract? Interpersonal complementarity versus similarity. *Journal of Personality and Social Psychology*, 72, 592-603. doi:10.1037/0022-3514.72.3.592
- Edens, J. F. (2009). Interpersonal characteristics of male criminal offenders: Personality, psychopathological, and behavioral correlates. *Psychological Assessment*, 21, 89-98. doi:10.1037/a0014856

- Frost, A., & Connolly, M. (2004). Reflexivity, reflection, and the change process in offender work. *Sexual Abuse: Journal of Research and Treatment, 16*, 365-380. doi:10.1177/107906320401600408
- Hardy, G. E., Cahill, J., Shapiro, D. A., Barkham, M., Rees, A., & Macaskill, N. (2001). Client interpersonal and cognitive styles as predictors of response to time-limited cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 69*, 841-845. doi:10.1037/0022-006X.69.5.841
- Hatcher, R. L., Barends, A. W., Hansell, J., & Gutfreund, M. J. (1995). Patients' and therapists' shared and unique views of the therapeutic alliance: An investigation using confirmatory factor analysis in a nested design. *Journal of Consulting and Clinical Psychology, 63*, 636-643. doi:10.1037/0022-006X.63.4.636
- Holdsworth, E., Bowen, E., Brown, S., & Howat, D. (2014). Offender engagement in group programs and associations with offender characteristics and treatment factors: A review. *Aggression and Violent Behavior, 19*, 102-121. doi:10.1016/j.avb.2014.01.004
- Horowitz, L. M., Wilson, K. R., Turan, B., Zolotsev, P., Constantino, M. J., & Henderson, L. (2006). How interpersonal motives clarify the meaning of interpersonal behavior: A revised circumplex model. *Personality and Social Psychology Review, 10*, 67-86. doi:10.1207/s15327957pspr1001_4
- Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. *Journal of Clinical Psychology, 56*, 163-173. doi:10.1002/(SICI)1097-4679(200002)56:2<163::AID-JCLP3>3.0.CO;2-D
- Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149. doi:10.3389/fpsyg.2011.00270
- Johansen, R., Melle, I., Iversen, V. C., & Hestad, K. (2013). Personality traits, interpersonal problems and therapeutic alliance in early schizophrenia spectrum disorders. *Comprehensive Psychiatry, 54*, 1169-1176. doi:10.1016/j.comppsy.2013.05.016
- Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research, 7*, 35-51. doi:10.1007/s11020-005-1964-4
- Kiesler, D. J. (1987). *Manual for the impact message inventory*. Palo Alto, CA: Consulting Psychologists Press, Inc.
- Kiesler, D. J., & Auerbach, S. M. (2003). Integrating measurement of control and affiliation in studies of physician-patient interaction: The interpersonal circumplex. *Social Science and Medicine, 57*, 1707-1722. doi:10.1016/S0277-9536(02)00558-0
- Kiesler, D. J., & Schmidt, J. A. (2006). *The Impact Message Inventory-Circumplex (IMI-C) manual: Sampler set, manual, test booklet, scoring key, work sheets*. Menlo Park, CA: Mind Garden.
- Kiesler, D. J., & Watkins, L. M. (1989). Interpersonal complementarity and the therapeutic alliance: A study of the relationship in psychotherapy. *Psychotherapy, 26*, 183-194. doi:10.1037/h0085418
- Kozar, C. J., & Day, A. (2012). The therapeutic alliance in offending behavior programs: A necessary and sufficient condition for change? *Aggression and Violent Behavior, 17*, 482-487. doi:10.1016/j.avb.2012.07.004
- Leary, T. (1957). *Interpersonal diagnosis of personality*. New York, NY: Ronald Press.
- Levenson, J. S., Macgowan, M. J., Morin, J. W., & Cotter, L. P. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: Journal of Research and Treatment, 21*, 35-56. doi:10.1177/1079063208326072

- Lillie, R. (2007). Getting clients to hear: Applying principles and techniques of Kiesler's Interpersonal Communication Therapy to assessment feedback. *Psychology and Psychotherapy: Theory, Research and Practice, 80*, 151-163. doi:10.1348/147608306X115198
- Marshall, W. L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment, 17*, 109-116. doi:10.1177/107906320501700202
- Marshall, W. L., & Burton, D. L. (2010). The importance of group processes in offender treatment. *Aggression and Violent Behavior, 15*, 141-149. doi:10.1016/j.avb.2009.08.008
- Marshall, W. L., Serran, G., Fernandez, Y. M., Mulloy, R., Mann, R., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression, 9*, 25-30. doi:10.1080/355260031000137940
- Marshall, W. L., Serran, G., Moulden, H., Mulloy, R., Fernandez, Y. M., Mann, R., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clinical Psychology and Psychotherapy, 9*, 395-405. doi:10.1002/cpp.335
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450. doi:10.1037/0022-006X.68.3.438
- McCarthy, L., & Duggan, C. (2010). Engagement in a medium secure personality disorder service: A comparative study of psychological functioning and offending outcomes. *Criminal Behaviour and Mental Health, 20*, 112-128. doi:10.1002/cbm.758
- McMurrin, M., Huband, N., & Duggan, C. (2008). A comparison of treatment completers and non-completers of an in-patient treatment programme for male personality-disordered offenders. *Psychology and Psychotherapy: Theory, Research and Practice, 81*, 193-198. doi:10.1348/147608308X288762
- Meier, P. S., & Donmall, M. C. (2006). Differences in client and therapist views of the working alliance in drug treatment. *Journal of Substance Use, 11*, 73-80. doi:10.1080/14659890500137004
- Morgan, R., Luborsky, L., Crits-Christoph, P., Curtis, H., & Solomon, J. (1982). Predicting outcomes of psychotherapy by the Penn Helping Alliance Rating Method. *Archives of General Psychiatry, 39*, 397-402. doi:10.1001/archpsyc.1982.04290040013002
- Olver, M. E., Stockdale, K. C., & Wormith, J. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology, 79*, 6-21. doi:10.1037/a0022200
- Ross, E. C., Polascheck, D. L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior, 13*, 462-480. doi:10.1016/j.avb.2008.07.003
- Schmidt, J. A., Wagner, C. C., & Kiesler, D. J. (1999). Psychometric and circumplex properties of the octant scale Impact Message Inventory (IMI-C): A structural evaluation. *Journal of Counseling Psychology, 46*, 325-334. doi:10.1037/0022-0167.46.3.325
- Serran, G., Fernandez, Y., Marshall, W., & Mann, R. (2003). Process issues in treatment: Application to sexual offender programs. *Professional Psychology: Research and Practice, 34*, 368-374. doi:10.1037/0735-7028.34.4.368
- Tichenor, V., & Hill, C. (1989). A comparison of six measures of working alliance. *Psychotherapy, 26*, 195-199. doi:10.1037/h0085419
- Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1*, 207-210. doi:10.1037/1040-3590.1.3.207

Chapter 5: Interpersonal Style and Ruptures in the Therapeutic Alliance

The Impact of Interpersonal Style on Ruptures and Repairs in the Therapeutic Alliance Between Offenders and Therapists in Sex Offender Treatment

Preamble for Chapter 5. The literature review presented in Chapter 1 of the thesis outlined the impact of ruptures in the therapeutic relationship on client engagement and treatment outcome. It was argued that repairing ruptures could lead to strengthened therapeutic alliance and improved outcomes for clients. It was noted that there is little research exploring ruptures in the sexual offender treatment research. Ruptures may determine whether offenders can maintain strong collaborative relationship with their therapists. Additionally, it is unknown what role offender interpersonal style plays on the stability and strength of the therapeutic alliance and the likelihood of a rupture.

Chapter 5 consists of the second empirical study of the thesis. Study Two aimed to examine the ruptures in the therapeutic relationship between sexual offenders and their therapists, and to determine how these ruptures impacted the course of the therapeutic alliance over the duration of the treatment programme. In addition, Study Two aimed to explore whether sexual offender interpersonal style impacted the likelihood of ruptures in the therapeutic relationship, the strength of the rupture and whether the ruptures were repaired.

The following manuscript was accepted for publication with *Sexual Abuse: A Journal of Research and Treatment* on 02 September 2015.

Watson, R., Thomas, S., & Daffern, M. (2015). The impact of interpersonal style on ruptures and repairs in the therapeutic alliance between offenders and therapists in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment*, accepted for publication. Impact factor: 2.113; 5 year impact factor: 1.85; Ranking: Criminology and Penology 9 out of 55; Psychology, Clinical 40 out of 119.

Declaration for Chapter 5

Declaration by Candidate

In the case of Chapter 5, the nature and extent of my contribution to the work was the following:

| Nature of contribution | Extent of contribution (%) |
|---|----------------------------|
| Generation of ideas, data collection and analysis, and write up | 80% |

The following co-authors contributed to the work. If co-authors are students at Monash University, the extent of their contribution in percentage terms must be stated:

| | Nature of contribution | Extent of contribution (%) for student co-authors only |
|----------------------------------|---------------------------------|---|
| Professor Michael Daffern | Critical revision of manuscript | N/A |
| Professor Stuart Thomas | Critical revision of manuscript | N/A |

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate and co-authors' contributions to this work.

| Candidate | | Date |
|----------------|------------|------------|
| Rachael Watson | [REDACTED] | 10/04/2016 |

| Main Supervisor | | Date |
|---------------------------|------------|------------|
| Professor Michael Daffern | [REDACTED] | 10/04/2016 |

The Impact of Interpersonal Style on Ruptures and Repairs in the Therapeutic Alliance Between Offenders and Therapists in Sex Offender Treatment

Rachael Watson¹, Stuart Thomas⁴, Michael Daffern^{2,3}

¹Monash University, Melbourne, Australia

²Centre for Forensic Behavioural Science, Swinburne University of Technology, Melbourne, Australia, ³Victorian Institute of Forensic Mental Health, Melbourne, Australia,

⁴University of Wollongong, Sydney, Australia

Corresponding Author:

Rachael Watson

Centre for Forensic Behavioural Science

Swinburne University of Technology

Melbourne

Australia

Abstract

The therapeutic relationship is a critical component of psychological treatment. Strain can occur in the relationship, particularly when working with offenders, and more specifically, those offenders with interpersonal difficulties; strain can lead to a rupture, which may impact treatment participation and performance. This study examined ruptures in the therapeutic relationship in sexual offenders participating in offence-focused group treatment. Fifty-four sex offenders rated the therapeutic alliance at the commencement and completion of treatment; at the completion of treatment they also reported on the occurrence of ruptures and whether they believed these ruptures were repaired. Ruptures were separated by type, according to severity—each relationship was therefore characterized as experiencing no rupture, a minor rupture, or a major rupture. Offender characteristics including; interpersonal style (IPS) and psychopathy, were assessed at the commencement of treatment; their relationship with ruptures was examined. Results revealed that over half of the offenders (approximately 55%) experienced a rupture in the therapeutic alliance, with one in four of these ruptures remaining unresolved. Offenders who did not report a rupture rated the therapeutic alliance significantly higher at the end of treatment compared to those offenders who reported a rupture that was not repaired. Offenders who reported a major rupture in the therapeutic relationship were higher in interpersonal hostility and hostile-dominance. No interpersonal or offence-specific factors impacted the likelihood of a rupture repair.

Keywords

Therapeutic alliance, interpersonal style, sex offender, rupture, treatment process

Treatment process variables, including the therapeutic relationship, account for around 25% of variance in outcomes in non-offender populations (Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). Although this appears to play a significant role in treatment outcomes, the impact of these treatment process variables in sexual offender treatment has received little empirical attention. A key purpose of the therapeutic relationship is to facilitate change by enhancing engagement and collaboration, and by creating a safe environment (Hill & Corbett, 1993). For sexual offenders, a safe therapeutic environment allows the therapist to engage and challenge the offender's crime minimization and denial, without being confrontational (Serran, Fernandez, Marshall, & Mann, 2003). The therapeutic relationship is a dynamic one that is influenced by each interactants' personality, interpersonal behavior and expectations (Ross, Polaschek, & Ward, 2008). Strain and conflict can occur within the relationship, which can lead to a relationship breakdown or rupture (Safran & Kraus, 2014). Although there is little research on the prevalence and impact of ruptures within the sex offender field, Safran and Kraus (2014) suggest that ruptures should be addressed to limit negative impacts, including withdrawal or non-attendance. Research in non-forensic settings suggests that when ruptures are recognized and repaired the therapeutic alliance may be strengthened (Safran & Kraus, 2014). The impact of ruptures and their repair on the therapeutic relationships offenders share with therapists has not been studied. This is the focus of this study.

Therapeutic Ruptures

Therapeutic alliance describes the collaborative relationship between client and therapist; it incorporates the relational bond and agreement on therapeutic tasks and goals (Bordin, 1979; Martin, Garske, & Davis, 2000). A positive therapeutic alliance has been associated with better therapeutic outcomes in non-offender (Martin,

Garske, & Davis, 2000) as well as offender populations (Frost & Connolly, 2004; Holdsworth, Bowen, Brown, & Howat, 2014). A review of therapeutic alliance literature has found a moderate and consistent relationship between the therapeutic alliance and therapeutic outcomes, with an effect size of .275 (Flückiger et al., 2012; Horvath, Del R, Flückiger, & Symonds, 2011; Martin et al., 2000). The therapeutic alliance has been found to have the same impact on outcomes for standardized, evidence-based therapies, such as CBT, as relational, non-standardized therapies (Flückiger et al., 2012). With sexual offenders, both therapist characteristics (e.g., warmth, flexibility, non-confrontational but directive) and offender characteristics (e.g., hostility) impact the therapeutic alliance (Marshall et al., 2002; Marshall et al., 2003). A weaker bond between sexual offenders and their therapists is related to increased sexual recidivism (Blasko & Jeglic, 2014). However, sexual offenders who have a positive perception of group leaders are more likely to be engaged in treatment (Levenson, Macgowan, Morin, & Cotter, 2009).

A rupture is the breakdown of the therapeutic bond, or a disagreement on tasks and goals (Safran, Muran, & Rothman, 2006). When a rupture is unresolved the therapeutic alliance can break down, potentially leading to treatment non-completion (Sharf, Primavera, & Diener, 2010), poorer treatment outcomes (Martin, Garske, & Davis, 2000; Holdsworth et al., 2014) and, in the case of offenders, a potential increase in treatment non-completion and recidivism (Hanson & Bussiere, 1998; McMurrin & Theodosi, 2007; Olver et al., 2011). Safran and Kraus (2014) note that therapists and clients can both contribute to ruptures, however the nature of this interaction and the level of contribution varies.

Ruptures sometimes occur when a client's dysfunctional interpersonal behavior is triggered by therapist behavior or therapeutic tasks (Safran, Crocker, McMain, &

Murray, 1990; Safran & Kraus, 2014). With child sexual offenders, it has been found that offenders occasionally compare therapists to parental figures (Drapeau, 2005), therefore, childhood interpersonal patterns may be played out within the therapeutic relationship. Therapists can often find themselves drawn into their client's dysfunctional relational pattern, awareness of this process can help the therapist to reflect this back to the client, and also to accept responsibility for their contribution to the rupture (Safran, Muran, & Rothman, 2006). When looking at clients' needs within the therapeutic alliance, Newman (1998) noted a number of rupture-related issues: clients feeling pressured to complete a task before they are ready, feeling overwhelmed by the activity of the therapist, being in competition with the therapist for control, seeing the therapist as patronizing, or reacting to anticipated abandonment. Furthermore, clients who value status and respect may perceive therapists as disrespectful when they take a dominant or directive stance (Holtforth & Castonguay, 2005). An overly directive therapist might also be perceived as patronizing by clients who value status or autonomy (Holtforth & Castonguay, 2005). Fears of failure and criticism might also contribute to ruptures (Holtforth & Castonguay, 2005).

Child sexual offenders may have interpersonal preferences related to autonomy (wanting to be competent and achieving) and control (wanting to avoid being dominated by others); therefore, a therapist who is overly controlling may experience resistance from clients (Drapeau, 2005). In particular, a confrontational reaction by therapists to sexual offenders' denial and minimization (Serran, Fernandez, Marshall, & Mann, 2003) may increase the likelihood of a rupture. Furthermore, sexual offenders may react with withdrawal or confrontation when challenged to disclose and discuss issues they may not feel ready to address. For a rupture to be repaired,

clients need to be able to declare their feelings and reactions, with the therapist being able to facilitate a repair by flexibly adjusting to the clients' needs and showing acceptance of the clients' experiences (Rhodes, Hill, Thompson, & Elliott, 1994). By addressing a rupture in the therapeutic alliance the client is able to gain insight into maladaptive personality patterns and to challenge them with help from the therapist. This can also help the client find adaptive ways to manage subsequent relationship strains (Critchfield & Benjamin, 2006).

Interpersonal Style and Offenders

Internal offender responsivity factors are characteristics of the offender that may impact engagement in and benefit from treatment (Andrews et al., 1990). They are important for determining who is likely to benefit from treatment for general, sexual and violent offenders (Olver, Beggs-Christofferson, Grace, & Wong, 2014). Individual responsivity factors may also help determine who is likely to experience a rupture. This proposition has however, yet to be explored.

Given that ruptures are often related to clients' dysfunctional interpersonal behaviors, the characteristic interpersonal style (IPS) of clients and therapists is a responsivity factor that is reasonably implicated in the breakdown of the therapeutic alliance. IPS is commonly conceptualized through a circumplex (Kiesler, 1987) with two axes, power/control (ranging from dominance to submission) and affiliation (ranging from hostility to friendliness/warmth; Blackburn & Renwick, 1996). IPS describes a consistent pattern of interpersonal behaviors, designed to pull or evoke an interpersonal behavior from another person (Kiesler, Schmidt, & Wagner, 1997; Lillie, 2007). Although ruptures have not been empirically examined in research with forensic populations, Tufekcioglu, Muran, Safran, and Winston (2013) noted that ruptures are likely to occur when dysfunctional behaviors, such as hostility,

dominance, impulsivity and emotional dysregulation elicit responses from the therapist, which confirms the clients' dysfunctional belief about the nature of interpersonal interactions.

Interpersonal difficulties are common within offender populations, with offenders having higher levels of hostility, self-centeredness, callousness, and self-defeating behaviors than non-offenders (Ross et al., 2008). Those offenders with hostile and dominant interpersonal behaviors are also likely to have difficulty establishing a good therapeutic alliance (Edens, 2009; Holdsworth et al., 2014); a hostile dominant interpersonal style is also associated with a poorer therapeutic relationship and aggression towards treatment providers in mental health units (Cookson, Daffern, & Foley, 2012; Daffern, Duggan, Huband, & Thomas, 2010; Daffern et al., 2010a, Daffern et al., 2010b).

Hostile interpersonal behaviors are also associated with an increased likelihood of program attrition and reduced participation in treatment (Holdsworth et al., 2014). Client hostility has been associated with difficulties within the therapeutic relationship, including the expression of rage by clients because of dislike for therapist action/inaction and negative therapist reactions (feelings of anxiety, incompetence, annoyance or frustration; Hill et al., 2003). Client hostility and defensiveness have also been shown to impede resolution of relational difficulties (Hill & Knox, 2009). Clients with a strong and inflexible need for dominance will likely experience difficulties within the therapeutic alliance when a therapist also seeks to dictate therapeutic activities (Baillargeon, Coté, & Douville, 2012); this can lead to an escalating battle for control, or client withdrawal from the therapeutic relationship. Although there is little related research with sexual offenders, the level of hostility of offenders (as perceived by their therapists) appears to have a greater

impact on the offenders' rating of therapeutic alliance than the offenders' need for interpersonal dominance (Watson, Daffern, & Thomas, 2015). In this study offenders rated the therapeutic alliance less favorably when they perceived the therapist was hostile or dominant; furthermore, if therapists rated offenders as being high in hostility or dominance their own ratings of the therapeutic alliance was also reduced.

The interpersonal and affective qualities of psychopathy, including glibness/superficiality, grandiosity, manipulation and shallowness of emotions (Hare, 2003) are also thought to make therapeutic relationships difficult to develop. Research has found that approximately one in four prisoners can be classified as psychopathic (Hare, 1991; Shine & Hobson, 1997), however, some variation has been noted (Cooke, 1997). Psychopathic traits have been found to be a strong negative predictor of the therapeutic alliance (Taft, Murphy, Musser, & Remington, 2004; McCarthy & Duggan, 2010). A higher level of psychopathy, particularly the affective traits of psychopathy, is related to higher rates of treatment attrition for sexual offenders (Olver & Wong, 2011).

Current Study

There is currently no known empirical research on ruptures and repairs in the offender rehabilitation literature. This is a crucial area of research since ruptures likely impact the therapeutic alliance, treatment dropout (Martin, Gaske, & Davis, 2000; Holdsworth et al., 2014) and potentially recidivism (McMurrin & Theodosi, 2007; Olver et al., 2011). Against this background, this study explored five aims; for experimental aims the corresponding hypotheses are listed:

1. to describe the occurrence of ruptures in a sexual offender sample in treatment;
2. to assess changes in offender-rated therapeutic alliance from commencement to end of treatment;

3. to determine whether change in therapeutic alliance over time differs for those who do not experience a rupture, compared to those who experience a rupture that is repaired, and those who experience a rupture that is not repaired;
 - a. it was hypothesized that offenders who experienced a rupture that was not repaired would rate the therapeutic alliance at the end of treatment as poorer compared to offenders who did not experience a rupture in the therapeutic alliance.
 - b. it was further hypothesized that those offenders who experienced a rupture that was repaired would rate the therapeutic alliance more strongly at the end of treatment than those offenders who reported a rupture that was not repaired.
4. to determine whether interpersonal hostility, hostile-dominance, and psychopathy impact ratings of end-of-treatment therapeutic alliance for those offenders who reported no rupture, a minor rupture or a major rupture;
 - a. it was hypothesized that offenders who reported a major rupture would have higher ratings of psychopathy, hostility and dominance than those who reported no rupture and a minor rupture
5. to determine whether interpersonal or offence-specific factors affect the likelihood of a rupture being repaired.

Method

Participants

The source sample comprised 75 male adult sex offenders; 60 were recruited from Marngoneet Correctional Centre, a medium security correctional facility, and 15 from Community Corrections (on community order or parole). The Sex Offender Program is run by the Victorian Department of Justice. Participants in the Sex

Offender Program were assessed as being Moderate-Low to High risk of sexual reoffending (Department of Justice, 2012) based on STATIC-99 assessment. The Community Based Sex Offender Program involves one three-hour session once per week and the Prison Based Sex Offender Program involves two weekly three-hour sessions. Total program hours range from 72 – 150 hours, lasting between three to eight months, depending on the offenders' levels of risk and their treatment needs.

Participants were aged between 21 and 73 years ($M= 44.97$, $SD= 15.15$) with the average age of first conviction for sexual offence being 30.45 years ($SD= 13.49$, range = 14 to 70 years). Forty-nine offenders were also convicted of at least one other offence, with the average age of first general non-sexual (violent or non-violent) offence being 22.39 years ($SD= 10.12$, range = 11 to 53 years). Twenty-seven (36%) participants had no prior sexual offences, 28 (37.3%) had one prior sex offence, and 19 (25.4%) had two or more prior sex offences, with one participant missing data (1.3%). Twelve (16%) offenders perpetrated sexual offences against adult victim(s), 42 (56%) perpetrated against child victim(s), and 20 (26.7%) offenders perpetrated against both adult and child victims, with 1 participant missing data (1.3%). Five (8.7%) participants reached the diagnostic cut-off for psychopathy on the PCL-SV ($M= 18.40$, $SD= .89$).

Of the 75 participants in the source sample, 54 completed all aspects of the study, 21 did not complete assessments of therapeutic alliance and ruptures/repairs towards the end of treatment (for full details of procedure see below). Attrition occurred within the community sample due to non-return of questionnaires (not posted back to the researcher) and within both settings due to non-completion of the program. In total, 67 offenders completed the treatment program, with five non-completers and three still ongoing at the time of the study. Reasons for non-

completion, as coded from official files, were: 1) mental health issues (active symptoms of psychosis), 2) offenders withdrawing after hostile and aggressive behavior towards therapists, and 3) re-offence whilst undertaking the program. In addition to the eight non-completers, 13 offenders did not return second stage questionnaires to the researcher. There was no significant difference in IPS, therapeutic alliance or Static-99 scores between those who did ($n = 54$) and did not ($n = 21$) complete all parts of the study. Level of offender risk, based on Static-99 category, was not associated with rupture ($p = .97$) and therefore was not included in further analyses.

Measures

The Impact Message Inventory (Schmidt, Wagner, & Kiesler, 1999). The IMI-C is a 56-item inventory that examines covert emotional experiences elicited from interpersonal behaviors or interactions (Kiesler & Auerbach, 2003). The IMI-C is designed to measure the emotional experiences elicited within dyadic interactions (Kiesler & Auerbach, 2003). The IMI-C consists of an octant scale (based on the traditional interpersonal circle format), and comprises seven items per subscale: *Dominant* (e.g., “when I am with this person he makes me feel taken charge of”), *Hostile-Dominant* (e.g., “when I am with this person he makes me feel that I should tell him he’s often quite inconsiderate”), *Hostile* (e.g., “when I am with this person he makes me feel distant from him”), *Hostile-Submissive* (e.g., “when I am with this person it appears to me that he’s nervous around me”), *Submissive* (e.g., “when I am with this person it appears to me that he thinks I have most of the answers”), *Friendly-Submissive* (e.g., “when I am with this person it appears to me that he would accept whatever I said”), *Friendly* (e.g., “when I am with this person he makes me feel that I can ask him to carry his share of the load”), and *Friendly-Dominant* (e.g.,

“when I am with this person it appears to me that he enjoys being with people”). Each octant scale has a 4-point rating scale ranging from *not at all* to *very much so*. The IMI-C has a Cronbach’s alpha ranging from .69 to .89 across the eight subscales (Schmidt, Wagner, & Kiesler, 1999).

The Working Alliance Inventory Short-Form (Tracey & Kokotovic, 1989).

The WAI- SF is a self-report measure of therapist-client therapeutic alliance. The short-form version comprises 12 items and can be completed by the client or therapist. The WAI has three subscale scores, comprising four items per subscale: *Bond* (e.g., “I believe [client] likes me”), *Goal* (e.g., “We are working towards mutually agreed upon goals”), and *Task* (e.g., “We agree on what is important for [client] to work on”) measured on a 7-point likert scale (ranging from *never* to *always*). The WAI-SF has a Cronbach’s alpha of .98 (clients’ form) and .95 (therapists’ form), therefore shows good internal consistency (Tracey & Kokotovic, 1989).

The Postsession Questionnaire (Muran, Safran, Samstag, & Winston, 1992).

The PSQ consists of self-report measures of the therapeutic alliance, as well as a self-report measure that asks about the occurrence of ruptures, the intensity of the ruptures and whether the ruptures were resolved, these are measured on a 5-point likert scale. Respondents may also add an open-ended description of the rupture/repair situation, this allows for further understanding of the context of the ruptures and repairs as well as process issues that may have contributed to the ruptures and/or repairs.

The Psychopathy Checklist Screening Version (Hart, Cox, & Hare, 1995).

The PCL is a rating scale design to measure psychopathic traits in forensic populations (Cooke, Michie, Hart, & Hare, 1999). The Psychopathy Checklist Screening Version (PCL-SV) is a screening measure of the Psychopathy Checklist

(PCL), which takes less time to administer and requires less case note information (Cooke et al., 1999). It has a 12-item rating scale, which is taken directly from the PCL; items have been made shorter and have been simplified, although the core meaning of each item is the same (Cooke et al., 1999). Items are rated on a 3-point scale, with scores over 18 being indicative of psychopathy (Cooke et al., 1999).

Procedure

Approval was gained for the study by the Monash University Human Research Ethics Committee (MUHREC) and the Department of Justice Human Research Ethics Committee (JHREC). Sexual offenders participating in sex offender treatment through Corrections Victoria (Corrections Victoria is part of the Department of Justice and is the state of Victoria, Australia's corrections department) and their therapists were invited to participate in the study. The study was not linked to the requirements of the treatment program, and participation was voluntary. Permission was received to begin recruitment/data collection in a medium security prison in Victoria, Australia, and through Victorian Community Corrections services in June 2012.

During the first stage of the study questionnaires (both offender and therapist rated WAI-SF and IMI-C) were administered 3-4 weeks after the commencement of treatment. Participants at Marngoneet Correctional Centre completed the WAI-SF and IMI-C whilst one of the authors, RW, was present, outside of treatment program time. Community participants were given the WAI-SF and IMI-C, with return paid and addressed envelopes, to complete outside of the treatment program time. At this time therapists were given the IMI-C to complete about the participants within their treatment group. There were two therapists per group, with each offender being asked

to complete questionnaires based on their perceptions of therapeutic alliance and IPS on both therapists.

The second stage of the study involved administration of questionnaires (offender rated PSQ, including WAI-SF) at approximately three quarters of the way through treatment (program length varied between three and eight months so for each participant this second phase was determined through consultation with therapists), prior to treatment completion. At this stage participants were given the PSQ and WAI. The PCL-SV was scored and offence-specific details (victim type: adult, child, adult and child; age at start of program; age at first sexual offence) were collated by RW from the clinical file following treatment completion. The PCL-SV was rated on file information pre-dating the start of treatment.

Data Preparation

Missing data were determined to be random, and three cases were discarded due to having more than 10% missing data. Of the remaining cases, 14 had 1.8% missing, and two had 3.6%, in these cases the participant's mean response for the specific subscale was used. Data were consolidated to use only one offender-therapist response in order to keep data independent. First, data was eliminated if there was no offender or therapist response; however if both sets were available, data from 'Therapist 1' was chosen. Therapist 1 and Therapist 2 were allocated randomly for each case. Therapist 1 and Therapist 2 data were correlated, except for therapists' view of the therapeutic alliance *bond* (see Table 1).

The reason for this lack of correlation is unclear. One suggestion is that within a forensic setting therapists may have different views on the importance of the therapeutic alliance *bond*, as some therapists may see this as a means through which they can be manipulated or exploited by offenders (Kozar & Day, 2012). In order to

set up ‘appropriate’ professional boundaries, they may instead focus on therapeutic alliance *tasks* and *goals*. It also may be that the offenders develop a stronger bond with one of the therapists, and a lesser bond with the other therapist. Given that the majority of the therapists’ data was correlated, in order to aid analyses, data was consolidated. It is noted that there is some loss of variance in regards to the therapeutic alliance *bond* due to this process.

Table 1

Correlations of Therapist 1 and Therapist 2 Impact Message Inventory and Working Alliance Inventory –Short Form Ratings

| | <i>Therapist 1</i> |
|--|--------------------|
| <i>Therapist 2</i> | |
| Working Alliance Inventory - Goal | .33* |
| Working Alliance Inventory - Task | .35* |
| Working Alliance Inventory - Bond | .24 |
| Working Alliance Inventory - Total | .33* |
| Impact Message Inventory - Dominant | .76** |
| Impact Message Inventory - Hostile-Dominant | .71** |
| Impact Message Inventory - Hostile | .71** |
| Impact Message Inventory - Hostile-Submissive | .53** |
| Impact Message Inventory - Submissive | .55** |
| Impact Message Inventory - Friendly-Submissive | .87** |
| Impact Message Inventory - Friendly | .72** |
| Impact Message Inventory - Friendly-Dominant | .42** |
| Impact Message Inventory - Control | .62** |
| Impact Message Inventory - Affiliation | .74** |

* p<.05 (2-tailed) ** p<.01 (2-tailed)

Approach to Analysis

A frequency analysis was run to determine frequency and percentage of ruptures in the therapeutic alliance, and frequency and percentage of rupture repairs. The presence of ruptures and repair were rated on a 5-point likert scale, with 1 being not at all and 2 to 5 being different levels of the rupture or repair occurring. The ratings of the strength of the ruptures were analyzed through a frequency analysis and then categorized into ‘no rupture’, ‘minor rupture’ or ‘major rupture’ conditions. There

were no ratings of 5 (constant problem in the therapeutic relationship); therefore 1 was categorized as no rupture, 2 as minor rupture, and 3-4 as a major rupture. The repair scale was converted to binary coding, where 1 was rated as a 0 or 'no repair', and 2-5 was rated as 1 or yes, a 'repair' had occurred. A chi-square test of association was performed to examine the relationship between major and minor rupture conditions and repair or no repair. A repeated-measures ANOVA was conducted to assess differences between offender ratings of the therapeutic alliance (task, goal and bond) at Time 1 (early) and Time 2 (late). A one-way between-groups ANOVA was conducted to assess the difference between independent variables on rupture condition. A mixed-model ANOVA was then conducted to assess the impact of different rupture conditions (no rupture, rupture with repair, rupture with no repair) on offenders' scores on the WAI-SF over the two time periods (Time 1 and Time 2). Individual multivariate logistic regressions were performed to assess the impact of independent variables on the likelihood of a rupture being repaired.

Results

Offender Rated Ruptures in the Therapeutic Alliance

Of 54 participants, 30 (55.6%) reported experiencing a rupture in the therapeutic relationship; 20 (66.7%) reported a minor rupture and 10 (33.3%) reported a major rupture. Of the 30 participants who reported a rupture, 15 (50%) reported the rupture was repaired, 8 (26.7%) reported the rupture was not repaired, with data missing data for seven offenders. There was no significant relationship between rates of ruptures that were repaired or ruptures that remained unrepaired for those who reported a major or minor rupture, $\chi^2(1, N = 30) = 1.45, p = .23$.

Change in offender rated therapeutic alliance between early and late treatment. Mean offender ratings of the therapeutic alliance at Time 2 were

significantly higher than ratings at Time 1 (Table 2). The *Goal*, *Task*, *Bond* and *Total* therapeutic alliance ratings all significantly increased over time.

Table 2

Mean Change Over Time of Working Alliance Inventory – Short Form

| | <i>Time 1</i> | | <i>Time 2</i> | | <i>F(1,53)</i> |
|------------------------------------|---------------|-----------|---------------|-----------|----------------|
| | <i>Mean</i> | <i>SD</i> | <i>Mean</i> | <i>SD</i> | |
| Working Alliance Inventory - Goal | 20.59 | 4.33 | 23.06 | 4.34 | 21.24** |
| Working Alliance Inventory - Task | 21.48 | 5.40 | 24.00 | 3.66 | 14.81** |
| Working Alliance Inventory - Bond | 18.67 | 5.54 | 21.26 | 4.31 | 13.93** |
| Working Alliance Inventory - Total | 60.74 | 13.78 | 68.31 | 10.84 | 20.66** |

* $p < .05$ (2-tailed) ** $p < .01$ (2-tailed)

Impact of ruptures and repairs on offender rated therapeutic alliance over time. There was no significant interaction between rupture type and time, Wilks' Lambda = .94, $F(2, 51) = 2.03$, $p = .20$, partial eta squared = .06. There was a substantial main effect for time, Wilks' Lambda = .70, $F(1, 51) = 21.46$, $p < .01$ partial eta squared = .30 with all three rupture conditions showing an increase in WAI-SF ratings from Time 1 to Time 2 (see Table 3). In addition, there was a main effect for the three rupture conditions, $F(2, 51) = 3.79$, $p = .03$, partial eta squared = .13. A post hoc Tukey test suggested that therapeutic alliance ratings by offenders who reported no ruptures and those who reported a rupture with no repair differed significantly, at $p = .043$. This had a large effect size at Time 1 ($d = 0.81$) and Time 2 ($d = 0.85$). There were no significant differences between offender ratings of the therapeutic alliance for those offenders who reported ruptures that were repaired and those who reported no ruptures ($p = .17$), as well as those who reported ruptures that were repaired and those that were not repaired ($p = .76$).

Table 3

Working Alliance Inventory - Short Form Total Ratings for No Rupture, Rupture/Repair, Rupture/No Repair Across Two Time Periods

| | <i>No Rupture</i> | | <i>Rupture/Repair</i> | | <i>Rupture/No Repair</i> | |
|-------------|-------------------|-----------|-----------------------|-----------|--------------------------|-----------|
| | <i>Mean</i> | <i>SD</i> | <i>Mean</i> | <i>SD</i> | <i>Mean</i> | <i>SD</i> |
| Time Period | | | | | | |
| Time 1 | 65.00 | 12.07 | 55.15 | 15.37 | 54.80 | 13.04 |
| Time 2 | 70.45 | 9.51 | 67.92 | 13.29 | 62.20 | 9.90 |

Offender variables impacting difference in ratings of no rupture, minor rupture or major rupture in the therapeutic alliance. Those offenders who reported no rupture, a minor rupture or major rupture did not differ in regards to offender age and age of first sex offence (see Table 4). Additionally, those who experienced no rupture, minor rupture or major rupture did not differ depending on PCL:SV Total score, Factor 1 and Factor 2 scores.

Table 4

ANOVA Difference Between No Rupture, Minor Rupture and Major Rupture Conditions

| | <i>df</i> | <i>F</i> | <i>n</i> | <i>P</i> |
|--|-----------|----------|----------|----------|
| Age at start of program | 2, 51 | 1.91 | 54 | .16 |
| Age first sex offence | 2, 50 | .57 | 53 | .57 |
| Psychopathy Checklist | 2, 50 | 1.07 | 53 | .35 |
| Psychopathy Checklist – Factor 1 | 2, 50 | 1.61 | 53 | .21 |
| Psychopathy Checklist – Factor 2 | 2, 50 | .95 | 53 | .40 |
| Dominance | 2, 44 | .32 | 47 | .73 |
| Hostility | 2, 44 | 4.06 | 47 | .02* |
| Hostile-Dominance | 2, 44 | 4.14 | 47 | .02* |
| Impact Message Inventory - Control | 2, 44 | .57 | 47 | .57 |
| Impact Message Inventory - Affiliation | 2, 44 | 9.45 | 47 | <.01** |

* p<.05 ** p<.01

Offender ratings of no rupture, minor rupture or major rupture differed depending on offender IMI Hostility and IMI Hostile-Dominance (see Table 5 for Means and Standard Deviations). A post hoc Tukey test showed that those offenders who reported a major rupture had significantly higher IMI Hostility than those who reported no rupture, $p = .02$, but there was no difference in IM Hostility for those who reported a minor rupture, $p = .06$. Offenders who reported a major rupture had significantly higher IMI Hostile-Dominance than those who reported no rupture, $p = .03$, and those who reported a minor rupture, $p = .03$. Offender ratings of no rupture, minor rupture or major rupture also differed depending on perceived offender affiliation. A post hoc Tukey test showed that there was a significant difference in perceived offender IMI Affiliation between major rupture and no rupture conditions, $p < .01$ and major rupture and minor rupture conditions, $p < .01$. Offender ratings of no rupture, minor rupture or major rupture did not differ depending on offender IMI Dominance and offender IMI Control.

Table 5

Mean and Standard Deviation of Offender Interpersonal Style and Age over Rupture Conditions

| | <i>No Rupture</i> | | <i>Minor Rupture</i> | | <i>Major Rupture</i> | |
|---|-------------------|-----------|----------------------|-----------|----------------------|-----------|
| | <i>Mean</i> | <i>SD</i> | <i>Mean</i> | <i>SD</i> | <i>Mean</i> | <i>SD</i> |
| Age at start of program | 42.04 | 12.37 | 47.50 | 17.22 | 52.10 | 12.51 |
| Age first sex offence | 30.17 | 10.56 | 28.85 | 13.13 | 34.00 | 15.14 |
| Psychopathy Checklist | 11.04 | 4.75 | 10.15 | 4.13 | 12.80 | 5.53 |
| Psychopathy Checklist – Factor 1 | 4.87 | 2.28 | 5.30 | 2.25 | 6.50 | 2.95 |
| Psychopathy Checklist – Factor 2 | 6.13 | 4.70 | 4.70 | 3.83 | 6.30 | 4.64 |
| Dominance | 1.74 | .67 | 1.90 | .82 | 1.94 | .72 |
| Hostility ₁ | 2.03 | .57 | 2.12 | .73 | 2.76 | .71 |
| Hostile-Dominance _{1,2} | 1.77 | .58 | 1.75 | .59 | 2.40 | .65 |
| Impact Message Inventory - Control | -.82 | 2.44 | -.06 | 2.38 | -.07 | 2.29 |
| Impact Message Inventory – Affiliation _{1,2} | -.23 | 1.51 | .33 | 1.83 | -2.47 | 1.26 |

₁ Significant difference between *No Rupture* and *Major Rupture* conditions.

₂ Significant difference between *Minor Rupture* and *Major Rupture* conditions.

Variables related to likelihood of reporting rupture repair in the therapeutic alliance. Logistic regressions were performed to assess the impact of a number of factors on the likelihood of a repair occurring in the rupture in the therapeutic relationship. None of the factors predicted the likelihood of a rupture being repaired (See Table 6).

Table 6

Logistic Regression Predicting Likelihood of Reporting Rupture Repair in the Therapeutic Alliance

| | B | S.E. | Wald | df | P | Odds Ratio | 95.0% C.I for Odds Ratio | |
|--|-------|------|------|----|-----|------------|--------------------------|-------|
| | | | | | | | Lower | Upper |
| Age at start of program | .00 | .03 | .00 | 1 | .97 | 1.00 | .95 | 1.06 |
| Victim Type | -1.04 | .55 | 3.55 | 1 | .06 | .35 | .12 | 1.04 |
| Age first sex offence | .00 | .03 | .01 | 1 | .93 | 1.00 | .94 | 1.07 |
| Psychopathy Checklist | -.18 | .11 | 2.71 | 1 | .10 | .83 | .67 | 1.04 |
| Psychopathy Checklist – Factor 1 | -.18 | .20 | .84 | 1 | .36 | .84 | .57 | 1.23 |
| Psychopathy Checklist – Factor 2 | -.17 | .12 | 2.13 | 1 | 1.5 | .84 | .67 | 1.08 |
| Psychopathy Checklist cut-off | -1.10 | 1.31 | .71 | 1 | .40 | .33 | .03 | 4.32 |
| Dominance | -.64 | .74 | .74 | 1 | .39 | .53 | .12 | 2.27 |
| Hostility | -.31 | .65 | .22 | 1 | .64 | .74 | .21 | 2.63 |
| Hostile-Dominance | -1.09 | .91 | 1.45 | 1 | .23 | .34 | .06 | 1.98 |
| Impact Message Inventory - Control | -.27 | .24 | 1.27 | 1 | .26 | .76 | .47 | 1.22 |
| Impact Message Inventory - Affiliation | .07 | .26 | .08 | 1 | .78 | 1.08 | .65 | 1.79 |

* p<.05 ** p<.01

Discussion

This study explored the nature of ruptures in the therapeutic alliance between sexual offenders and their therapists in a structured group sex offender treatment program. More than half of the sample (30 of 54 sexual offenders) reported a rupture occurring in the therapeutic relationship; these were more likely to be minor rather than major ruptures. When ruptures were reported, one in four were not repaired.

Given that unrepaired ruptures were associated with a poorer therapeutic alliance and a poorer therapeutic alliance may adversely impact outcomes, this is a critical finding with important clinical outcomes. The second aim of the study was to determine the level of change in offender-rated therapeutic alliance over the course of treatment. Results showed that offender ratings of all aspects of the therapeutic alliance (bond, task and goal) improved over the course of treatment.

The third aim was to determine whether a change in therapeutic alliance over time differed for those who did not experience a rupture, to those who experienced a rupture and repair, or those who experienced a rupture that was not repaired. It was hypothesized that offenders who experienced a rupture without a repair would rate the therapeutic alliance as poorer than those offenders who did not experience a rupture. This hypothesis was supported; those offenders who did not experience a rupture had a higher therapeutic alliance rating at both Time 1 and Time 2 than those who experienced a rupture without a repair. This suggests that offenders perceiving a rupture in the relationship that is not repaired have a poorer view of the therapeutic alliance. It may be that this particular group will have worse outcomes, due to a poorer alliance, leading to potentially higher recidivism rates (Holdsworth et al., 2014; Martin, Garske, & Davis, 2000; McMurrin & Thoedosi, 2007), although this hypothesis should be subjected to empirical scrutiny.

It was further hypothesized that a repair of the rupture would positively impact the therapeutic alliance. This hypothesis was not supported; those who experienced a rupture that was repaired had the same level of improvement in their ratings of the therapeutic alliance as those who reported a rupture without a repair. This suggests that having a rupture that is repaired did not improve ratings of therapeutic alliance. The absence of a rupture may be more beneficial for the therapeutic alliance than the

potential change experienced through repairing a rupture. However, the therapeutic alliance was similar for those offenders who reported a rupture that was repaired with those offenders who reported no rupture. This may indicate that there was some improvement in the therapeutic alliance when a repair occurred but that the therapeutic alliance was still somewhat tarnished as a result of the rupture. The relatively small sample size may have obscured possible differences between groups in this regard. Nevertheless, this finding contradicts suggestions by Safran and Kraus (2014) that ruptures that are properly addressed can actually strengthen the therapeutic alliance.

Regardless of the rupture condition, all ratings of the therapeutic alliance increased over time. Offenders who reported no rupture in the therapeutic alliance, as well as those who reported a rupture and repair of that rupture, and those who reported a rupture without a repair, all rated the therapeutic alliance as being stronger towards the end of treatment. This is promising as it suggests that even with the presence of a rupture, the therapeutic alliance can still be strengthened over time. This suggests that offenders who are experiencing unrepaired ruptures may be able to continue in treatment and can work to strengthen this relationship over time, or that therapists can persist with the development of the therapeutic alliance even in the light of relationship difficulties.

The fourth aim of the study was to determine whether there was a relationship between offender IPS and no rupture, a minor rupture or a major rupture. Offenders who reported a major rupture were higher in hostility or hostile-dominance than those offenders who did not report a rupture. There was also a significant increase in hostile-dominance in those offenders who reported a major rupture, compared to a minor rupture. This finding is consistent with research suggesting that client hostility

is associated with a poorer therapeutic relationship (Hill et al., 2003). Sexual offenders who reported a major rupture were also more likely to fall on the hostile end of the IMI Affiliation axis compared to those who reported no rupture or a minor rupture. This suggests that perceived offender friendliness was associated with less relational difficulties between offender and therapist. Future research should explore the difficulties that arise in treatment with hostile and hostile-dominant offenders and how these difficulties may be avoided or overcome.

The hypothesis that offenders who reported a rupture would have higher levels of psychopathy was not supported. There was no difference in psychopathy ratings for those offenders who reported no rupture, minor rupture or major rupture. It is noted that due to the small sample size, there may not have been enough power in the analysis to determine significance in the relationship.

Offenders who reported a rupture did not have higher levels of interpersonal dominance. This was consistent with findings from a concurrent study by Watson, Daffern, and Thomas (2015), which found that IMI Dominance did not impact the quality of the therapeutic alliance in a sexual offender sample. This is inconsistent with suggestions that clients with a dominant IPS have difficulty establishing a positive therapeutic alliance (Edens, 2009; Holdsworth et al., 2014).

The fifth aim of the study was to determine whether interpersonal or offence-specific factors increase the likelihood of a rupture in the therapeutic alliance being repaired. None of the factors included in the current study predicted the likelihood of an offender reporting a repair following a therapeutic alliance rupture. It may be that other offender or therapist characteristics not examined in this study contributed to this resolution process. Future research should examine the characteristics of the ruptures and other qualities of therapists and offenders that may determine repair. It

should be noted that victim type [child only victim(s), adult only victim(s), child and adult victim(s)] approached traditional statistical significance level cut-off $p=.06$, which may have been impacted by the small sample size restricting power. Future research might elucidate the characteristics of these offender groups to explore what it is about these different sex offenders that impact their ability or willingness to resolve therapeutic ruptures.

Overall, these findings provide important guidance for clinical practice. Sexual offenders who are experiencing a rupture in the therapeutic relationship are likely to view the collaborative relationship with their therapist more poorly. Although it is unknown what level of therapeutic alliance specifically is related to poorer outcomes, it is noted that there is a positive relationship between the alliance and therapeutic outcomes (Martin et al., 2000), therefore a decrease in the alliance is likely to be related to poorer outcomes. Therapists may not be aware of the ruptures that offenders are experiencing, particularly as withdrawal ruptures can involve an offender becoming subservient (Safran & Kraus, 2014), which may be interpreted as compliance. However, given the current findings, therapists may view hostile interpersonal behaviors (or hostile-dominant behaviors) as potential indicators of ruptures in the therapeutic relationship. These behaviours could include: belittling or criticizing others, intolerance to others' mistakes or weaknesses, showing anger or irritability, or being contemptuous of others (Schmidt et al., 1999). Therapists may need to tolerate the expression of their offender-clients' negative emotions, and allow the offender to talk about their needs and fears, whilst responding with empathy toward them (Safran & Kraus, 2014). However, it is noted that even with a rupture, the therapeutic alliance can still improve over time.

Limitations/Future Research

One limitation of the current study was the lack of concise information about the timing of the therapeutic rupture; it may be that the rupture occurred in the first few weeks of treatment, which would have impacted the rating of the first stage therapeutic alliance. Another limitation was the consolidation of the dataset from two therapists to one, which reduced variation in the data. However, it is noted that the random allocation of therapists into the two groups may help reduce these effects. It would have been ideal to gain ratings of the presence of a rupture after each session, however due to the burden on participants this was not permitted. Another limitation in the current study was the modest sample size, potentially impacting the power of the analyses and leading to wide confidence intervals in the regression analyses. This was partially due to the community sample completion rate (non-return of questionnaires) being low, leading to a reduction in participation in the final stage of data collection. It is noted that factors influencing rupture repairs, and an interaction between rupture condition and therapeutic alliance ratings may be found with a larger sample. The sample of those with incomplete ruptures data may also have differed in regards to their experiences of ruptures and repairs during treatment, which was not captured by the current study.

Due to the interactive nature of the therapeutic alliance, future research could gather rupture data from the perspective of the therapists. The differences between rates of ruptures and repairs for those on community orders or parole and those offenders still incarcerated would be worthy of exploration, however due to the small number of second stage data for the community sample this was not analyzed in the current study. Future research may also benefit from a qualitative understanding of therapeutic ruptures from the perspective of both offenders and their therapists, which

would allow for exploration of additional factors relevant to the rupture and repair process. Although a poorer therapeutic alliance has been found to be related to poorer outcomes (Holdsworth et al., 2014; Martin et al., 2000), it is unknown, based on the body of research, what level of therapeutic alliance is optimal for positive therapeutic gain. Therefore, future research can analyze the level of therapeutic alliance that is related to poorer outcomes, or positive therapeutic gains.

Conclusions

The current study explored the nature of therapeutic ruptures in a sample of sex offenders participating in structured offence-specific group treatment. More than half of the sample experienced a rupture in the therapeutic relationship, with 26.7% of those ruptures remaining unrepaired. Offenders who reported a rupture had higher levels of interpersonal hostility and hostile-dominance, with more serious ruptures being related to significantly higher interpersonal hostility and hostile-dominance. The origins and nature of these actions is presently unclear, although they may reflect dysfunctional interpersonal patterns that are triggered by the demands of the intense therapeutic relationship. It is important for therapists to remain cognizant of offender clients' interpersonal sensitivities, to understand the interpersonal processes that may activate unpleasant thoughts and emotions that manifest in hostility, confrontation and withdrawal, and not respond with increased hostility. Such responses likely escalate conflict, reduce the likelihood of a repair and further tarnish the therapeutic alliance. Offender dominance, control and offence-specific variables did not impact the likelihood of a rupture. None of these variables impacted the likelihood of a rupture being repaired. Offenders who experienced an unrepaired rupture had a poorer rating of the therapeutic alliance at the end of treatment when compared to those offenders who did not experience a rupture. However, even when a rupture

occurred the therapeutic alliance still improved over time. This shows that offender IPS is important for developing and maintaining a positive therapeutic alliance, however more needs to be done to elucidate those factors associated with the development of ruptures, particularly with those offenders with hostile and hostile-dominant traits. Finally, it is noted that these are preliminary findings, due to the lack of replicated research findings, and the small sample size of the current study.

References

- Andrews, D., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P., & Cullen, F.T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, *28*, 369-404. doi:10.1111/j.1745-9125.1990.tb01330.x
- Baillargeon, P., Coté, R., & Douville, L. (2012). Resolution process of therapeutic alliance ruptures: A review of the literature. *Psychology*, *3*, 1049-1058. doi:10.4236/psych.2012.312156
- Blackburn, R., & Renwick, S.J. (1996). Rating scales for measuring the interpersonal circle in forensic psychiatric patients. *Psychological Assessment*, *8*, 76-84. doi:10.1037/1040-3590.8.1.76
- Blasko, B.L., & Jeglic, E.L. (2014). Sexual offenders' perceptions of the client-therapist relationship: The role of risk. *Sexual Abuse: A Journal of Research and Treatment*, 1-20. doi:10.1177/1079063214529802
- Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*, 252-260. doi:10.1037/h0085885
- Cooke, D.J. (1997). Psychopaths: Oversexed, overplayed but not over here? *Criminal Behaviour and Mental Health*, *7*, 3-11. doi:10.1002/cbm.141
- Cooke, D.J., Michie, C., Hart, S., & Hare, R.D. (1999). Evaluating the Screening Version of the Hare Psychopathy Checklist-Revised (PCL:SV). *Psychological Assessment*, *11*, 3-13. doi:10.1037/1040-3590.11.1.3

- Cookson, A., Daffern, M., & Foley, F. (2012). The relationship between aggression, interpersonal style and therapeutic alliance during short-term psychiatric hospitalisation. *International Journal of Mental Health Nursing, 21*, 20-29. doi:10.1111/j.1447-0349.2011.00764.x
- Critchfield, K.L., & Benjamin, L.S. (2006). Principles for psychosocial treatment of personality disorder: Summary of the APA Division 12 Task Force/NASPR review. *Journal of Clinical Psychology, 62*, 661-674. doi:10.1002/jclp.20255
- Daffern, M., Duggan, C., Huband, N., & Thomas, S. (2010). Staff and patient's perceptions of each other's interpersonal style: Relationship with severity of personality disorder. *International Journal of Offender Therapy and Comparative Criminology, 54*, 611-624. doi:10.1177/0306624X09335111
- Daffern, M., Thomas, S.D.M., Podubinski, P., Hollander, Y., Kulkarni, J., de Castella, A., et al. (2010b). The impact of psychiatric symptoms, interpersonal style and coercion on aggression during psychiatric hospitalization. *Psychiatry and Biological Processes, 73*, 365–382. doi:10.1521/psyc.2010.73.4.365
- Daffern, M., Tonkin, M., Howells, K., Krishnan, G., Ijomah, G., & Milton, J. (2010a). The impact of interpersonal style and perceived coercion on aggression and self-harm in personality-disordered patients admitted to a secure psychiatric hospital. *Journal Of Forensic Psychiatry & Psychology, 21*, 426-445. doi:10.1080/14789940903505951
- Drapeau, M. (2005). Research on the processes involved in treating sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 17*, 117-125. doi:10.1177/107906320501700203

- Edens, J.F. (2009). Interpersonal characteristics of male criminal offenders: Personality, psychopathological, and behavioral correlates. *Psychological Assessment, 21*, 89–98. doi:10.1037/a0014856
- Flückiger, C., Del Re, A.C., Wampold, B.E., Symonds, D., & Horvath, A.O. (2012). How central is the alliance in psychotherapy? A Multilevel Longitudinal Meta-Analysis. *Journal of Counseling Psychology, 59*, 10-17. doi:10.1037/a0025749
- Frost, A., & Connolly, M. (2004). Reflexivity, reflection, and the change process in offender work. *Sexual Abuse: Journal of Research and Treatment, 16*, 365–380. doi:10.1177/107906320401600408
- Hanson, K.R., & Bussière, M.T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362. doi:10.1037/0022-006X.66.2.348
- Hare, R.D. (1991). *The Hare Psychopathy Checklist—Revised*. Toronto: Multi-Health Systems.
- Hare, R.D. (2003). *Hare Psychopathy Checklist—Revised: 2nd ed. (PCL-R 2nd ed.)*. Toronto, Ontario, Canada: Multi-Health Systems.
- Hart, S.D., Cox, D.N., & Hare, R.D. (1995). *The Hare Psychopathy Checklist: Screening Version (1st ed.)*. Toronto, Ontario, Canada: Multi-Health Systems.
- Hill, C.E., & Corbett, M.M. (1993). A perspective on the history of process and outcome research in counseling psychology. *Journal of Counseling Psychology, 40*, 3-24. doi:10.1037/0022-0167.40.1.3
- Hill, C.E., Kellems, I.S., Kolchakian, M.R., Wonnell, T.L., Davis, T.L., & Nakayama, E.Y. (2003). The therapist experience of being the target of hostile versus suspected-unasserted client anger: Factors associated with resolution. *Psychotherapy Research, 13*, 475-491. doi:10.1093/ptr/kpg040

- Hill, C.E., & Knox, S. (2009). Processing the therapeutic relationship. *Psychotherapy Research, 19*, 13-29. doi:10.1080/10503300802621206
- Holdsworth, E., Bowen, E., Brown, S., & Howat, D. (2014) Offender engagement in group programs and associations with offender characteristics and treatment factors: A review. *Aggression and Violent Behavior, 19*, 102–121. doi:10.1016/j.avb.2014.01.004
- Holtforth, M.G., & Castonguay, L.G. (2005). Relationship and techniques in cognitive-behavioral therapy – a motivational approach. *Psychotherapy: Theory, Research, Practice, Training, 42*, 443-455. doi:10.1037/0033-3204.42.4.443
- Horvath, A.O., Del Re, A.C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*, 9-16. doi:10.1037/a0022186
- Kiesler, D.J. (1987). *Manual for the Impact Message Inventory*. CA: Consulting Psychologists Press, Inc.
- Kiesler, D.J., & Auerbach, S.M. (2003). Integrating measurement of control and affiliation in studies of physician-patient interaction: The interpersonal circumplex. *Social Science & Medicine, 57*, 1707-1722. doi:10.1016/S0277-9536(02)00558-0
- Kiesler, D.J., Schmidt, J.A., & Wagner, C.C. (1997). A circumplex inventory of impact messages: An operational bridge between emotion and interpersonal behavior. In R. Plutchik, & H.R. Conte (Eds.), *Circumplex models of personality and emotions*. Washington, DC, US: American Psychological Association
- Kozar, C.J., & Day, A. (2012). The therapeutic alliance in offending behavior programs: A necessary and sufficient condition for change? *Aggression and Violent Behavior, 17*, 482–487. doi:10.1016/j.avb.2012.07.004

- Levenson, J.S., Macgowan, M.J., Morin, J.W., & Cotter, L.P. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: A Journal of Research and Treatment, 21*, 35-56.
doi:10.1177/1079063208326072
- Lillie, R. (2007). Getting clients to hear: Applying principles and techniques of Kiesler's Interpersonal Communication Therapy to assessment feedback. *Psychology and Psychotherapy: Theory, Research and Practice, 80*, 151-163.
doi:10.1348/147608306X115198
- Marshall, W.L, Serran, G., Fernandez, Y.M., Mulloy, R., Mann R., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression, 9*, 25-30. doi:10.1080/355260031000137940
- Marshall, W.L, Serran, G., Moulden, H., Mulloy, R., Fernandez, Y.M., Mann R., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clinical Psychology and Psychotherapy, 9*, 395–405. doi:10.1002/cpp.335
- Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438–450. doi:10.1037//0022-006X.68.3.438
- McCarthy, L., & Duggan, C. (2010). Engagement in a medium secure personality disorder service: A comparative study of psychological functioning and offending outcomes. *Criminal Behaviour and Mental Health, 20*, 112–128.
doi:10.1002/cbm.758

- McMurrin, M., & Theodosi, E. (2007). Is treatment non-completion associated with increased reconviction over no treatment? *Psychology, Crime & Law, 13*, 333-343. doi:10.1080/10683160601060374
- Morgan, R., Luborsky, L., Crits-Christoph, P., Curtis, H., & Solomon, J. (1982). Predicting outcomes of psychotherapy by the Penn Helping Alliance Rating Method. *Archives of General Psychiatry, 39*, 397-402. doi:10.1001/archpsyc.1982.04290040013002
- Muran, J.C., Safran, J.D., Samstag, L.W., & Winston, A. (1992). *Patient and Therapist Postsession Questionnaires, Version 1992*. Beth Israel Medical Center, NY.
- Newman, C.F. (1998). The therapeutic relationship and alliance in short-term cognitive therapy. In J. Safran, & C.J. Muran (Eds.), *The Therapeutic Alliance in Brief Psychotherapy*. Washington, DC, US: American Psychological Association
- Olver, M.E., Beggs Christofferson, S.M., Grace, R.C., & Wong, S.C.P. (2014). Incorporating change information into sexual offender risk assessments using the violence risk scale-sexual offender version. *Sexual Abuse: A Journal of Research and Treatment, 26*, 472-499. doi:10.1177/1079063213502679
- Olver, M.E., Stockdale, K.C., & Wormith, J. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology, 79*, 6-21. doi:10.1037/a0022200
- Olver, M.E., & Wong, S. (2011). Predictors of sex offender treatment dropout: Psychopathy, sex offender risk, and responsivity implications. *Psychology, Crime & Law, 17*, 457-471. doi:10.1080/10683160903318876
- Rhodes, R.H., Hill, C.E., Thompson, B.J., & Elliot, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counseling Psychology, 41*, 473-483. doi:10.1037//0022-0167.41.4.473

- Ross, E.C., Polaschek, D.L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior, 13*, 462-480. doi:10.1016/j.avb.2008.07.003
- Safran, J.D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy, 27*, 154-165. doi:10.1037/0033-3204.27.2.154
- Safran, J.D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy, 3*, 381-387. doi:10.1037/a0036815
- Safran, J.D., Muran, J.C., & Rothman, M. (2006). The therapeutic alliance: Cultivating and negotiating the therapeutic relationship. In W. O'Donohue, N.A. Cummings, & J.L. Cummings (Eds.), *Clinical Strategies for Becoming a Master Psychotherapist*. Amsterdam. Boston: Elsevier Academic Press.
- Schmidt, J.A., Wagner, C.C., & Kiesler, D.J. (1999). Psychometric and circumplex properties of the octant scale Impact Message Inventory (IMI-C): A structural evaluation. *Journal of Counseling Psychology, 46*, 325-334. doi:10.1037/0022-0167.46.3.325
- Serran, G., Fernandez, Y., Marshall, W., & Mann, R. (2003). Process issues in treatment: Application to sexual offender programs. *Professional Psychology: Research and Practice, 34*, 368-374. doi:10.1037/0735-7028.34.4.368
- Sharf, J., Primavera, L.H., & Diener, M.J. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 47*, 637-645. doi:10.1037/a0021175
- Shine, J., & Hobson, J. (1997). Construct validity of the Hare Psychopathy Checklist, Revised, on a UK prison population. *Journal of Forensic Psychiatry, 8*, 546-561. doi:10.1080/09585189708412275

- Taft, C.T., Murphy, C.M., Musser, P.H., & Remington, N.A. (2004). Personality, interpersonal, and motivational predictors of the working alliance in group cognitive behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology, 72*, 349–354. doi:10.1037/0022-006X.72.2.349
- Tracey, T.J., & Kokotovic, A.M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1*, 207–210. doi:10.1037/1040-3590.1.3.207
- Tufekcioglu, S., Muran, J.C., Safran, J.D., & Winston A. (2013). Personality disorder and early therapeutic alliance in two time-limited therapies. *Psychotherapy Research, 6*, 646-657. doi:10.1080/10503307.2013.843803
- Watson, R., Daffern, M., & Thomas, S. (2015). The Impact of Interpersonal Style and Interpersonal Complementarity on the Therapeutic Alliance between Therapists and Offenders in Sex Offender Treatment. Manuscript submitted for publication.

Chapter 6: Interpersonal Style, the Therapeutic Alliance, Readiness and Gain

The Impact of Sex Offender's Interpersonal Style, Treatment Readiness and the Therapeutic Alliance on Treatment Gain

Preamble for Chapter 6. The literature review presented in Chapter 1 of the thesis described the impact of offender responsivity on treatment engagement and treatment outcome. Past research has typically focused on offender psychopathy; however there are other aspects of clients, treatment providers and the context in which treatment occurs that may impact offender engagement and change. The review noted that the therapeutic alliance accounts for a significant proportion of variance in treatment outcome, however research in the sexual offender treatment field is limited. Furthermore, it is unknown how offender responsivity variables impact the alliance to increase or decrease offender change.

Chapter 6 consists of the third empirical study of the thesis. Study Three aimed to determine whether offender interpersonal style, the strength of the therapeutic alliance or their pre-treatment measure of treatment readiness would predict their ability to make treatment gain (as measured by within-treatment changes). Furthermore, Study Three aimed to determine whether the relationship between offender interpersonal style and treatment gain would be moderated by the therapeutic alliance.

The following manuscript is under review with the *Sexual Abuse: A Journal of Research and Treatment* on 24 May 2015.

Watson, R., Daffern, M., & Thomas, S. (2015). The impact of sex offender's interpersonal style, treatment readiness and the therapeutic alliance on treatment gain. *Sexual Abuse: A Journal of Research and Treatment*, under review. Impact factor: 2.113; 5 year impact factor: 1.85; Ranking: Criminology and Penology 9 out of 55; Psychology, Clinical 40 out of 119.

Declaration for Chapter 6

Declaration by Candidate

In the case of Chapter 6, the nature and extent of my contribution to the work was the following:

| Nature of contribution | Extent of contribution (%) |
|---|----------------------------|
| Generation of ideas, data collection and analysis, and write up | 80% |

The following co-authors contributed to the work. If co-authors are students at Monash University, the extent of their contribution in percentage terms must be stated:

| | Nature of contribution | Extent of contribution (%) for student co-authors only |
|----------------------------------|---------------------------------|---|
| Professor Michael Daffern | Critical revision of manuscript | N/A |
| Professor Stuart Thomas | Critical revision of manuscript | N/A |

The undersigned hereby certify that the above declaration correctly reflects the nature and extent of the candidate and co-authors' contributions to this work.

| Candidate | | Date |
|----------------|------------|------------|
| Rachael Watson | [REDACTED] | 10/04/2016 |

| Main Supervisor | | Date |
|---------------------------|------------|------------|
| Professor Michael Daffern | [REDACTED] | 10/04/2016 |

**The Impact of Sex Offender's Interpersonal Style, Treatment Readiness and the
Therapeutic Alliance on Treatment Gain**

Rachael Watson¹, Michael Daffern^{2,3}, Stuart Thomas⁴

¹Monash University, Melbourne, Australia

²Centre for Forensic Behavioural Science, Swinburne University of Technology,
Melbourne, Australia, ³Victorian Institute of Forensic Mental Health, Melbourne,
Australia,

⁴Legal Intersections Research Centre, University of Wollongong, Sydney, Australia

Corresponding Author:

Rachael Watson

Centre for Forensic Behavioural Science

Swinburne University of Technology

Melbourne

Australia

Abstract

The impact of offender internal responsivity and therapeutic process variables on treatment gain for sex offenders has received little empirical attention. This study examined how the following factors impacted treatment gain: 1) treatment readiness, psychopathy and offender's interpersonal style (IPS), and 2) therapeutic alliance and the presence of ruptures in the therapeutic relationship. Participants were 75 sex offenders enrolled in group-based sex offender treatment either in prison or the community. Results showed that offender interpersonal dominance, hostile-dominance and the affective and interpersonal characteristics of psychopathy, as measured by the Psychopathy Checklist: Screening Version (PCL:SV) Factor 1 score, negatively impacted treatment gain. Pre-treatment readiness, client ratings of the therapeutic alliance at the commencement of treatment and whether or not there were therapeutic ruptures during treatment had no association with gain. Ratings of therapeutic alliance late in treatment were positively related to treatment gain but the strength of the therapeutic alliance later in treatment did not moderate the relationship between offender interpersonal style or psychopathy and treatment gain.

Keywords

Treatment gain, therapeutic alliance, interpersonal style, sexual offender, ruptures, treatment readiness

Contemporary sexual offender treatments typically have a positive impact on recidivism (Lösel & Schumacker, 2005), with Hanson and colleagues (2002) reporting that treated sexual offenders recidivated at a rate of 12.3%, compared to non-treated sexual offenders, 16.8%. In subsequent research Hanson, Bourgon, Helmus, and Hodgson (2009) reported a sexual offence recidivism rate of 10.9% compared to a comparison group of 19.2%. However, treatment effects range from moderate (Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999) to small (Hall, 1995), to no difference between treated and untreated sexual offenders (Långström et al., 2013; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005). What does appear to be clear is that treatment does not positively impact all participants, with 12% to 30% of treatment completers reoffending within 5 years of release (Hanson et al., 2002; Marques et al., 2005).

Measures of intra-individual within-treatment change taken directly after treatment completion can be used to determine benefit at the individual level (Beggs, 2010). Beggs (2010) identified three commonly used approaches to the measurement of within-treatment change: 1) assessing dynamic risk factors pre-post treatment, 2) employing risk assessment tools pre- and post-treatment (although we note these measures often contain dynamic risk factors so there is overlap with the first measurement approach), and 3) clinically rated post-treatment gain (which can include participation and behavioral conduct in treatment). Composite measures of clinically rated post-treatment change such as the Treatment Readiness, Responsivity, and Gain Scale: Short Version (TRRG-SV; Serin, Kennedy, & Mailloux, 2005) incorporate aspects of the treatment process (such as participation and within-group behaviors) and may complement multi-item dynamic risk assessment measures to ensure a comprehensive assessment of treatment gain. In one of few studies

comparing these measurement approaches, Beggs and Grace (2011) reported a positive correlation between a pre-post treatment measure of change and clinical post-treatment ratings, and that higher ratings on both predicted a reduction in sexual recidivism.

Internal Responsivity and Interpersonal Style

Internal responsivity characteristics may determine offenders' capacity for treatment gain (Andrews et al., 1990). Although they have rarely been subjected to empirical scrutiny it has been proposed that characteristics such as motivation to change, problem awareness, personal identity and the emotional capacity to engage may all impact participation and performance in treatment (Ward, Day, Howells, & Birgden, 2004). One internal responsivity factor that has recently been the focus of increased research attention is offender interpersonal style (IPS). According to interpersonal theory (Kiesler, 1987), interpersonal behavior represents a blend of two basic motivations: Agency, ranging from submission to dominance, and Communion, which ranges from friendliness to hostility. These dimensions are organized respectively on the horizontal and vertical axes of the Interpersonal Circumplex (Kiesler, 1987). In general, a person's interpersonal style can be considered as the balance between the dimensions of Communion and Agency. Adaptive interpersonal functioning is characterized by flexibility and moderation on both dimensions; well-functioning individuals adapt their interpersonal behavior to situational demands, their interpersonal activity is also moderate rather than extreme. Extant research, conducted primarily within forensic mental health inpatient samples, has established a relationship between a hostile-dominant IPS and aggression (Daffern et al., 2010) and a poorer therapeutic alliance (Cookson, Daffern, & Foley, 2012). Within psychotherapeutic settings, negative therapeutic outcomes (lower within-treatment

change) have been found to relate to higher levels of hostile interpersonal interactions between clients and therapists (Coady 1991; Samstag et al., 2008). Clients who have hostile and dominant interpersonal behaviors are also likely to have difficulty establishing a strong therapeutic alliance (Muran, Segal, Samstag, & Crawford, 1994). Associations between hostile and dominant IPS and lower therapeutic alliance within sexual offender treatment have also been reported (Watson, Daffern, & Thomas, 2015).

Psychopathy is a form of personality disorder characterized by a hostile-dominant interpersonal style. Psychopathy is typically separated into two components, one incorporating the interpersonal and affective characteristics of psychopathy (or the psychopathic personality) and the other incorporating the antisocial lifestyle characteristics of psychopathy (or antisocial behaviors; Hare, 1991; 2003). Psychopathy impacts offenders' engagement in treatment (Ross, Polaschek, & Ward, 2008) and higher levels of psychopathy are associated with increased risk of recidivism (Looman, Abracen, Serin, & Marquis, 2005). Early research found that offenders who score high on measures of psychopathy do not respond well to therapeutic interventions (Hare, Clarke, Grann, & Thornton, 2000; Hobson, Shine, & Roberts, 2000). It has been suggested that psychopathy creates a barrier to effective treatment, although one that may be overcome (Duggan, 2009; Mullen & Ogloff, 2009; Sheldon & Tennant, 2011). For instance, sexual offenders with high scores on measures of psychopathy who also had a negative treatment response reoffended sooner than those high psychopathy scorers who responded positively to treatment (Langton, Barbaree, Harkins, & Peacock, 2006). This finding is consistent with Polaschek (2014) who found that irrespective of level of

psychopathy, psychological treatment can still be beneficial if there is good engagement in treatment.

Therapeutic Alliance

The therapeutic alliance is the collaborative relationship that develops between therapist and client. The therapeutic alliance is an important treatment process variable (Frost & Connolly, 2004; Holdsworth, Bowen, Brown, & Howat, 2014), accounting for approximately 25% of variance of within-treatment change (Morgan, Lubrosky, Crits-Christoph, Curtis, & Solomon, 1982). In addition to treatment gain, the therapeutic alliance has been found to impact recidivism (McMurrin & Theodosi, 2007; Olver, Stockdale, & Wormith, 2011). Bender (2005) has suggested that people with challenging interpersonal styles (psychopathic traits, or characteristic hostility or dominance) are more likely to have attitudes and behaviors that interfere with the development of the therapeutic alliance, leading to reduced treatment gain.

Psychopathy, hostile and hostile-dominant interpersonal styles have also been shown to contribute to ruptures in the therapeutic relationship within a sex offender population (Watson, Thomas, & Daffern, submitted 2015). A rupture can be conceptualized as a breakdown in the therapeutic alliance (Safran, Muran, & Rothman, 2006). Therapists and clients often view the therapeutic alliance differently (Tichenor & Hill, 1989; Watson, Daffern, & Thomas, 2015); however, there are inconsistent views as to whether this impacts the therapeutic process or treatment outcomes. One study found no relationship between therapist-client ratings of the therapeutic alliance and treatment attrition (Meier & Donmall, 2006). However, Auerbach, May, Stevens, and Kiesler (2008) found that larger discrepancies between therapist-client ratings of the therapeutic alliance were associated with poorer adolescent behavioral functioning. They suggested that treatment process factors such

as the therapeutic alliance impact offenders' engagement in treatment and therefore their engagement in treatment-related change.

One way to address the challenge of a poor therapeutic alliance is to assess offenders' readiness prior to treatment commencement; doing so allows treatment to be targeted towards those with higher pre-treatment readiness, or for readiness to be targeted and enhanced prior to and during treatment. Casey and colleagues (2007) conceptualized treatment readiness factors that have been shown to impact the therapeutic alliance as offenders' attitudes towards treatment, their motivation to change, emotional reaction to their offending, beliefs about their offence, and self-efficacy. Although these pre-treatment treatment readiness factors have been proposed to impact the development of the therapeutic alliance (Day et al., 2010), it is unknown whether and how they may influence within-treatment change.

Current Study

Sexual offender treatment has been shown to reduce recidivism, however, research findings remain equivocal. Therefore, beyond treatment completion, enhanced understanding of recidivism risk can be explored through an understanding of within-treatment gain. Further, internal responsivity factors and therapeutic process variables may influence offenders' within-treatment change. Against this background this study explores the impact of psychopathy, IPS, therapeutic alliance and treatment readiness on treatment gain. The current study had two aims:

1. to ascertain whether offender psychopathy, IPS, treatment readiness or ratings of the therapeutic alliance predicted treatment gain.
2. to determine whether the association between offender characteristics and treatment gain was moderated by the therapeutic alliance.

Due to the impact of challenging offender interpersonal styles on therapeutic engagement (Muran, Segal, Samstag, & Crawford, 1994) and therapeutic outcomes (Coady 1991; Looman, Abracen, Serin, & Marquis, 2005; Samstang et al., 2008), it was hypothesized that offender hostility, dominance, hostile-dominance and psychopathy would negatively impact treatment gains. Treatment readiness and motivation has been found to be related to therapeutic engagement (Howells & Day, 2006) and has been suggested by Serin and Kennedy (1997) to be associated with treatment gain. Therefore, it was hypothesized that treatment readiness would positively impact treatment gains. Additionally, the therapeutic alliance has been found to have a strong association with therapeutic outcomes (Martin, Garske, & Davis, 2000) with ruptures in the therapeutic relationship potentially reducing the strength of the alliance. It was also hypothesized that offender ratings of the therapeutic alliance would predict treatment gain, and that the presence of a therapeutic rupture would be negatively related to treatment gain. Although extant results are inconsistent, one study looking at adolescent substance use treatment found that a larger discrepancy between therapist-client ratings of the therapeutic alliance lead to poorer adolescent behavioral functioning (Auerbach, May, Stevens, & Kiesler, 2008). Therefore, the difference in offender-therapist therapeutic alliance ratings was hypothesized to negatively relate to treatment gain. Finally, it has been reported that offender characteristics impact treatment gain due to their impact on the therapeutic alliance. Therefore it was hypothesized that the relationship between offender characteristics and treatment gain would be moderated by the therapeutic alliance.

Method

Participants

Male participants over the age of 18 years were recruited from the Sex Offender Program run by Department of Justice (Corrections Victoria being a part of Department of Justice) in Australia. Participants were moderate-low to high risk of sexual reoffending according to STATIC-99 assessment (some participants risk rating had been increased from low risk due to clinical over-ride despite STATIC-99 assessment). The Sex Offender Program targets dynamic risk factors related to sexual offending. The Community Based Program comprises of one three-hour session per week and the Prison Based Program comprises of two three-hour sessions per week. Total program hours range from 72 – 150 hours, with program length varying between three to eight months, depending on level of risk posed by the offender and their treatment needs.

The sample comprised 75 participants, with 60 recruited from Marngoneet Correctional Centre and 15 from Community Corrections; those undertaking the program in the community were either on a community order or parole. Those offenders undertaking the program in Marngoneet Correctional Centre commenced the program towards the end of their sentences, whereas community-based offenders commenced the program near the beginning of their community or parole orders. Participant ages ranged from 21-73 years ($M=44.97$, $SD=15.15$). Offender demographics and offence variables are presented in Table 1. There were 17 facilitators who participated in the study, with 13 female and 4 male facilitators. The data on facilitators' ages were incomplete, and therefore not included in the study.

Sixty-seven participants completed the treatment program, five did not complete and three were ongoing at the time data collection ended. Reasons for non-completion were 1) re-offending whilst undertaking the program, 2) offenders withdrawing after hostile, aggressive behavior towards therapists, and 3) mental

health concerns (symptoms of psychosis). Most participants were rated as moderate-high or high risk of reoffending, with 28 (37.3%) classified as moderate-high and 26 (34.7%) classified as high. Eighteen (24%) fell within the low, moderate-low or moderate risk of reoffending (with 3 [4%] not specified although regarded as moderate to high risk given their inclusion in the treatment program). A one-way between-subjects ANOVA was conducted to compare the effect of risk level on treatment gain, with no significant difference found, $F(21, 68) = 1.47, p = .14$. Five (8.7%) participants reached the cut-off for psychopathy (PCL total score of 18 or higher), with 69 (92%) participants falling below the cut-off, 1 (1.3%) was unspecified.

Table 1
Offender Demographics and Offence Variables

| | <i>n</i> |
|---|------------|
| <i>Country of Birth</i> | |
| Australia | 61 (81.3%) |
| Other | 13 (17.3%) |
| Unspecified | 1 (1.4%) |
| <i>Education Level</i> | |
| Less than Yr 10 (less than 10 years of education) | 27 (36%) |
| Less than Yr 12 | 30 (40%) |
| Completed Yr 12 | 8 (10.7%) |
| Tertiary (complete or incomplete) | 10 (8.3%) |
| <i>Victim Age</i> | |
| Adult only | 12 (16%) |
| Child only | 42 (56%) |
| Adult and Child | 20 (26.7%) |
| Unspecified | 1 (1.4%) |
| <i>Victim Gender</i> | |
| Male | 9 (12%) |
| Female | 57 (76%) |
| Male and Female | 8 (10.7%) |
| Unspecified | 1 (1.4%) |
| <i>Victim Relationship</i> | |
| Extrafamilial | 49 (65.3%) |
| Intrafamilial | 8 (10.7%) |
| Extrafamilial and Intrafamilial | 17 (22.7%) |
| Unspecified | 1 (1.4%) |

Measures

Corrections Victoria Treatment Readiness Questionnaire (Casey, Day, Howells, & Ward, 2007). The CVTRQ is a 20-item self-report measure, which provides a treatment readiness score, based on the Multifactor Offender Readiness Model (MORM: Ward et al., 2004). High scores (greater than 72) are indicative of treatment readiness. There are four subscales: 1) attitudes and motivation, 2) emotional reactions, 3) offending beliefs, and 4) efficacy. These subscales can be used to direct interventions if the readiness score is low. The CVTRQ has good internal consistency and shows high levels of discriminant and convergent validity (Casey et al., 2007). The scores on the CVTRQ are positively correlated with therapeutic engagement, as measured at the midpoint of the therapeutic program (Casey et al., 2007).

Impact Message Inventory (Schmidt, Wagner, & Kiesler, 1999). The IMI-C is a 56-item questionnaire that assesses the covert experience of interpersonal dyadic interactions (Kiesler & Auerbach, 2003). The IMI-C was used to measure the impact of offenders' interpersonal behaviors on their therapists. The IMI-C consists of an octant scale based on the traditional interpersonal circle format, with seven items per subscale: *Dominant* (e.g., "when I am with this person he makes me feel taken charge of"), *Hostile-Dominant* (e.g., "when I am with this person he makes me feel that I want to stay away from him"), *Hostile* (e.g., "when I am with this person it appears to me that he doesn't want to get involved with me"), *Hostile-Submissive* (e.g., "when I am with this person it appears to me that he thinks he will be ridiculed if he asserts himself with others"), *Submissive* (e.g., "when I am with this person he makes me feel dominant"), *Friendly-Submissive* (e.g., "when I am with this person it appears to me that he would accept whatever I said"), *Friendly* (e.g., "when I am with this

person he makes me feel welcome with him”), and *Friendly-Dominant* (e.g., “when I am with this person he makes me feel as if he’s the class clown”). Each octant scale is rated on a 4-point rating scale, ranging from *not at all* to *very much so*. The IMI-C has an internal consistency ranging from .69 to .89 across the eight subscales (Schmidt, Wagner & Kiesler, 1999).

Postsession Questionnaire (Muran, Safran, Samstag, & Winston, 1992). The PSQ contains a self-report measure of the therapeutic alliance (Working Alliance Inventory; Horvath & Greenberg, 1989), as well as a self-report measure of ruptures. The following aspects of ruptures were rated on a 5-point likert scale: occurrence (ranging from 1 = *Not at all*, 3 = *Occasionally* and 5 = *Constantly*), intensity (ranging from 1 = *Mildly*, 3 = *Moderately* and 5 = *Extremely*) and resolution (ranging from 1 = *Not at all*, 3 = *Somewhat* and 5 = *Very much*) of ruptures. Respondents may also include an open-ended description of the rupture/repair, providing context of the ruptures and repairs as well as process issues that may have contributed to the ruptures and/or repairs.

Psychopathy Checklist Screening Version (Hart, Cox, & Hare, 1995). The PCL is a rating scale designed to measure the presence of psychopathic traits (Cooke, Michie, Hart, & Hare, 1999). The Psychopathy Checklist Screening Version (PCL-SV) is a screening measure of the Psychopathy Checklist (PCL), with shorter administration time and requires less case note information (Cooke et al., 1999). The PCL-SV has a 12-item rating scale, which is directly drawn from the PCL; however with shorter and more simplified items (Cooke et al., 1999). Items are rated on a 3-point scale, with scores over 18 being indicative of psychopathy (Cooke et al., 1999). Part 1 of the PCL-SV is representative of Factor 1 on the PCL-R (interpersonal and affective characteristics), and Part 2 of the PCL-SV is representative of Factor 2 on

the PCL-R (antisocial lifestyle characteristics; Hare, 1991; 2003). The PCL-SV has an internal consistency of .84 (Hart et al., 1995).

Treatment Readiness Responsivity Gain Scale: Short Version (TRRG:SV; Serin, Kennedy, & Mailloux, 2005). The TRRG:SV has three domains (Treatment Readiness, Treatment Responsivity and Treatment Gain). For the purposes of this study the Treatment Gain domain was used. The Treatment Gain Scale is a post-treatment clinical rating scale that assesses a combination of knowledge, participation and competencies. The purpose of the domain is to provide an overall estimate of an offender's performance, rather than a measure of specific program targets (Serin et al., 2005). The Treatment Gain Scale consists of eight items, rated on a scale of 0 (poor) to 3 (very good), with descriptions provided to assist scoring. Higher scores are indicative of higher treatment gain. The eight items include: 1) evidence of increased skills from program, 2) disclosure in program, 3) application of knowledge, 4) application of skills, 5) depth of emotional understanding of program content, 6) appropriateness of behavior in group, 7) participation, and 8) therapeutic alliance. Data on predictive validity were not available on this measure at the time of writing.

Working Alliance Inventory Short-Form (Tracey & Kokotovic, 1989). The WAI-SF is a 12-item self-report measure of the therapeutic alliance between therapist and client, and can be rated by either participant. The WAI-SF has three subscales, with four items per subscale; *Bond* ("I believe [client] likes me"), *Goal* ("We are working towards mutually agreed upon goals"), and *Task* (e.g., "We agree on what is important for [client] to work on"). Each item is measured on a 7-point likert scale, ranging from *never* to *always*. The WAI-SF has an internal consistency of .98 (client's form) and .95 (therapist's form; Tracey & Kokotovic, 1989).

Procedure

Sexual offenders participating in Corrections Victoria (Victoria, Australia's correction's department) sex offender treatment program, and their therapists, were invited to participate in the study. The study was not associated with the requirements of the program, and as such participation was voluntary. The study was approved by the Monash University Human Research Ethics Committee (MUHREC) and the Department of Justice Human Research Ethics Committee (JHREC). Permission was received in June 2012 to begin recruitment and data collection at Marngoneet Correctional Centre (a medium security prison in Victoria, Australia) and through Victorian Community Corrections services. Within prison, participants were recruited outside of group time. Community participants were recruited pre or post allocated group time, or prior to completing psychometrics required for the sexual offender program. Participants signed consent forms, and were assigned unique codes upon recruitment, to maintain confidentiality. These codes were used to align data at different stages of data collection.

During the first stage of the study, questionnaires were administered prior to the commencement of treatment. Participants at Marngoneet Correctional Centre completed the CVTRQ whilst the researcher was present, outside of treatment program time. Community participants were given the CVTRQ, with return paid and addressed envelopes, to complete outside of treatment program time. During the second stage of the study, questionnaires were administered 3-4 weeks after the commencement of treatment. Participants were given the WAI-SF to complete outside of treatment program time; at this stage therapists were given the IMI-C and WAI-SF to be completed about the participants in their treatment group. There were two therapists per group, with each participant filling in a questionnaire on their view

of the therapeutic alliance with each therapist, and each therapist filling in a questionnaire regarding their view of participants' IPSs and the therapeutic alliance. During the third stage of the study, participants were given the WAI-SF and PSQ to complete outside of treatment program time. This occurred approximately three quarters of the way through the treatment program, as program length varied between three to eight months for each participant, this time was determined in consultation with therapists. A file review was conducted by the researcher to score the PCL-SV, as well as demographic and offence-related data, with the PCL-SV being scored on pre-treatment data only. Treatment gain was scored post-treatment by the researcher, and was based on the Completion Report and clinical files notes.

Data Preparation

Missing data were determined to be random; five cases were removed due to having more than 10% data missing. Eighteen cases had 1.8% missing, five had 3.6% missing, four had 5% missing, and 8 had 8.3% missing, in these cases the participant's mean response for the specific subscale was used. Data were consolidated to use only one offender-therapist response, to keep data independent. Data were first eliminated if no offender or therapist response was available; if both full sets were available 'Therapist 1' was chosen. 'Therapist 1' and 'Therapist 2' were randomly allocated during data collection. All Therapist 1 and Therapist 2 data sets were correlated (See Table 2); this suggests that although there may have been some differences in therapists' perceptions of the working relationship and the clients' interpersonal style there was significant agreement in the way the two therapists viewed the therapeutic alliance and offenders' IPSs. Since therapists' perceptions were correlated, data were consolidated for subsequent analyses. Benjamini and Hochberg's False Discovery Rate (FDR) corrections were conducted

to control for Type I errors that might arise from multiple analyses. This is considered to be a less conservative but a more powerful statistical approach than Bonferroni adjustments (Benjamini & Hochberg, 1995). In addition post-hoc power calculations were conducted.

Table 2

Correlations of Therapist 1 and Therapist 2 Impact Message Inventory and Working Alliance Inventory – Short Form Ratings

| | <i>Therapist 1</i> |
|---|--------------------|
| <i>Therapist 2</i> | |
| Working Alliance Inventory - Total | .33* |
| Impact Message Inventory - Dominant | .76** |
| Impact Message Inventory - Hostile-Dominant | .71** |
| Impact Message Inventory - Hostile | .71** |

* $p < .05$ (2-tailed) ** $p < .01$ (2-tailed)

Approach to Analyses

Individual regression analyses were used to explore whether *Hostile*, *Dominant*, or *Hostile-Dominant* IPSs, *Psychopathy Total*, *Psychopathy Factor 1* (interpersonal affective characteristics), *Psychopathy Factor 2* (antisocial lifestyle characteristics), *Treatment Readiness*, *Early Therapeutic Alliance* (3 weeks into treatment), *Late Therapeutic Alliance* (approximately $\frac{3}{4}$ way through treatment), *Therapeutic Rupture* or *Difference in early offender-therapist therapeutic alliance* ratings were associated with treatment gain. Ruptures in the therapeutic relationship were categorized as a dichotomous variable (separated into no rupture or minor rupture, and major rupture conditions), in order to determine whether major breakdowns in the therapeutic relationship were related to therapeutic outcome. The presence of ruptures were rated on a 5-point likert scale, with 1 being not at all, and 2 to 5 being different levels of rupture taking place. The ratings of the strength of the ruptures were analyzed using a

frequency analysis, and were subsequently categorized into ‘no rupture’, ‘minor rupture’ or ‘major rupture’ conditions. As there were no ratings of 5 (constant problem noted in the therapeutic relationship), 1 was categorized as no rupture, 2 as a minor rupture and 3-4 as a major rupture.

Procedurally, *Hostile-Dominance* was found to be the strongest IPS predictor of treatment gain at the univariate level, consequently this variable was selected for further moderation analyses. Similarly, as *PCL Factor 1* was the strongest psychopathy-related predictor of treatment gain at the univariate level, this variable was chosen for further moderation analysis. *Hostile-Dominance* and *Late therapeutic alliance* variables were centered (Mean – X; Jaccard, Wan, & Turrisi, 1990) and an interaction variable was created (HD x therapeutic alliance). A multiple regression analysis was then conducted to determine whether the relationship between *Hostile-Dominance* (HD) and treatment gain was moderated by the therapeutic alliance assessed late in treatment. The same analysis was then computed, substituting PCL Factor 1 score for HD.

Results

Means and standard deviations for offender treatment gain, IPS variables, Treatment Readiness and the Therapeutic Alliance are shown in Table 3. Correlations between offender IPS, Treatment Readiness and Therapeutic Alliance variables are shown in Table 4.

Offender IPS, Treatment Readiness, Therapeutic Alliance and Treatment Gain

Higher therapists’ ratings of offender *Dominance* and *Hostile-Dominance* were associated with lower *Treatment Gain* (Table 5). Therapists’ ratings of offender *Hostility* were not associated with *Treatment Gain*. Higher *Total Psychopathy* score and PCL-SV *Factor 1* scores were associated with lower *Treatment Gain*, whereas

PCL-SV *Factor 2* was not associated with *Treatment Gain*. There was no association between *Early offender-rated therapeutic alliance* and *Treatment Gain*, however higher *Late offender-rated therapeutic alliance* was associated with *Treatment Gain*.

Table 3

Means and Standard Deviations of Treatment Gain, Offender IPS, Treatment Readiness and the Therapeutic Alliance

| | N | Mean | SD | Range |
|---|----|-------|-------|-------------|
| Treatment Gain | 71 | 11.76 | 5.31 | 0 - 23 |
| Therapist rating of offender <i>hostility</i> | 58 | 2.25 | .75 | 1.00 - 4.00 |
| Therapist rating of offender <i>dominance</i> | 58 | 1.84 | .76 | 1.00 - 3.57 |
| Therapist rating of offender <i>hostile-dominance</i> | 58 | 1.93 | .72 | 1.00 - 3.71 |
| Psychopathy Checklist Total | 74 | 10.35 | 4.80 | 1 - 20 |
| Psychopathy Checklist Factor 1 | 74 | 4.95 | 2.35 | 1 - 11 |
| Psychopathy Checklist Factor 2 | 74 | 5.35 | 3.80 | 0 - 12 |
| Treatment Readiness Total | 72 | 83.44 | 7.93 | 55 - 99 |
| Offender-rated therapeutic alliance – Early | 64 | 61.75 | 13.70 | 30 - 83 |
| Offender-rated therapeutic alliance – Late | 54 | 68.31 | 10.84 | 36 - 84 |
| Difference ratings of therapeutic alliance | 54 | 15.81 | 9.02 | 0-36 |
| Rupture in Therapeutic Relationship | | | | |
| No Rupture | 24 | - | - | - |
| Minor Rupture | 20 | - | - | - |
| Major Rupture | 10 | - | - | - |

Offender-rated *Ruptures* in the therapeutic alliance were not associated with *Treatment Gain*; differences in early offender-therapist therapeutic alliance ratings were not associated with lower *Treatment Gain*. There were no associations between *Treatment Readiness* and *Treatment Gain*. With the FDR adjustment, offender *Dominance* and *Late offender-rated therapeutic alliance* no longer reached statistical significance. Post-hoc power calculations are presented in Table 5.

Table 4

Correlations between Offender IPS, Treatment Readiness and Therapeutic Alliance Variables

| | Host | Dom | Host-Dom | PCL Total | PCL F1 | PCL F2 | Readiness | Early TA | Late TA | TA Diff | Rupture |
|-----------|--------|-------|----------|-----------|--------|--------|-----------|----------|---------|---------|---------|
| Rupture | .39** | .06 | .40** | .18 | .23 | .09 | -.14 | -.22 | -.54** | -.05 | - |
| TA Diff | .26 | .13 | .05 | -.07 | .02 | -.10 | -.27 | .14 | .05 | - | -.05 |
| Late TA | -.49** | -.21 | -.39** | -.28* | -.32 | -.15 | .36** | .53** | - | .05 | -.54** |
| Early TA | -.41** | -.20 | -.29* | -.22 | -.14 | -.19 | .29* | - | .53** | .14 | -.22 |
| Readiness | -.40** | -.05 | -.04 | -.02 | -.01 | -.02 | - | .29* | .36** | -.27 | -.14 |
| PCL F2 | -.02 | .10 | .18 | .87** | .17 | - | -.02 | -.19 | -.15 | -.10 | .09 |
| PCL F1 | .14 | .38** | .29* | .63** | - | .17 | -.01 | -.14 | -.32* | .02 | .23 |
| PCL Total | .05 | .27* | .29* | - | .63** | .87** | -.02 | -.22 | -.28* | -.07 | .18 |
| Host-Dom | .52** | .76** | - | .29* | .29* | .18 | -.04 | -.29* | -.39** | .05 | .40** |
| Dom | .38** | - | .76** | .27* | .38** | .10 | -.05 | -.20 | -.21 | .13 | .06 |
| Host | - | .38** | .52** | .05 | .14 | -.02 | -.40** | -.41** | -.49** | .26 | .39** |

* p<.05 (2-tailed) ** p<.01 (2-tailed). Dependent variable: treatment gain

Offender IPS, Treatment Gain and Therapeutic Alliance Moderation

Hostile-Dominance and *Late offender-rated therapeutic alliance* explained a significant proportion of the variance in *Treatment Gain* ($F(3, 43) = 3.52, p = .02, R^2 = .20, R^2_{\text{Adjusted}} = .14$); while *Late offender-rated therapeutic alliance* did not predict *Treatment Gain* ($\text{Beta} = .17, t(43) = 1.12, p = .27$), offender *Hostile-Dominance* did predict *Treatment Gain* ($\text{Beta} = -.35, t(43) = -2.33, p = .03$). The *Hostile-Dominance* and *therapeutic alliance interaction* variable was not statistically significant ($\text{Beta} = -.00, t(43) = -.01, p = .99$).

PCL Factor 1 and *Late offender-rated therapeutic alliance* level explained a significant amount of the variance in *Treatment Gain* ($F(3, 48) = 5.12, p < .001, R^2 = .24, R^2_{\text{Adjusted}} = .20$), *Late offender-rated therapeutic alliance* did not predict *Treatment Gain* ($\text{Beta} = .13, t(48) = .89, p = .38$), however *PCL-SV Factor 1* did predict *Treatment Gain* ($\text{Beta} = -.41, t(48) = -3.07, p < .001$). The *PCL-SV Factor 1* and *therapeutic alliance interaction* variable was not statistically significant ($\text{Beta} = .14, t(48) = 1.02, p = .32$).

Discussion

The first aim of the study was to determine whether offender IPS, treatment readiness or ratings of the therapeutic alliance predicted treatment gain. It was hypothesized that offender hostility, dominance, hostile-dominance and psychopathy would impact treatment gain. This hypothesis was partially supported, with higher offender dominance and hostile-dominance associated with lower treatment gain. However, this finding should be interpreted with caution; when using a more conservative approach to analysis, offender dominance did not reach statistical significance. Given the explorative nature of this study, the findings will nevertheless be explored using the less conservative approach. However, replication is required

Table 5

Individual Regression Analyses of Offender IPS, Treatment Readiness and Therapeutic Alliance and the Related Offender Treatment Gain

| | Standardised B | t | Adjusted R ² | N | p | Adjusted p | Post-hoc power |
|--|-------------------|-------------|----------------------------|----|----------|---------------|-------------------|
| Therapist rating of offender <i>hostility</i> | -.21 | -1.60 | .03 | 58 | .115 | .169 | .37 |
| Therapist rating of offender <i>dominance</i> | -.27 | -2.11* | .06 | 58 | .039* | .086 | .57 |
| Therapist rating of offender <i>hostile- dominance</i> | -.45 | - 3.75** | .19 | 58 | < .001** | .001** | .97 |
| Psychopathy checklist Total | -.32 | - 2.84** | .09 | 71 | .006** | .022* | .82 |
| Psychopathy checklist Factor 1 | -.35 | - 3.14** | .11 | 71 | .002** | .011* | .89 |
| Psychopathy checklist Factor 2 | -.19 | .12 | .02 | 71 | .123 | .169 | .35 |
| Treatment Readiness Total | .05 | .38 | -.01 | 68 | .707 | .707 | .05 |
| Offender-rated therapeutic alliance – Early | .05 | .40 | -.01 | 61 | .694 | .707 | .06 |
| Offender-rated therapeutic alliance – Late | .30 | 2.23* | .07 | 52 | .031* | .085 | .62 |
| Rupture | -.15 | -1.08 | .00 | 52 | .286 | .350 | .19 |
| Difference ratings of therapeutic alliance | -.10 | -1.30 | .01 | 54 | .199 | .169 | .26 |

* p<.05 (2-tailed) ** p<.01 (2-tailed). Dependent variable: treatment gain

before definitive conclusions concerning offender dominance and treatment gain can be assumed. Previous research has shown that dominant interpersonal behaviors can lead to problems with developing a therapeutic alliance (Muran, Segal, Samtag, & Crawford, 1994). It may be that offender dominance impacts the ability of the offender to work collaboratively with their therapist, and to engage in the program and make within-treatment changes.

Although offender hostile-dominance impacted within-treatment change, offender hostility alone did not. However, dominance was highly correlated with hostile-dominance, suggesting that in the current sample a large proportion of dominant offenders also showed a hostile-dominant interpersonal style. Therefore, these results suggest that dominant or hostile-dominant interpersonal behaviors limit the change process more than hostility. Although offender hostility has been shown to impact the development of the therapeutic alliance (Muran et al., 1994; Watson, Daffern, & Thomas, 2015), hostile offenders may still be able to make changes in treatment. It may be that those sex offenders with a dominant or hostile-dominant IPS are less flexible and adaptive to new ways of thinking and behaving.

Psychopathy was also negatively related to treatment gain, with higher levels of psychopathy being associated with less gain. This result may differ in populations high in psychopathy, a limitation of the current study was that only five offenders breached the traditional PCL-SV cut-off score. However, this finding is consistent with research that suggests that offenders with high ratings of psychopathy do not respond well to therapeutic interventions (Hare et al., 2000; Hobson, Shine, & Roberts, 2000), have a poorer engagement in treatment (Ross et al., 2008) and have higher rates of recidivism (Looman et al., 2005). The current findings suggest that the affective and interpersonal characteristics of psychopathy (rather than the behavioral

or lifestyle factors) can interfere with within-treatment change; this may indicate an important responsivity issue to take into account during treatment. This is consistent with research conducted by Olver, Sewall, Sarty, Lews, and Wong (2015) who found that offenders with higher levels of the antisocial behavioral traits of psychopathy (as opposed to affective and interpersonal characteristics) were more likely to achieve greater treatment gain. However, it was noted that the changes made by psychopaths who had higher affective and interpersonal traits were more likely to be related to reductions in recidivism. Therefore, even smaller treatment gains made by these subtypes of psychopaths may lead to greater reductions in reoffending. It should also be noted that other researchers have found that offenders with high psychopathy who are not responding well to treatment are also likely to reoffend more quickly than those who make treatment gains (Langton et al., 2006). Therefore, understanding how psychopathy creates a barrier to the change process is important, because positive response to treatment may impact recidivism.

The hypothesis that the relationship between offender characteristics and treatment gain would be moderated by the therapeutic alliance was not supported in this study. Both offender hostile-dominance, and the affective and interpersonal characteristics of psychopathy were stronger predictors of treatment gain than the therapeutic alliance, and the presence of a stronger or weaker alliance did not moderate the effect between the offenders' IPSs and within-treatment change. Although previous research has found a relationship between IPS and the therapeutic alliance (Watson, Daffern, & Thomas, 2015), there also seems to be a direct relationship between offender IPS and within-treatment change. This suggests that offenders' IPSs may determine how willing, or able, an offender is to enact change, or that there are other aspects of the therapeutic relationship (that are not incorporated into the theoretical

understanding of the therapeutic alliance) that moderate offenders' engagement in the therapeutic process.

The hypothesis that treatment readiness would impact on treatment gains was not supported. Although pre-treatment readiness was not associated with the composite measure of within-treatment gain, it may predict other important aspects of engagement that influence change in specific risk factors. Therefore, more research may need to be conducted into the nature of the engagement and change process and how the therapeutic alliance influences this change process. This finding also suggests that even those offenders with lower levels of readiness prior to treatment may still be able to achieve positive therapeutic outcomes. The measure of treatment readiness used here incorporates offenders' attitudes and motivation, emotional reactions, offending beliefs and self-efficacy. The lack of significant findings with treatment gain suggests that the treatment readiness measure could be expanded to include further responsivity factors, such as IPS, to adequately capture those characteristics that impact the change process and treatment gain.

The hypothesis that early and late offender ratings of therapeutic alliance would predict treatment gain, as would the presence of a therapeutic rupture and the difference in offender-therapist therapeutic alliance ratings was partially supported. Early offender ratings of the therapeutic alliance were not related to treatment gain; however late offender ratings of the therapeutic alliance were associated with treatment gain. This suggests that being able to maintain or develop a stronger therapeutic alliance throughout the treatment process is more important to within-treatment change than the initial therapeutic alliance. Therefore, even if the therapeutic alliance starts off poorly, this does not necessarily have a negative impact

on treatment gain if the therapeutic alliance is subsequently developed over the course of treatment.

Surprisingly it was found that the presence of major ruptures in the therapeutic alliance did not impact treatment gain, although the low base-rate of therapeutic ruptures reported in the current study may have impacted this result. A poor therapeutic alliance has been noted to impact treatment outcomes (Martin, Garske, & Davis, 2000), with ruptures being associated with a breakdown in the therapeutic alliance (Safran, Muran, & Rothman, 2006). However, in this case the presence of a rupture may not have been indicative of a poor therapeutic alliance overall, therefore may not have impacted within-treatment change. Furthermore, the hypothesis that the difference in offender-therapist therapeutic alliance ratings would impact treatment gain was not supported, as difference in offender-therapist ratings of the therapeutic alliance was not associated with reduced treatment gain.

Limitations and Future Research

The findings presented here need to be considered in light of several limitations. One limitation was the composite measure of treatment gain used, as this does not provide information on the impact offender IPS, readiness and therapeutic alliance have on the changes made in relation to different risk factors or treatment components. Adequately capturing this information would allow for further exploration of the change process. It is also noted that the measure of treatment gain used in the current study incorporated the therapeutic alliance, which may provide some overlap when compared to offender-rated therapeutic alliance (although offender, therapist and third party ratings of the alliance often differ; Tichenor & Hill, 1989). In addition, treatment gain was rated based on treatment completion reports written by therapists, which may have been influenced by the therapists' views of

offenders' IPS. Another limitation was the lack of inter-rater reliability analyses, which would have provided greater confidence in the assessment of treatment gain. In addition, the lack of recidivism data was a further limitation, as this would provide information on whether within-treatment change is associated with reduction in offending post-treatment. A further limitation was the modest sample size, as there may not have been enough power in the analyses used to detect more nuanced relationships between the variables. Finally, the use of a consolidated dataset may have reduced variability in the data.

As the gain measure is a composite of all skills and knowledge gained and applied, this does not allow a direct comparison between specific content or risk factors that were targeted in treatment. Future research should aim to incorporate recidivism data to determine whether a composite measure of within-treatment change can adequately predict recidivism. Further research is also required to determine whether specific risk-related changes in dynamic risk factors contained in multi-item structured professional judgment risk assessment measures are better indicators of treatment change than global measures like the TRRG:SV (see Klepfisz, O'Brien, & Daffern, 2015; Olver, Beggs Christofferson, & Wong, 2015). Further, research is required to determine how the results of these assessments can benefit from incorporation of behavioral observations, clients' self-reported perceptions of change, and other collateral information (e.g., the opinions of family and other treatment or management staff concerning the clients performance in treatment). Further exploration of the change process may also help determine which within-treatment changes are most related to reductions in recidivism and how best to measure these changes. Importantly, it appears that offenders' IPS impacts this

change process; however further research into the mechanism of this impact is unknown.

Conclusion

This study explored the impact of internal responsivity factors on within-treatment gain. Results showed that offender interpersonal dominance and hostile-dominance and the interpersonal and affective features of psychopathy negatively impacted treatment gain. Early ratings of the therapeutic alliance were not associated with treatment gain, however late ratings of the therapeutic alliance were, which suggests that even if the therapeutic alliance starts off poorly, or the person may not be ready, that treatment gain can still be achieved. Ruptures in the therapeutic alliance were not negatively associated with treatment gain, suggesting that within-treatment change can still occur when there are breakdowns in the therapeutic relationship. Finally, analyses of moderation and mediation showed that the therapeutic alliance did not moderate or mediate the relationship between offender IPS and treatment gain, suggesting that offender hostile-dominance, and the affective and interpersonal characteristics of psychopathy may have a direct relationship with the within-treatment change process, rather than merely impacting gain via a deleterious impact on therapeutic alliance.

References

- Andrews, D., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, *28*, 369-404. doi:10.1111/j.1745-9125.1990.tb01330.x
- Auerbach, S.M, May, J.C., Stevens, M., & Kiesler, D.J, (2008). The interactive role of working alliance and counselor-client interpersonal behaviors in adolescent substance abuse treatment. *International Journal of Clinical and Health Psychology*, *8*, 617-629. Recovered from <http://www.redalyc.org/articulo.oa?id=33712016001>
- Beggs, S.M. (2010). Within-treatment outcome among sexual offenders: A review. *Aggression and Violent Behavior*, *15*, 369–379. doi:10.1016/j.avb.2010.06.005
- Beggs, S.M., & Grace, R.C. (2011). Treatment gain for sexual offenders against children predicts reduced recidivism: A comparative validity study. *Journal of Consulting and Clinical Psychology*, *79*, 182-192. doi:10.1037/a0022900
- Bender, D.S. (2005). The therapeutic alliance in the treatment of personality disorders. *Journal of Psychiatric Practice*, *11*, 73-87. doi:10.1080/10503300512331327047
- Benjamini, Y., & Hochberg, Y. (1995). Controlling the false discovery rate: A practical and powerful approach to multiple testing. *Journal of the Royal Statistical Society: Series B (Methodological)*, *57*, 289–300. Retrieved from <http://www.jstor.org/stable/2346101>

- Casey, S., Day, A., Howells, K., & Ward, T. (2007). Assessing suitability for offender rehabilitation: Development and validation of the Treatment Readiness Questionnaire. *Criminal Justice and Behaviour*, *34*, 1427-1440.
doi:10.1177/0093854807305827
- Coady, N.F. (1991). The association between client and therapist interpersonal processes and outcomes in psychodynamic psychotherapy. *Research on Social Work Practice*, *1*, 122-138. doi:10.1177/104973159100100202
- Cooke, D.J., Michie, C., Hart, S., & Hare, R.D. (1999). Evaluating the Screening Version of the Hare Psychopathy Checklist-Revised (PCL:SV). *Psychological Assessment*, *11*, 3-13. doi:10.1037/1040-3590.11.1.3
- Cookson, A., Daffern, M., & Foley, F. (2012). The relationship between aggression, interpersonal style and therapeutic alliance during short-term psychiatric hospitalisation. *International Journal of Mental Health Nursing*, *21*, 20-29.
doi:10.1111/j.1447-0349.2011.00764.x
- Daffern, M., Thomas, S.D.M., Ferguson, M., Podubinski, T., Hollander, Y., Kulkarni, J., de Castella, A., & Foley, F. (2010). The impact of psychiatric symptoms, interpersonal style and coercion on aggression and self-harm during psychiatric hospitalization. *Psychiatry: Interpersonal and Biological Processes*, *73*, 365-381. doi:10.1521/psyc.2010.73.4.365
- Day, A., Casey, S., Ward, T., Howells, K., & Vess, J. (2010). *Transitions to Better Lives: Offender Readiness and Rehabilitation*. Devon, UK: Willan Publishing.
- Duggan, C. (2009). A treatment guideline for people with antisocial personality disorder: Overcoming attitudinal barriers and evidential limitations. *Criminal Behaviour and Mental Health*, *19*, 219-223 doi:10.1002/cbm.726

- Frost, A., & Connolly, M. (2004). Reflexivity, reflection, and the change process in offender work. *Sexual Abuse: A Journal of Research and Treatment*, *16*, 365–380. doi:10.1177/107906320401600408
- Gallagher, C.A., Wilson, D.B., Hirschfield, P., Coggeshall, M.B., & MacKenzie, D.L. (1999). A quantitative review of the effects of sex offender treatment on sexual reoffending. *Corrections Management Quarterly*, *3*, 19–29. Recovered from <http://search.proquest.com.ezproxy.lib.monash.edu.au/docview/214564784?accountid=12528>
- Hall, G.C.N. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology*, *6*, 802–809. doi:10.1037/0022-006X.63.5.802
- Hanson, R.K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior*, *36*, 865–891. doi:10.1177/0093854809338545
- Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V.L., et al. (2002). First report of the Collaborative Outcome Project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, *14*, 169–194. doi:10.1177/107906320201400207
- Hare, R.D. (1991). *The Hare Psychopathy Checklist—Revised*. Toronto: Multi-Health Systems.
- Hare, R.D. (2003). *Hare Psychopathy Checklist—Revised: 2nd ed. (PCL-R 2nd ed.)*. Toronto, Ontario, Canada: Multi-Health Systems.

- Hare, R.D., Clarke, D., Grann, M., & Thornton, D. (2000). Psychopathy and the predictive validity of the PCL-R: An international perspective. *Behavioral Sciences and the Law, 18*, 623–645. doi:10.1002/1099-0798(200010)18:5<623::AID-BSL409>3.0.CO;2W
- Hart, S.D., Cox, D.N., & Hare, R.D. (1995). *The Hare Psychopathy Checklist: Screening Version (1st ed.)*. Toronto, Ontario, Canada: Multi-Health Systems.
- Hobson, J., Shine, J., & Roberts, R. (2000). How do psychopaths behave in a prison therapeutic community? *Psychology, Crime, and Law, 6*, 139–154. doi:10.1080/10683160008410838
- Holdsworth, E., Bowen, E., Brown, S., & Howat, D. (2014) Offender engagement in group programs and associations with offender characteristics and treatment factors: A review. *Aggression and Violent Behavior, 19*, 102–121. doi:10.1016/j.avb.2014.01.004
- Horvath, A.O., & Greenberg, L.S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233. doi:10.1037/0022-0167.36.2.223
- Howells, K., & Day, A. (2006). Affective determinants of treatment engagement in violent offenders. *International Journal of Offender Therapy and Comparative Criminology, 50*, 174-186. doi:10.1177/0306624X05281336
- Jaccard, J., Wan, C.K., & Turrisi, R. (1990) The detection and interpretation of interaction effects between continuous variables in multiple regression. *Multivariate Behavioral Research, 25*, 467-478. doi:10.1207/s15327906mbr2504_4
- Kiesler, D.J. (1987). *Manual for the Impact Message Inventory*. CA: Consulting Psychologists Press, Inc.

- Kiesler, D.J., & Auerbach, S.M. (2003). Integrating measurement of control and affiliation in studies of physician-patient interaction: The interpersonal circumplex. *Social Science & Medicine*, *57*, 1707-1722. doi:10.1016/S0277-9536(02)00558-0
- Klepfisz, G., O'Brien, K., & Daffern, M. (2014). Violent offenders' within-treatment change in anger, criminal attitudes, and violence risk: Associations with violent recidivism. *International Journal of Forensic Mental Health*, *13*, 348-362. doi:10.1080/14999013.2014.951107
- Långström, N., Enebrink, P., Laurén, E.M., Lindblom, J., Werkö, S., & Hanson, R. K. (2013). Preventing sexual abusers of children from reoffending: systematic review of medical and psychological interventions. *BMJ*, *347*, 1-11. doi:10.1136/bmj.f4630
- Langton, C.M., Barbaree, H.E., Harkins, L., & Peacock, E.J. (2006). Sexual offenders' response to treatment and its association with recidivism as a function of psychopathy. *Sexual Abuse: A Journal of Research and Treatment*, *18*, 99-120. doi:10.1177/107906320601800107
- Looman, J., Abracen, J., Serin, R., & Marquis, P. (2005). Psychopathy, treatment change, and recidivism in high-risk, high-need sexual offenders. *Journal of Interpersonal Violence*, *20*, 549-568. doi:10.1177/0886260504271583
- Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, *1*, 117-146. doi:10.1007/s11292-004-6466-7

- Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438–450. doi:10.1037//0022-006X.68.3.438
- Marques, J.K., Wiederanders, M., Day, D.M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment, 17*, 79–107. doi:10.1007/s11194-005-1212-x
- McMurrin, M., & Theodosi, E. (2007). Is treatment non-completion associated with increased reconviction over no treatment? *Psychology, Crime & Law, 13*, 333-343. doi:10.1080/10683160601060374
- Meier, P.S., & Donmall, M.C. (2006). Differences in client and therapist views of the working alliance in drug treatment. *Journal of Substance Use, 11*, 73-80. doi:10.1080/14659890500137004
- Morgan, R., Luborsky, L., Crits-Christoph, P., Curtis, H., & Solomon, J. (1982). Predicting outcomes of psychotherapy by the Penn Helping Alliance Rating Method. *Archives of General Psychiatry, 39*, 397-402. doi:10.1001/archpsyc.1982.04290040013002
- Mullen, P., & Ogloff, J. (2009) Providing mental health services to adult offenders in Victoria, Australia: Overcoming barriers. *European Psychiatry, 24*, 395-400, doi:10.1016/j.eurpsy.2009.07.003
- Muran, J.C., Safran, J.D., Samstag, L.W., & Winston, A. (1992). *Patient and Therapist Postsession Questionnaires, Version 1992*. Beth Israel Medical Center, NY.

- Muran, J.C., Segal, Z.V., Samstag, L.W., & Crawford, C.E. (1994). Patient pretreatment interpersonal problems and therapeutic alliance in short-term cognitive therapy. *Journal of Consulting and Clinical Psychology, 62*, 185-190. doi:10.1037/0022-006X.62.1.185
- Olver, M.E., Beggs Christofferson, S.M., & Wong, S.C.P. (2015). Evaluation and applications of the clinically significant change method with the Violence Risk Scale-Sexual Offender Version: Implications for risk-change communication. *Behavioral Sciences and the Law, 33*, 92-110. doi:10.1002/bsl.2159
- Olver, M.E., Sewall, L.A., Sarty, G.E., Lews, K., & Wong, S. (2015). A cluster analytic examination and external validation of psychopathic offender subtypes in a multisite sample of Canadian federal offenders. *Journal of Abnormal Psychology, 124*, 355-371. doi:10.1037/abn0000038
- Olver, M.E., Stockdale, K.C., & Wormith, J. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology, 79*, 6-21. doi:10.1037/a0022200
- Polaschek, D.L. (2014). Adult criminals with psychopathy: Common beliefs about treatability and change have little empirical support. *Current Directions in Psychological Science, 23*, 296-301. doi:10.1177/0963721414535211
- Ross, E.C., Polaschek, D.L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior, 13*, 462-480. doi:10.1016/j.avb.2008.07.003
- Safran, J.D., Muran, J.C., & Rothman, M. (2006). The therapeutic alliance: Cultivating and negotiating the therapeutic relationship. In W. O'Donohue, N.A. Cummings, & J.L. Cummings (Eds.), *Clinical Strategies for Becoming a Master Psychotherapist. Amsterdam. Boston: Elsevier Academic Press.*

- Samstag, L.W., Muran, J.C., Wachtel, P.L., Slade, A., Safran, J.D., & Winston, A. (2008). Evaluating negative process: A comparison of working alliance. *American Journal of Psychotherapy*, 62, 165-194. Retrieved from <http://search.proquest.com/docview/1441834817?accountid=12528>
- Schmidt, J.A., Wagner, C.C., & Kiesler, D.J. (1999). Psychometric and circumplex properties of the octant scale Impact Message Inventory (IMI-C): A structural evaluation. *Journal of Counseling Psychology*, 46, 325–334. doi:10.1037/0022-0167.46.3.325
- Serin, R.C., & Kennedy, S. (1997). *Treatment Readiness Responsivity: Contributing to Effective Correctional Programming (Research Report R-54)*. Ottawa, ON: Correctional Service of Canada.
- Serin, R.C., Kennedy, S., & Mailloux, D.L. (2005). *Manual for the Treatment Readiness, Responsivity, and Gain Scale: Short Version (TRRG:SV)*. Carlton University, Ontario Canada.
- Sheldon, K., & Tennant, A. (2011). Considerations for working with personality-disordered patients. *The British Journal of Forensic Practice*, 13, 44-53
doi:10.5042/bjfp.2011.0049
- Tichenor, V., & Hill, C. (1989). A comparison of six measures of working alliance. *Psychotherapy*, 26, 195-199. doi:10.1037/h0085419
- Tracey, T.J., & Kokotovic, A.M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment*, 1, 207–210. doi:10.1037/1040-3590.1.3.207
- Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and Violent Behavior*, 9, 645-673.
doi:10.1016/j.avb.2003.08.001

Watson, R., Daffern, M., & Thomas, S. (2015). The Impact of Interpersonal Style and Interpersonal Complementarity on the Therapeutic Alliance Between Therapists and Offenders in Sex Offender Treatment. *Sexual Abuse: A Journal of Research and Treatment*, 1-21. doi:10.1177/1079063215580969

Watson, R., Thomas, S., & Daffern, M. (submitted 2015). The Impact of Interpersonal Style on Ruptures and Repairs in the Therapeutic Alliance Between Offenders and Therapists in Sex Offender Treatment. Submitted for publication.

Chapter 7: Integrated Discussion

The main aim of this thesis was to explore both individual responsivity and treatment process factors in a sexual offender treatment programme. This was addressed through analysing the nature of the therapeutic alliance, the impact of offenders' and therapists' interpersonal styles on the alliance, any breakdown in the therapeutic relationship, and the level of treatment gain made by offenders. The thesis comprised three studies, which each explored components of this overall aim. In this integrated discussion, the research aims are restated and the research findings are summarised and integrated. Implications for the findings are explored, as are limitations of the research, finally future research directions and overarching conclusions are provided.

Overview of Research Aims

The research aims for Study One covers the gap in the literature regarding the sexual offender therapeutic alliance and the impact of sexual offender characteristics, and complementarity of offender-therapist interpersonal style, on the development of the therapeutic alliance. The aims included: a) to describe and compare the nature of the therapeutic alliance from the perspective of therapists and offenders; (b) to determine the relationship between therapists' and offenders' interpersonal styles and the therapeutic alliance; (c) to explore whether offender hostility and dominance is related to assessments of the therapeutic alliance; (d) to explore the level of complementarity in interpersonal style between therapists and offenders and determine whether complementarity is related to therapeutic alliance. The research aims for Study Two addressed the gap in the literature regarding ruptures in the therapeutic alliance between sexual offenders and their therapists, and sought to determine whether offenders' interpersonal styles differed for those who experienced

no ruptures, or those that experienced minor or major ruptures. The aims included: a) to describe the occurrence of ruptures in a sexual offender sample; b) to assess changes in offender rated therapeutic alliance from commencement to end of treatment; c) to determine whether change in therapeutic alliance over time differs for those who do not experience a rupture, compared to those who experience a rupture that is repaired, and those who experience a rupture that is not repaired; d) to determine whether interpersonal hostility, hostile-dominance, and psychopathy impact ratings of end-of-treatment therapeutic alliance for those offenders who reported no rupture, a minor rupture or a major rupture; and e) to determine whether interpersonal or offence-specific factors affect the likelihood of a rupture being repaired. The research aims for Study Three addressed the gap in the literature regarding the impact of responsivity and process factors on sexual offender treatment gain. These aims included: a) to ascertain whether offender psychopathy, interpersonal style, treatment readiness or ratings of the therapeutic alliance predict treatment gain; and b) to determine whether the association between offender characteristics and treatment gain was moderated by the therapeutic alliance. The key findings will be discussed below.

Summary of Key Findings

Research aims Study One: The therapeutic alliance, interpersonal style and offender-therapist complementarity. Internal responsivity factors are important to the Risk Need Responsivity model (RNR; Andrews et al., 1990); however these are under-researched compared to the risk and need domains. Responsivity factors impact how an offender engages in treatment, and includes offender characteristics such as motivation, personal identity and emotional capacity to engage (Andrews et al., 1990). Engagement in treatment is often conceptualised through the therapeutic

alliance, which is an important aspect of the treatment process (examining those aspects that impact the nature of treatment delivery, rather than theoretical and needs driven treatment targets). In a non-offender population, process factors such as therapist characteristics, the group climate and the therapeutic alliance, have been shown to account for as much as 25% of variance in treatment outcome (Marshall & Burton, 2010). Research on offenders has found that the therapeutic alliance alone impacts treatment engagement and recidivism (Frost & Connolly, 2004; Holdsworth, Bowen, Brown, & Howat, 2014). Extending upon the idea that personal identity and emotional capacity to engage impact engagement, it is thought that the responsivity factor of offender interpersonal style, may impact how the therapeutic alliance develops and is maintained over the course of therapy. As Ross, Polaschek, and Ward (2008) note in their Revised Theory of the Therapeutic Alliance, both offender and therapist characteristics are important to the therapeutic alliance. The first study investigated this by examining the impact of sexual offenders' and therapists' interpersonal styles on the strength of the therapeutic alliance early in treatment, as well as the impact of interpersonal complementarity on the strength of the therapeutic alliance.

Offender characteristics. The first aim of Study One was *to describe and compare the nature of the therapeutic alliance from the perspective of therapists and offenders*. Results showed a significant difference in offender-therapist ratings of the therapeutic alliance, in the areas of therapeutic alliance task and goals, however there was no difference between offenders' and therapists' ratings of the therapeutic alliance bond. On all aspects but the bond, the offenders' ratings of the therapeutic alliance were significantly higher than therapists' ratings, suggesting that the offenders view the collaborative aspects of the therapeutic alliance more positively

early in treatment than therapists did, however were more cautious or negative regarding the therapeutic bond. These findings are mostly consistent with previous studies that have found a discrepancy between client-therapist ratings of the therapeutic alliance (Auerbach et al., 2008; Tichenor & Hill, 1989), although with the one noted difference with respect to bond ratings. When compared to two other samples (adolescent substance users; Auerbach, May, Stevens, & Kiesler, 2008; and patients with schizophrenia; Johansen, Melle, Iversen, & Hestad, 2013) therapists treating sexual offenders in this study viewed the therapeutic alliance as significantly weaker, however sexual offender views of the therapeutic alliance were comparable to the client views of the alliance in those samples. This suggests that therapists working with sexual offenders may be particularly pessimistic or cautious in their early view of the relationship. Previous research has noted inconsistent findings as to whether this difference in perception is important to therapeutic outcomes (Auerbach et al., 2008; Meier & Donmall, 2006). In these studies outcomes differed, with difference ratings having no impact on attrition (Meier & Donmall, 2006), but related to poorer functioning (increased substance use and use of illegal activity in past 90 days; Auerbach et al., 2008). In Study Three, it was shown that there was no significant association between differences in offender-therapist therapeutic alliance ratings and treatment gain (a measure of within-treatment change). Therefore, it appears that the difference in perceptions of therapeutic alliance early in treatment is not an important indicator of change, or treatment noncompletion.

Study One found that sexual offender interpersonal style impacted the strength of the therapeutic alliance. As such, offender interpersonal style can be considered an important responsivity factor that is relevant to offender engagement and the treatment process. It was found that offender hostility and dominance (as perceived

by the therapist) was related to lower ratings of the therapeutic alliance (as perceived by the therapist early in treatment). This finding suggests that if therapists view sexual offenders as having a hostile or dominant interpersonal style, they are also more likely to see those offenders as having less agreement of therapeutic tasks, goals and a poorer therapeutic bond. Alternatively, it may be because the clients cannot form a bond and do not agree with goals and tasks, they are assessed as being hostile or dominant. This interpretation is consistent with previous non-forensic and forensic findings, with hostile or dominant interpersonal problems being related to poorer therapeutic alliance for domestic violence offenders (late treatment therapist ratings only; Taft, Murphy, Musser, & Remington, 2004), psychiatric patients (Muran, Segal, Samstag, & Crawford, 1994), depressed clients (Hardy et al., 2001) and offenders undertaking substance use treatment programmes (Simpson et al., 2012). This consistency of findings suggests that similar mechanisms are active, regardless of the type of client involved in the therapeutic relationship and the treatment type. It is noted that the findings from the current study are from the perspective of the therapist, whereas the majority of previous studies have rated the therapeutic alliance (except for the Taft et al., 2004) or level of engagement from the perspective of the client, therefore these results may not be directly comparable. Taft and colleagues (2004) found no significant association between early therapist ratings of the therapeutic alliance and offender hostile-dominance in domestically violent offenders, but found a significant association later in treatment.

These findings suggest that sexual offenders with hostile and dominant interpersonal styles may find it difficult to build a collaborative relationship with their therapist. Hostile and dominant interpersonal behaviour is likely established early in life, when offenders develop expectations around how interpersonal

interactions typically unfold (Safran, Crocker, McMain, & Murray, 1990; Safran & Kraus, 2014). Hostile or dominant offenders may find it difficult to develop trusting relationships, and potentially have a greater focus on autonomy over affiliation (Holtforth & Castonguay, 2005). Undertaking mandated treatment may also undermine an offender's sense of autonomy and create additional challenges for those who already do not comfortably develop trusting, healthy relationships with others. It is possible that offenders who have dysfunctional interpersonal patterns, may enact those patterns in a therapeutic relationship (Safran, Crocker, McMain, & Murray, 1990; Safran & Kraus, 2014).

However, the relationship between offenders' interpersonal style and therapeutic alliance was different for the offenders' perspectives of the therapeutic alliance, compared to the therapists' perspectives. This further speaks to the first aim, *to describe and compare the nature of the therapeutic alliance from the perspective of therapists and offenders*. Sexual offenders' interpersonal style (as perceived by the therapist) had an impact on offenders' ratings of the therapeutic alliance, however it was only hostile sexual offenders who were likely to perceive the therapeutic alliance poorly. Dominant sexual offenders were not more likely to perceive the therapeutic alliance poorly. Therefore, therapists found developing a collaborative relationship with offenders more challenging with both dominant and hostile offenders, however only hostile offenders viewed the relationship negatively. This suggests that while therapists might find more dominant sexual offenders difficult to work with, dominant offenders may not share this view. This answers the first aim of the Study, showing that offender-therapists perceptions of the therapeutic alliance can differ, as offender interpersonal style may impact upon therapists' perceptions of the alliance, but not negatively impact the offender's perception of the alliance.

In Study One, it was determined that offender-rated therapeutic alliance would be a more important indicator of outcomes, consistent with research that has shown that client-rated therapeutic alliance is more predictive of outcomes than therapist-rated therapeutic alliance (Horvath & Symonds, 1991; Horvath, 2000). If this were the case (based on findings in Study One), the offender characteristic of hostility would be thought to be more crucial to sexual offender outcomes, as this is associated with offender ratings of the therapeutic alliance, whereas offender dominance was not. To clarify this issue, further analyses were conducted (provided in Appendix B) to determine whether therapist or offender therapeutic alliance ratings were more predictive of outcomes (treatment gain). These additional analyses suggest that early in treatment, therapists' ratings of the therapeutic alliance were predictive of treatment gain, whereas offenders' ratings were not. However, offenders' ratings of the therapeutic alliance were predictive of treatment gains later in treatment. This suggests that not only was there a difference in ratings of the therapeutic alliance based on who the rater was, but also the timing of the rating was important. It is noted that the current study did not collect therapists' ratings of the therapeutic alliance later in treatment to compare with offender ratings, due to the increased burden this would place on therapists' time.

This result is broadly consistent with Taft and colleagues (2004), who found that hostile-dominance was significantly related to late therapist ratings of the therapeutic alliance, but not early ratings or client ratings. This would suggest that therapists' ratings of the therapeutic alliance (from Study One) would be more indicative of treatment outcomes. Analyses in Study Three provide further clarification of this relationship, with sexual offender dominance and hostile-dominance (not hostility alone) found to be related to treatment gain. Although sexual offender hostility was

found to be related to offenders' views on the collaborative nature of the therapeutic alliance, it was offender dominance and hostile-dominance that was related to within-treatment change. This was more closely aligned to the therapist's perception of the therapeutic alliance (with offender dominance impacting their view of the collaborative relationship). Early ratings of the therapeutic alliance that are most relevant to treatment outcome are those ratings made by therapists; therefore, offender hostility and dominance are thought to both be important traits impacting the therapeutic alliance (rather than hostility alone). However, hostile interpersonal behaviours in sexual offenders can potentially be used as an indicator that those offenders are also likely to be viewing the therapeutic alliance negatively. This may be useful because it can be difficult at times for therapists to be aware of how offenders perceive the therapeutic alliance. Given these findings, offender interpersonal style is likely to be an important responsivity factor to consider in sexual offender treatment, particularly dominant and hostile interpersonal traits.

Therapist characteristics. Therapist interpersonal style was also found to impact the strength of the therapeutic alliance. When sexual offenders viewed their therapists as being either hostile or dominant, they were also likely to view the therapeutic alliance with their therapist more negatively. This is consistent with extant findings from both non-forensic and forensic populations, which suggest that therapists who are perceived as being hostile towards their clients can negatively impact on the therapeutic relationship (Drapeau, 2005; Dunkle, 1996; Marshall et al., 2003). The current findings support the assertions by Marshall and colleagues (2003) that overly confrontational or hostile therapist behaviour can impact sexual offender therapeutic relationships. In addition, it has now been shown that an overly dominant, controlling or directive approach can also have a negative impact on the therapeutic alliance

within sexual offender treatment. These findings add further understanding to the assertion by Serran, Fernandez, Marshall, and Mann (2003), who note the importance of developing a safe therapeutic environment to allow for exploration of the offence process. The Study findings suggest that therapist hostility or dominance has a negative impact on the therapeutic alliance, potentially undermining the safe, explorative environment in which an offender can be challenged. Hostile therapists may make offenders feel unsafe to disclose personal information in the therapeutic environment. Dominant therapists may challenge those offenders who have a higher need for autonomy, or who have a dysfunctional interpersonal behaviours related to dominance and submission in interpersonal relationships. Therefore, when confronted by sexual offenders' dysfunctional interpersonal behaviours, it is important for therapists not to respond with hostility or dominance.

Therapists may find it difficult to deal with dominant offenders, particularly if they feel the offender's agenda or needs are diverting them from delivering treatment. Given this competing need, therapists may respond with increased dominant behaviour in order to redirect the offender. Given the therapist's role in facilitating the group program, responding to a dominant offender with submission may not be appropriate; conversely an overly dominant approach may also potentially damage the therapeutic alliance. Marshall and colleagues (2003) suggested that it may be beneficial to respond to a dominant offender with the use of open-ended questions, rather than being overly directive (which may challenge the offender's sense of autonomy; Holtforth & Castonguay, 2005). It may also be necessary to allow the offender to express their opinion and to articulate the underlying feelings associated with their view (Rhodes, Hill, Thompson, & Elliott, 1994). However, an additional consideration is the competing needs for therapists in delivering the programme

content, as well as meeting the needs of other group members, which may at times be challenging. Recognising dysfunctional patterns of behaviour may allow the therapist to resist responding automatically to offender hostility or dominance.

Findings from Study One provide support for the Revised Theory of the Therapeutic Alliance proposed by Ross, Polaschek and Ward (2008). It has been found that both offender and therapist interpersonal style impact the quality of the therapeutic alliance in a sexual offender population. If either party views the other as being either hostile or dominant then this impacts the quality of the collaborative relationship and the therapeutic bond. Hostile sexual offenders, regardless of how they view the therapist's interpersonal style, are also likely to have a negative view of the collaborative relationship. These findings provide some support for the use of measures of interpersonal style in conjunction with the analysis of the therapeutic alliance for offender populations. In addition, Ross and colleagues (2008) propose that both therapist and offender characteristics impact the collaborative relationship, and that these factors also interact, and impact their behaviours towards each other. This was further explored in the current thesis through an examination of offender-therapist interpersonal complementarity.

Offender-therapist complementarity. The final aim of Study One was *to explore complementarity in interpersonal style between therapists and offenders and determine whether complementarity was related to the therapeutic alliance.* It was found that sexual offender-therapist control complementarity differed from the two samples described in the IMI-C manual (diabetic patients-Physicians and Traumatic Brain Injury Patients-Physicians; TBI; Kiesler & Schmidt, 2006). The current sexual offender sample had lower levels of complementarity along the control axis, suggesting that there was a lower level of reciprocation between dominant and

submissive interpersonal styles than has been found in the normative samples. This suggests that sexual offenders, or their therapists, were less likely to respond to dominance with submission or to submission with dominance than Traumatic Brain Injury or diabetic patients and their physicians. This highlights the possibility that the therapists in forensic populations have different demands when dealing with client interpersonal behaviours, or may have a different pattern of responding to offenders' interpersonal behaviours. This was further explored through looking at the mean scores for offenders and therapists on the control axis (see Appendix B); it appears that therapists sit roughly in the middle of the axis between dominance and submission, however the average control axis score for offenders fell towards the submissive end of the axis. This suggests that, although there were offenders with a dominant interpersonal style, sexual offenders tended to be more submissive. This finding helps to explain the lower level of control complementarity, as it appears that on average therapists did not respond to submissive offenders with an overly dominant or directive approach.

Of note, study findings suggested that sexual offender-therapist interpersonal style complementarity was not associated with the strength of the therapeutic alliance; therefore having reciprocation on the control axis (dominance to submission) or correspondence on the affiliation axis (friendliness to hostility) did not influence the strength of the therapeutic alliance. This suggests that a strong therapeutic alliance is able to tolerate non-complementary dyadic interactions. It is noted that Horowitz and colleagues' (2006) revised circumplex model suggests that a complementary response would be one that matched the motives behind behaviours, rather than the behaviour itself. A structured therapeutic setting may reduce some of the ambiguity behind people's behaviours, and there might some degree of

expectation by offenders and therapists that they would experience some challenging or atypical interactions in this setting. Therefore, experiencing interactions with others, who do not respond in their preferred way, might be balanced by the atypical situation they are in. This may be addressed by therapists at the start of treatment (i.e. that the therapist may challenge them at times, and that offenders may experience discomfort with this experience) in order to prepare offenders for any discomfort or challenge to their usual interpersonal processes.

Ross and colleagues (2008) suggest in their Revised Theory of the Therapeutic Alliance, that the interaction between therapists and offenders is important in determining the strength of the therapeutic alliance, however based on the current findings, this cannot be explained through the circumplex complementarity model. This is consistent with previous research by Auerbach and colleagues (2008) who also found no relationship between complementarity and the therapeutic alliance in an adolescent substance use programme, but differs to the positive relationship between complementarity and the therapeutic alliance found in client-patient relationships in medical settings (Kiesler & Auerbach, 2003). At this stage there is no published research to suggest that complementarity is relevant to the strength of the overall therapeutic alliance in a forensic setting.

One important significant finding was the relationship between control complementarity and the difference in offender-therapist ratings of the therapeutic bond; an increase in non-complementarity on the control axis (dominance to submission) was related to a greater difference in the ratings of the therapeutic bond between therapists and sexual offenders. Although complementarity was unrelated to the strength of the therapeutic alliance overall, a lack of complementarity may cause one party to view the bond more poorly. For example, if a therapist does not respond

with the desired level of submission to a dominant offender, that offender may then be less likely to report a strong, trusting therapeutic bond. Or the therapist, noting the offender's dominant interpersonal behaviours might believe that the therapeutic bond is not as strong as the offender perceives. It is not known how this discrepancy impacts the therapeutic relationship overall, however it was found to be unrelated to the offender's level of within treatment change (Study Three).

Research aims Study Two: Ruptures and repairs in the therapeutic relationship. Although the quality of the therapeutic relationship has been found to be important for offender engagement and therapeutic outcomes (Blasko & Jeglic, 2014; Holdsworth et al., 2014), not much is known about the breakdown or ruptures that occur within offender-therapist relationships. The therapeutic alliance is one theoretical conceptualisation of the therapeutic relationship, which comprises the collaboration between therapist and client on tasks, goals and the development of a relational bond. A rupture in the therapeutic relationship is often conceptualised as a breakdown in the three aspects of the therapeutic alliance (Safran & Muran, 2006). It is thought that ruptures would be important in offender treatment programmes due to the higher base rate of interpersonal difficulties in offender populations, potentially impacting the therapeutic relationship. In addition, as poorer therapeutic alliance has been associated with increased attrition and poorer outcomes generally (Holdsworth et al., 2014; Martin, Garske, Davis, 2000), this is particularly important in a forensic setting due to the possibility that this could contribute to increased recidivism rates. It has been theorised that offender responsivity factors may impact the quality of the therapeutic alliance and that those offenders with more challenging interpersonal styles may be more likely to experience a rupture in the therapeutic relationship. This hypothesis has not previously been researched. Therefore, Study Two was a

preliminary study exploring the nature of ruptures in sexual offender-therapist therapeutic relationships, how this impacts the quality of the therapeutic alliance, and whether offender interpersonal style is associated with ruptures and repairs in the therapeutic relationship.

Ruptures in the therapeutic relationship and the therapeutic alliance. Study Two analysed ruptures in the therapeutic relationship and the change in therapeutic alliance over time. The first aim was *to describe the occurrence of ruptures in a sexual offender sample in treatment.* Over half of the sexual offenders reported a rupture in the therapeutic relationship, with two thirds of those ruptures being defined as minor ruptures, and the remaining one third as a major rupture. This shows that a significant proportion of sexual offenders in the current sample encountered an issue during the treatment programme, which impacted how they viewed the therapeutic relationship. Approximately one in four of the ruptures that were reported by the participants remained unresolved. Interestingly, there was no difference in the rate of rupture repair for those offenders who experienced a minor rupture or a major rupture, suggesting that severity of rupture was not a determinant of whether the rupture could be repaired. Therefore, even a significant breakdown in the therapeutic relationship can be repaired at the same rate as minor disturbances, which may be encouraging for therapists when it comes to repair efforts.

The second and third aims of Study Two were *to assess changes in offender rated therapeutic alliance from commencement to the end of treatment, and to determine whether changes in therapeutic alliance over time differed for those who did not experience a rupture, compared to those who experience a rupture that was repaired, and those who experience a rupture that is not repaired.* It was found that the therapeutic alliance was significantly weaker for those sexual offenders who

reported a rupture in the therapeutic relationship that was not repaired than those who reported that there was no rupture in the therapeutic relationship. This was the case early in treatment and later in treatment. This suggests that a rupture or breakdown in the therapeutic relationship that has not been resolved significantly can reduce the strength of agreement on tasks and goals and the therapeutic bond. Of note, these ruptures may or may not be apparent to the therapist, as this was not assessed in the current study.

These findings provide an initial understanding of the presence and nature of ruptures in the therapeutic relationship in sexual offender treatment, and speak to the need to further research this topic. It is unknown, for example, whether these ruptures could be classified as withdrawal or confrontational ruptures (Safran & Kraus, 2014); this is important because there may be a difference in rupture type and whether different types of ruptures are resolved. It is possible that therapists more readily observe a confrontational rupture as an issue that needs addressing, and therefore that these ruptures may be more often resolved. This is of course speculative at this stage, and future research could examine the type of rupture that occurs within sexual offender treatment, and whether repairs are more likely for one type of rupture.

Further to these aims, it was found that offender ratings of the therapeutic alliance improved over the course of treatment, and that ratings improved regardless of whether a rupture had occurred or not, and whether the rupture had been repaired. This was somewhat inconsistent with Safran and Kraus' (2014) views, which suggests that resolving problems within the therapeutic relationship can actually strengthen that relationship, compared to having no therapeutic rupture. It is noted that although there was no significant interaction found, the rupture with repair condition was trending towards showing a greater improvement in therapeutic

alliance ratings over time. It may be that the small sample size did not allow for enough statistical power in the analyses for a statistically significant relationship to be found, increasing the Type II error rate. It was also found that no rupture being reported was associated with a significantly stronger alliance than a rupture without repair. However, the current findings also suggest that regardless of whether a rupture occurs, or is resolved, there was an improvement in the therapeutic alliance over time. Although the presence of ruptures were still important, as offenders who experienced no rupture still reported a significantly stronger alliance later in treatment compared to the offenders who experienced a rupture without repair.

However, based on findings from Study Three, there was no impact of ruptures on treatment gain. At this stage, the non-significant findings suggest the presence of ruptures in the therapeutic relationship do not impact an offender's ability to make within-treatment changes. However, the therapeutic alliance (offender late ratings) was found to be related to treatment gain, highlighting the potential differences in constructs being measured. This suggests that it was not so much whether the offender noted the presence of a rupture within the therapeutic relationship, but how they viewed their collaboration on tasks, goals and the therapeutic bond late in treatment that was relevant to whether they were likely to make within treatment changes. It remains unknown at this time how the presence of ruptures or rupture repairs in the therapeutic relationship relates to future recidivism rates. However, future research can determine whether this is an important aspect of the treatment process to focus on during treatment, to further reduce sexual offender recidivism rates.

Interpersonal style and ruptures. Offender interpersonal style was one responsivity factor that was thought to impact the development and maintenance of

the therapeutic relationship. The fourth aim of Study Two *was to determine whether interpersonal hostility, hostile-dominance, and psychopathy impact ratings of end-of-treatment therapeutic alliance for those offenders who reported no rupture, a minor rupture or a major rupture.* In Study One sexual offender dominance and hostility were both found to impact the strength of the therapeutic alliance (as assessed by the therapist). Results from Study Two showed that sexual offenders who reported a major rupture in the therapeutic relationship differed in their level of hostility and hostile-dominant traits compared to those who reported no therapeutic rupture. Additionally, sexual offenders who reported a major rupture had significantly higher levels of hostile-dominance, compared to those that experienced a minor rupture. Offender dominance alone and psychopathy did not differ for those who experienced no rupture, a minor rupture or major rupture. These findings suggest that therapists of sexual offenders who are dominant may struggle to build a collaborative relationship, however offenders who are hostile may experience more breakdowns, or major ruptures in the therapeutic relationship.

Based on these findings, it is proposed that hostile sexual offenders in treatment, or offenders with hostile and dominant behaviours, have dysfunctional interpersonal patterns of behaviour that lead to breakdowns in the therapeutic relationship. It also may be that ruptures are triggered at certain stages of treatment for different types of offenders. As Horvath and Luborsky (1993) note, a critical stage for the therapeutic alliance is when the therapist challenges the client's dysfunctional patterns or beliefs. Westra and colleagues (2011) note that clients with higher levels of hostility tend to have a lower belief in achieving a positive therapeutic outcome. Therefore, it is possible that hostile sexual offenders may have lower confidence in the efficacy of treatment programmes, or their therapists, or in their perceived ability to make

changes overall, and this may lead to an increased likelihood of experiencing a rupture in the therapeutic relationship. However, this needs further exploration. In addition, it may be beneficial to know whether hostile sexual offenders are more likely to have confrontational or withdrawal type ruptures, and whether these two types of rupture differ in strength and likelihood of repair.

Based on the findings from Study Two, sexual offenders with a more dominant interpersonal style alone were not more likely to experience a rupture in the therapeutic relationship. It was suggested by Drapeau (2005) that offenders with a preference for autonomy or control may be more resistant to therapists being overly dominant or controlling. However, therapists may not have responded to dominant offenders with an overly dominant or directive response. In this study the level of psychopathy also did not differ for those who experienced no rupture, a minor rupture or a major rupture. This was contrary to expectations, as psychopathy has been found to be associated with difficulties with engagement in treatment (Ross et al., 2008) and psychopaths have been shown to have disruptive behaviours within treatment (Hobson, Shine, & Roberts, 2000). Psychopathy has also been shown to be positively correlated with hostile-dominant interpersonal behaviours (Blackburn, 1998; Hillege, Das, & de Ruiter, 2010). It is noted that the lack of significant relationship may be due to the small sample size, or to impression management on behalf of offenders when self-reporting ruptures. In this case it would be beneficial to have the view of therapists on the presence and level of therapeutic ruptures, to determine whether offenders high in psychopathy, and their therapists, experience more breakdowns in the therapeutic relationship.

Rupture repair. The final aim for Study Two was *to determine whether interpersonal or offence-specific factors affect the likelihood of a rupture being*

repaired. Half of the ruptures reported by offenders in this sample were considered to have been repaired. None of the offenders' interpersonal styles or offence-specific factors (age of first sexual offence, victim type) were related to the likelihood of a rupture being repaired. Although offender hostility and hostile-dominance were associated with ruptures in the therapeutic relationship, lower levels of offender hostility was not associated with a higher likelihood of a rupture being repaired. Higher levels of offender affiliation were also not associated with the likelihood of a rupture being repaired. This suggests that even with high levels of offender hostility or dominance, ruptures may still be resolved; more friendly sexual offenders being no more likely to resolve ruptures than those who are considered hostile. It may be that the interpersonal style aspects being measured in the current study did not cover the offender traits that contribute to resolution of ruptures in the therapeutic relationship.

There was no difference in the likelihood of a repair occurring for sexual offenders who had adult victims, child victims, or adult and child victims, although this almost met statistical significance, with the small sample size potentially obscuring any statistically significant relationship. Therefore there may be differences in traits between sexual offenders who have committed offences against adult victims or child victims that may be related to the propensity or ability of a sexual offender to resolve difficulties in the therapeutic relationship. Research on rupture repairs typically focuses on strategies therapists can use to resolve conflict or unresolved emotional states of clients, however there is no known research into the client's contribution to this resolution process. Further research into this field may allow increased understanding into those offender-clients who may be resistant to rupture repairs, or may provide additional challenges for therapists in the resolution process.

Research aims Study Three: Treatment readiness, the therapeutic alliance, interpersonal style and treatment gain. Internal responsivity factors are those individual client characteristics that may impact an offender-clients' ability to benefit from treatment (Andrews et al., 1990). One commonly researched responsivity factor is offender psychopathy, which is thought to impact an offender's ability to make gains from treatment (Seto & Barbaree, 1999). In addition, the interpersonal traits of hostility and dominance have been shown to impact the development of a strong therapeutic alliance (Muran, Segal, Samstag, & Crawford, 1994), however it is currently unknown how these interpersonal traits impact the change process, particularly in sexual offender treatment. It has been shown that a poorer therapeutic alliance is linked to poorer therapeutic outcomes (Polaschek & Ross, 2010), therefore an offender's interpersonal style may impact treatment gain through its impact on the therapeutic alliance. Treatment readiness refers to a pretreatment measure of offender characteristics that may impact their future engagement (Day et al., 2010), and subsequently, treatment gain. There is limited research on treatment readiness in sexual offender populations, although it has been hypothesised that poorer readiness to change would be linked to a poorer therapeutic alliance and reduced treatment gain. A pre-treatment measurement of engagement may be beneficial for therapists undertaking treatment with offenders, as it gives an early intervention point for those who are unlikely to engage in and therefore benefit from treatment.

Therapeutic alliance and treatment gain. The first aim of Study Three was *to ascertain whether offender psychopathy, interpersonal style, treatment readiness or ratings of the therapeutic alliance predict treatment gain.* Looking specifically at whether ratings of the therapeutic alliance would predict treatment gain, it was found that early sexual offender ratings of the therapeutic alliance were unrelated to

treatment gain, whereas offender ratings of therapeutic alliance taken later in treatment were related to treatment gain. This suggests that offenders' views of the therapeutic alliance early in treatment are unrelated to their engagement in future within-treatment change processes and cannot be used to predict outcome. It appears that the development of the therapeutic alliance over the course of treatment may be more indicative of offender change. Those sexual offenders who view the therapeutic alliance more positively later in treatment are more likely to have made (or continue to make) within-treatment changes. Ratings of the therapeutic alliance later in treatment may identify those offenders who have developed a positive collaboration with their therapist/s over the course of treatment. Further analyses were conducted to test this assertion (see Appendix B). It was found that there was a significant difference in offender treatment gain for those offenders who had an improvement in the therapeutic alliance later in treatment, to those who had a reduction in the strength of the therapeutic alliance. It is unknown, based on the current study, whether this is a high-low-high pattern of alliance as suggested by Horvath and Luborsky (1993), or a directly linear improvement in the therapeutic alliance over the course of treatment (Stevens, Muran, Safran, Gorman, & Winston, 2007). It may be beneficial for future research to determine whether a specific treatment module in the programme adversely impacts the therapeutic alliance (potentially creating rupture events), due to therapists challenging offenders' dysfunctional patterns or beliefs (Horvath & Luborsky, 1993), or whether the therapeutic alliance continues to develop in a linear way, with any rupture events occurring in smaller, more localised ways (Stevens et al., 2007). Importantly, these findings suggest that it is important not just to look at the therapeutic alliance as a static score, but rather to note the pattern of, and changes to, the therapeutic alliance over time.

Unlike offenders' early ratings of the therapeutic alliance, therapists' early ratings of the therapeutic alliance were related to offender within-treatment change (see Appendix B). This shows that therapists' perceptions of a poor therapeutic alliance early in treatment is related to a lower level of offender change over the course of treatment. It is noted that therapists' ratings of the therapeutic alliance were significantly lower than offender ratings of the therapeutic alliance at the same time point (as assessed in Study One), they were also found to be significantly lower than offender ratings of the therapeutic alliance late in treatment (see Appendix B). Both therapist and offender-rated therapeutic alliance had a moderate effect on treatment gain. Morgan, Luborsky, Crits-Christoph, Curtis, and Solomon (1982) reported that the treatment process accounts for approximately 25% of variance in treatment outcome in a non-forensic setting. The treatment process was noted to incorporate therapists' characteristics, client's perspective of the therapist, the group climate and the therapeutic alliance. Looking at the therapeutic alliance in isolation, this has consistently been found to have an effect size of approximately .22 to .28 with non-forensic psychotherapy populations (Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin et al., 2000). The current study found that, within a sexual offender population, the relationship between early therapists' ratings of the therapeutic alliance and treatment gain had an effect size of .32, with 10% of variance in treatment gain accounted for by the therapeutic alliance. The relationship between late offender ratings of the therapeutic alliance and treatment gain was consistent with therapists' ratings, with an effect size of .30 and 9% of variance in treatment gain explained by the therapeutic alliance. This suggests that the therapeutic alliance accounts for a significant proportion of the variance explained by the treatment process overall, however other aspects could be incorporated into future research,

such as the group climate, to further account for the influence of process variables on therapeutic outcome.

Although therapists' early ratings of the therapeutic alliance were more pessimistic overall compared to offenders' ratings (findings from Study One), they were still significantly related to the offender's therapeutic outcome. They were also more indicative of whether an offender would make change within-treatment than were offender's perceptions of the therapeutic alliance at that time point. It is unknown whether therapists ratings of the therapeutic alliance later in treatment would be related to therapeutic change, as this data was not collected in the current study due the extra burden this would place on therapists. Therapists and offenders viewed the therapeutic alliance differently, and their views of the therapeutic alliance also had a different relationship with offender within-treatment change. These findings are inconsistent with findings by Polaschek and Ross (2010) who found that early therapist ratings of the therapeutic alliance with a violent offender population did not predict treatment outcome, however, like the current study, positive change in the therapeutic alliance over time did predict treatment outcome. Although looking at a different population, the inconsistencies noted here suggest that further studies would be needed to determine whether the findings from the current study are consistent over different samples. Tentatively, these preliminary findings suggest that a better measure of the therapeutic alliance earlier in the change process would be therapists' ratings of the alliance, whereas, the significant offender ratings of the therapeutic alliance occurred much later in the change process, towards the end of treatment, leaving less time to intervene. Ascertaining therapists' ratings of the therapeutic alliance may encourage intervention earlier in treatment to potentially improve therapeutic outcomes.

Surprisingly, this study found that a breakdown or rupture in the therapeutic relationship was not related to treatment gain, as there was no difference in level of treatment gain for those sexual offenders who experienced no rupture/minor rupture, or a major rupture in treatment. Although there was a significant difference in gain ratings for sexual offenders whose therapeutic alliance reduced over the course of treatment, and those whose therapeutic alliance increased over the course of treatment. This suggests that specific, discrete incidents of therapeutic ruptures were less important to whether offenders made within-treatment changes than the overall growth or trajectory of the therapeutic alliance. This is consistent with research by Stevens and colleagues (2007), who found that that the therapeutic alliance for psychotherapy patients with personality disorders typically increased in strength over the course of the therapeutic programme, and that although half of the clients in the study reported ruptures in the therapeutic alliance, these ruptures were not related to therapeutic outcomes. It is thought that if a repaired rupture can lead to improved therapeutic outcomes (Stiles et al., 2004; Strauss et al., 2006), that the presence of a rupture itself would be detrimental to an offender's ability to make within-treatment changes, however this was not supported by the current study. One possible explanation for this is the smaller sample size of offenders who reported experiencing a rupture in the therapeutic alliance, reducing the statistical power of the analyses. Beyond looking at the strength of the ruptures, the nature of these ruptures may be further explored to determine their impact on within-treatment change, including the length of the rupture, the impact on an offender's view of engagement while the rupture is occurring, whether the rupture impacts an offender's view of treatment, if the rupture is related to treatment content, or whether the rupture generalises to both therapists (when treatment is co-facilitated) or to group members. There may be

certain types or patterns of ruptures that have greater impact on the therapeutic alliance, within-treatment change and recidivism.

Interpersonal style and treatment gain. Sexual offenders with more dominant and hostile-dominant interpersonal styles had lower levels of treatment gain, however offender hostility was unrelated to treatment gain. Therefore, dominant and hostile-dominant offenders were less likely to make therapeutic changes within treatment. This is somewhat inconsistent with previous research, as it was found that for depressed patients, low levels of affiliation was also associated with reduced treatment gain (Hardy et al., 2001), albeit this was a non-forensic study. However, there is limited information about the impact of interpersonal style on within-treatment change in offender populations. Given this finding, and the findings from Study One and Study Two, it appears that dominant offender interpersonal traits may impact their therapist's ability to establish or maintain a collaborative therapeutic relationship, and the offender's ability make changes during treatment. Dominant sexual offenders did not view the therapeutic alliance poorly, and did not experience increased ruptures in the therapeutic alliance. Offenders with dominant traits may be less open to making change.

Hostile sexual offenders were more likely to rate the therapeutic alliance as weaker; they were also more likely to experience ruptures in the therapeutic alliance. This suggests that hostile sexual offenders may struggle to maintain a strong and consistent therapeutic relationship, but they are still able to make within-treatment change, even with conflict or relational instability being present. It is noted that hostile sexual offenders were also more likely to view the therapeutic alliance negatively, whereas dominant offenders did not (Study One). Therefore, it appears that hostility and dominance have different impacts upon the therapeutic relationship

(including the therapeutic alliance) and within-treatment changes. This suggests that hostile and dominant sexual offenders possibly have different relational needs, and their behaviours may have different functional drives that potentially need to be addressed in different ways by therapists. For example, it appears that hostile offenders are more likely to perceive difficulties with others, which may stem from early relational patterns, therefore therapists may focus on addressing any relational concerns. By contrast, dominant offenders may not be aware of the difficulties posed by their dominant behaviours, and may be less concerned with relational difficulties. These offenders may benefit from addressing their challenges with tasks or goals, or with applying treatment-related changes.

In addition to offender dominance and hostile-dominance impacting within-treatment change, total psychopathy scores were also related to treatment gain, however this was related specifically to the affective and interpersonal component of psychopathy, rather than the antisocial lifestyle component (which was not related to treatment gain). Those offenders with higher levels of affective and interpersonal psychopathic traits, indicative of the psychopathic personality, were less likely to make within-treatment change. Therefore, traits of glibness/superficiality, grandiosity, shallowness of emotions and a lack of empathy may impact sexual offenders' level of change made throughout treatment. This is consistent with previous research, which found that the personal/affective traits of psychopathy were more related to negative outcome for psychopathic offenders (including increased recidivism rates and disruptive within-group behaviours; Hare, Clark, Grann, & Thornton, 2000; Hobson, Shine, & Roberts, 2000). It is unknown, from the current study, whether psychopathic sexual offenders had poorer group behaviours, a lack of participation or were unable to demonstrate applied changes to newly developed

skills or knowledge. However, it is noted that there was no statistical relationship between psychopathy and the presence of ruptures in the therapeutic relationship (Study Two), although this may be due to the small sample size in the current study. It is noted that in the body of literature the relationship between within-treatment change for psychopathic offenders and recidivism rates is not straightforward. For example, previous studies found that those psychopathic offenders who made positive gains reoffended at a higher rate than those who made poorer gains (Seto & Barbaree, 1999). Although upon follow up (Barbaree, 2005) over an extended period of time, the differences between groups became non-significant (although the trend was still noted). Therefore, it is unknown whether a lack of treatment gain for psychopathic offenders in the current study would be related to increased recidivism.

Moderation effect. The second aim of Study Three was *to determine whether the association between offender characteristics and treatment gain was moderated by the therapeutic alliance*. Surprisingly there was no interaction between offender interpersonal style (hostile-dominance or psychopathic personality) and the therapeutic alliance upon treatment gain. Therefore, the presence of a stronger or weaker therapeutic alliance did not moderate the effect of interpersonal style on treatment gain. When combined, it was found that offender hostile-dominance was a significant predictor of treatment gain, whereas late-rated therapeutic alliance was not significantly associated. This was also found with offender psychopathic personality. This suggests that there is a considerable overlap in the constructs being measured, particularly in regards to their impact on offender's within-treatment change. Although, independently, therapeutic alliance and hostile-dominance or psychopathic personality) are predictors of treatment gain, it appears that offender hostile-dominance and psychopathy are stronger predictors of treatment gain than the

therapeutic alliance. Offender interpersonal style has been found to predict both the therapeutic alliance (hostility and dominance) and treatment gain (dominance and hostile-dominance), however, if an offender's interpersonal style impacts their therapeutic alliance within-treatment change can still be made, particularly with hostile offenders.

Treatment readiness and treatment gain. Sexual offender treatment readiness was not related to treatment gain. Although the therapeutic alliance was found to be related to treatment gain, this pre-treatment measure of engagement (conceptualised through the alliance) did not predict gains in treatment. However, in the current study, treatment readiness was found to be related to both therapist and offender ratings of the therapeutic alliance early in treatment (see Appendix B); however this does not relate to whether an offender will make within-treatment changes. Other studies have reported that treatment readiness has impact on ratings of the therapeutic alliance, and the therapeutic alliance has been found to impact within-treatment change. However, readiness itself does not have a direct relationship with a sexual offenders' level of within-treatment change. This suggests that sexual offenders with low efficacy, attitudes supportive of their offending, low motivation to change and a low level of guilt and remorse for offending, may still be able to make positive treatment-related changes.

Implications

Sexual offender interpersonal style has been found to be an important responsivity factor that impacts not only the treatment process, but also treatment outcome. Sexual offender dominance has been found to be related to within-treatment change, whereas hostility is important to the breakdown or ruptures in the therapeutic relationship. Therefore, these different interpersonal traits impact offender

responsivity differently, with dominance impacting offender change, and hostility impacting the therapeutic relationship. Even with these concerns, in this study the therapeutic alliance strengthened over time, showing that the alliance can, to a certain degree, withstand challenges and difficulties stemming from interpersonal style. This is supported by the finding that ruptures are unrelated to offender change, therefore the change process can still occur even though difficulties occur in the therapeutic relationship. These findings provide support for Ross and colleagues (2008) Revised Theory of the Therapeutic Alliance, as both offender and therapist interpersonal style have been found to impact the therapeutic alliance, although there is a greater complexity discovered here, as it differs depending upon who is perceiving the therapeutic alliance. Sexual offender hostility alone was found to be relevant across perspectives. This would need to be taken into account in any future work on this Revised Theory. In addition, the therapeutic alliance assessed at different stages of treatment, as well as the different perspectives (therapist and offender), had different relationships with therapeutic gain. The findings suggest that therapist ratings are more relevant earlier in treatment, and offender ratings later in treatment; therefore, not only is it important who the rater of the therapeutic alliance is, but also when the therapeutic alliance is rated. Overall, the findings from the current study support the broader findings in the general literature, however they also highlight the differential role that different interpersonal styles play when impacting the therapeutic alliance and also within-treatment change.

When looking at the implications of these findings for therapists working in sexual offender rehabilitation, it is important to understand that different offender interpersonal difficulties can impact the treatment process differently. Dysfunctional interpersonal behaviours stem from childhood experiences, and may provide a

different function for different offenders. Consistent with past research, the current findings suggest that therapists' behaviours can and do impact the quality of the therapeutic alliance, particularly in regards to how the offender views the alliance. This can also impact the level of change made by offenders during treatment, particularly if the alliance is still viewed poorly towards the end of treatment. It is noted that when challenges occur in the therapeutic relationship, that it is often best for therapists to respond in a non-defensive manner and to allow space for offenders to give voice to their concerns and to explore underlying feelings.

From the current findings, it is noted that therapists can differentiate problems that may arise based on the presentation of the offender. Hostile offenders are likely to view the therapeutic relationship (including the therapeutic alliance) itself poorly, whereas more dominant offenders are potentially less likely to make change. Therefore, a different approach can be recommended based on presenting interpersonal behaviours of the offender. With dominant sexual offenders, these findings suggest that it may be beneficial to focus on applying skills or knowledge attained during treatment (and any barriers they may have to applying these skills), whereas with hostile offenders, it may be more beneficial to process any challenges within the therapeutic relationship. Therapists can draw on the knowledge that ruptures in the therapeutic relationship do not have to lead to reduced therapeutic gains, and that improvement of the therapeutic alliance over time can increase overall gains. Therefore, even with challenging clients, improvement can be made over time.

Limitations

A key limitation to the current study is the small sample size, which may have obscured some potentially relevant findings. Therefore, future research is needed before ruling out relationships that were found to be statistically non-significant here.

The current study's sample was limited due to the community sample not returning questionnaires, as they were required to complete them outside of group time and return the completed questionnaires to the researcher by post. The small sample was also associated with more limited success with receiving completed responses from treating therapists. In addition, community-based offenders were more challenging to recruit due to the timings of the group session conflicting with other clinical training requirements and commitments of the key researcher.

Another limitation was the lack of measure of impression management, given the mandated setting, with the majority of offenders coming up for parole; this may have biased their responses even though they were informed the study would have no impact on their treatment. Given the inclusion of sexual offenders with psychopathic personality traits, inclusion of a measure of social desirability would also have been beneficial, as it has previously been found that positive perspectives of engagement and change of psychopathic offenders by therapists did not always lead to real-world changes. This could be conducted using a measure of impression management, as available in a sub-scale of the Paulhus Deception Scale, to provide additional support for the accuracy and robustness of study findings. Furthermore, the lack of recidivism data, due to the constraints of time, did not allow for an analysis on how these responsivity factors, process factors and within-treatment changes apply to reduced reoffending over time. Another limitation was the measurement of ruptures at the three quarter point of treatment, as ruptures may have occurred after this time and thus were not accounted for in our analyses.

A final limitation was the low cronbach's alpha levels found for the offender-ratings on the IMI-C, suggesting poor internal consistency for the subscales of; hostility, submission, and friendly-dominance. As well as a low cronbach's alpha

found for the efficacy subscale on the CVTRQ, which may have impacted the reliability of the results drawn from these subscales.

The current study was also limited in its exploration of ruptures. Further data could have been gathered in regards to whether therapists viewed ruptures in the therapeutic relationship and also whether these ruptures were specifically related to any reduced sense of collaboration on tasks, goals or reduction in the strength of the bond. A future study focused specifically on ruptures could explore this in more detail. One way to do this would be to include measures of working alliance at more regular intervals during treatment, as well as providing space for open-ended questions to further explore the nature of the ruptures in a more nuanced and detailed manner. However given the breadth of the current study this was deemed to be too burdensome for the participants which may have led to further compromise of the sample size. Further, the group dynamic itself was not measured; it is possible the offenders' perspectives of the therapeutic alliance were impacted by the secondary facilitator or by other group dynamics, however this was not explored here. Finally, the composite measure of change used did not allow for a more complex exploration of the impact of responsivity and treatment process factors on how offenders engage in specific aspects of the group content, or participation factors.

Future Research Directions

Future research could focus on how responsivity and process factors influence the within-treatment change process, and whether they can improve upon the current reductions in treated offenders' recidivism (average of 20%). This can include analysis of the impact of these factors on sexual, general and violent recidivism. The within-treatment change process can be further explored through measuring specific indices of change, such as individual components of treatment or criminogenic needs,

or aspects of participation and within-group behaviours. Additionally, some offenders may find change itself difficult, regardless of the specific situation where change is required. The findings from the current study suggest that dominant sexual offenders are less likely to make changes. This could be further explored through qualitative research, or through specific measures related to change, or openness to change.

In order to further understand how hostility may impact breakdowns or ruptures in the therapeutic relationship, as well as poorer therapeutic alliance (as rated by both therapists and offenders), other narrative based approaches could be used to explore and document hostile offenders' views on the therapeutic alliance and their expectations regarding these relationships. Additionally, the current study did not find a significant relationship between offender characteristics and rupture repair. Future researchers with a larger sample size could possibly explore this further (as these results approached statistical significance); it may be that sexual offenders with child victims are more likely to repair a rupture than sexual offenders with adult victims. This repair process could be further explored by ascertaining the views of both offenders and therapists to determine likely areas that have the most influence on this repair process, using open-ended, explorative questions. Guidance may also be gained from previous research, as it has been suggested that therapists allowing space for offenders to acknowledge and express their feelings, without the therapists being defensive, allows for repairs to occur. In addition, there may be a different process for withdrawal and confrontational ruptures, and for ruptures that have been recognised by therapists and those that have not.

Another area of potential future research would be to consider the potential influence of group dynamics. It may be useful to know how sexual offender and therapist interpersonal style impacts the group dynamic, and whether this group

dynamic impacts the perception of the therapeutic alliance, as well as the level of treatment gain. To further explore the relevance of the Revised Theory of the Therapeutic Alliance, additional offender and therapists characteristics can be analysed to determine their relevance to the development of the therapeutic alliance and ruptures or repairs in the alliance (for example attachment style, or schemas).

Conclusions

In conclusion, sexual offender interpersonal style was found to impact both the treatment process via the therapeutic alliance, as well as treatment gain directly. Both therapists' and sexual offenders' hostile or dominant interpersonal styles impacted the strength of the alliance. However, complementarity in interpersonal styles was not found to be important for a strong therapeutic alliance. Specifically, hostile or hostile-dominant offender interpersonal styles increased the chance of ruptures in the therapeutic relationship, however offender dominance did not. Alternatively, offender dominance, hostile-dominance, psychopathic personality and the therapeutic alliance were all found to be related to treatment gain. Therefore, it appears that hostile offenders are more likely to have a poorer view of the therapeutic relationship, whereas dominant offenders have difficulty making within-treatment changes. Those offenders who experienced no rupture in the therapeutic relationship had a stronger view of the therapeutic alliance than offenders who experienced a rupture in the therapeutic relationship that was not repaired. However, there was no significant difference between those that experienced a rupture with repair. This is inconsistent with theories that suggest repairing a rupture in the therapeutic relationship can strengthen the alliance compared to those who experience no ruptures. Overall, the expected relationship that offenders' interpersonal styles impacts treatment gain through its moderation of the therapeutic alliance was not supported. Therefore, the

mechanisms of how offenders' interpersonal styles impact this change process need further empirical investigation.

References

- ABS (2011). Prisoners in Australia, 2011. *ABS cat. no. 45170.0* Retrieved 6 Jan, 2011, from <http://www.abs.gov.au/ausstats/abs@.nsf/mf/45170.0>
- Ackerman, S.J., & Hilsenroth, M.J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, *38*, 171-185. doi:10.1037/0033-3204.38.2.171
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Andrews, D., & Bonta, J. (2010). Rehabilitating criminal justice policy and practice. *Psychology, Public Policy, and Law*, *16*, 39-55. doi:0.1037/a0018362
- Andrews, D., Bonta, J., & Wormith, J. (2011). The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention? *Criminal Justice and Behavior*, *38*, 735-755. doi:10.1177/0093854811406356
- Andrews, D., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P., & Cullen, F.T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, *28*, 369-404. doi:10.1111/j.1745-9125.1990.tb01330.x
- Ashby, J.D., Ford, D.H., Guernsey, B.G., & Guernsey, L.F. (1957). Effects on clients of a reflective and leading type of psychotherapy. *Psychological Monographs*, *71*, 1-32. doi:10.1037/h0093778

- Auerbach, S.M, May, J.C., Stevens, M., & Kiesler, D.J, (2008). The interactive role of working alliance and counselor-client interpersonal behaviors in adolescent substance abuse treatment. *International Journal of Clinical and Health Psychology, 8*, 617-629. Recovered from <http://www.redalyc.org/articulo.oa?id=33712016001>
- Australian Institute of Criminology (2011). Prison-based correctional rehabilitation: An overview of intensive interventions for moderate to high-risk offenders. *Trends & Issues in Crime and Criminal Justice, 412*, 1-6. Retrieved from http://www.aic.gov.au/media_library/publications/tandi_pdf/tandi412.pdf
- Baillargeon, P., Coté, R., & Douville, L. (2012). Resolution process of therapeutic alliance ruptures: A review of the literature. *Psychology, 3*, 1049-1058. doi:10.4236/psych.2012.312156
- Baldry, E., McDonnell, D., Maplestone, P., & Peeters, M. (2006). Ex-prisoners, homelessness and the State in Australia. *Australian and New Zealand Journal of Criminology, 39*, 20-33. doi:10.1375/acri.39.1.20
- Barbaree, H.E. (2005). Psychopathy, treatment behavior, and recidivism: An extended follow-up of Seto and Barbaree. *Journal of Interpersonal Violence, 20*, 1115-1131. doi:10.1177/0886260505278262
- Barnett, G. Wakeling, H., Mandeville-Norden, R., & Rakestrow, J. (2013). Does change in psychometric test scores tell us anything about risk of reconviction in sexual offenders? *Psychology, Crime & Law, 19*, 85-110. doi:10.1080/1068316X.2011.607820

- Barrett, M., Wilson, R.J., & Long, C. (2003). Measuring motivation to change in sexual offenders from institutional intake to community treatment. *Sexual Abuse: A Journal of Research and Treatment, 15*, 269-283.
doi:10.1177/107906320301500404
- Beauford, J.E., McNiel, D.E., & Binder, R.L. (1997). Utility of the initial therapeutic alliance in evaluating psychiatric patients' risk of violence. *The American Journal of Psychiatry, 154*, 1272-1276. doi:10.1176/ajp.154.9.1272
- Beazley, P., & Gudjonsson, G. (2011). Motivating inpatients to engage with treatment: The role of depression and ward atmosphere. *Nordic Journal of Psychiatry, 65*, 95-100. doi:10.3109/08039488.2010.502244
- Becker, J.V., Abel, G.G., Blanchard, E.B., Murphy, W.D., & Coleman, E. (1978). Evaluating social skills of sexual aggressives. *Criminal Justice and Behavior, 5*, 357-367. doi:10.1177/009385487800500407
- Beech, A., & Ford, H. (2006). The relationship between risk, deviance, treatment outcome and sexual reconviction in a sample of child sexual abusers completing residential treatment for their offending. *Psychology, Crime & Law, 12*, 685-701. doi:10.1080/10683160600558493
- Beech, A., & Fordham, A.S. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment, 9*, 219-237.
doi:10.1177/107906329700900306
- Beech, A., & Hamilton-Giachritsis, C.E. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment, 17*, 127-140.
doi:10.1177/107906320501700204

- Beggs, S.M. (2010). Within-treatment outcome among sexual offenders: A review. *Aggression and Violent Behavior, 15*, 369–379.
doi:10.1016/j.avb.2010.06.005
- Beggs, S.M., & Grace, R.C. (2011). Treatment gain for sexual offenders against children predicts reduced recidivism: A comparative validity study. *Journal of Consulting and Clinical Psychology, 79*, 182-192. doi:10.1037/a0022900
- Belding, M.A., Iguchi, M.Y., Morral, A.R., & McLellan, A.T. (1997). Assessing the helping alliance and its impact in the treatment of opiate dependence. *Drug and Alcohol Dependence, 48*, 51–59. doi:10.1016/S0376-8716(97)00103-8
- Bender, D.S. (2005). The therapeutic alliance in the treatment of personality disorders. *Journal of Psychiatric Practice, 11*, 73-87.
doi:10.1080/10503300512331327047
- Benjamini, Y., & Hochberg, Y. (1995). Controlling the false discovery rate: A practical and powerful approach to multiple testing. *Journal of the Royal Statistical Society: Series B (Methodological), 57*, 289–300. Retrieved from <http://www.jstor.org/stable/2346101>
- Best, D., Day, E., Campbell, A., Flynn, P.M., & Simpson, D. (2009). Relationship between drug treatment engagement and criminal thinking style among drug-using offenders. *European Addiction Research, 15*, 71-77.
doi:10.1159/000189785
- Bethea, A.R., Acosta, M.C., & Haller, D.L. (2008). Patient versus therapist alliance: Whose perception matters? *Journal of Substance Abuse Treatment, 35*, 174-183. doi:10.1016/j.jsat.2007.09.007

- Bilgin, H. (2009). An evaluation of nurses' interpersonal styles and their experiences of violence. *Issues in Mental Health Nursing, 30*, 252-259.
doi:10.1080/01612840802710464
- Black, S., Hardy, G., Turpin, G., & Parry, G. (2005). Self-reported attachment styles and therapeutic orientation of therapists and their relationship with reported general alliance quality and problems in therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 78*, 363-377.
doi:10.1348/147608305X43784
- Blackburn, R. (1998). Criminality and the interpersonal circle in mentally disordered offenders. *Criminal Justice and Behavior, 25*, 155-176.
doi:10.1177/0093854898025002001
- Blackburn, R. (1998). Relationship of personality disorders to observer ratings of interpersonal style in forensic psychiatric patients. *Journal of Personality Disorders, 12*, 77-85. doi:10.1521/pedi.1998.12.1.77
- Blackburn, R., & Renwick, S.J. (1996). Rating scales for measuring the interpersonal circle in forensic psychiatric patients. *Psychological Assessment, 8*, 76-84.
doi:10.1037/1040-3590.8.1.76
- Blasko, B.L., & Jeglic, E.L. (2014). Sexual offenders' perceptions of the client-therapist relationship: The role of risk. *Sexual Abuse: A Journal of Research and Treatment, 1-20*. doi:10.1177/1079063214529802
- Bonta, J., & Andrews, D.A. (2007). *Risk-Need-Responsivity Model for Offender Assessment and Rehabilitation 2007-06*. Ottawa: Public Safety Canada.
- Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*, 252-260.
doi:10.1037/h0085885

- Brown, P.D., & O'Leary, K. (2000). Therapeutic alliance: Predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting and Clinical Psychology, 68*, 340-345. doi:10.1037/0022-006X.68.2.340
- Casey, S., Day, A., & Howells, K. (2005). The application of the transtheoretical model to offender populations: Some critical issues. *Legal and Criminological Psychology, 10*, 157-171. doi:10.1348/135532505X36714
- Casey, S., Day, A., Howells, K., & Ward, T. (2007). Assessing suitability for offender rehabilitation: Development and validation of the Treatment Readiness Questionnaire. *Criminal Justice and Behavior, 34*, 1427-1440. doi:10.1177/0093854807305827
- Caspar, F., Grossman, C., Unmüssig, C., & Schramm, E. (2005). Complementary therapeutic relationship: Therapist behavior, interpersonal patterns and therapeutic effects. *Psychotherapy Research, 15*, 91-102. doi:10.1080/10503300512331327074
- Chen, M.K., & Shapiro, J.M. (2007). Do harsher prison conditions reduce recidivism? A discontinuity based approach. *American Law and Economics Review, 9*, 1-29. doi:10.1093/aler/ahm006
- Coady, N.F. (1991). The association between client and therapist interpersonal processes and outcomes in psychodynamic psychotherapy. *Research on Social Work Practice, 1*, 122-138. doi:10.1177/104973159100100202
- Cooke, D.J. (1997). Psychopaths: Oversexed, overplayed but not over here? *Criminal Behaviour and Mental Health, 7*, 3-11. doi:10.1002/cbm.141
- Cooke, D.J., Michie, C., Hart, S., & Hare, R.D. (1999). Evaluating the screening version of the Hare Psychopathy Checklist-Revised (PCL:SV). *Psychological Assessment, 11*, 3-13. doi:10.1037/1040-3590.11.1.3

- Cookson, A., Daffern, M., & Foley, F. (2012). The relationship between aggression, interpersonal style and therapeutic alliance during short-term psychiatric hospitalisation. *International Journal of Mental Health Nursing, 21*, 20-29. doi:10.1111/j.1447-0349.2011.00764.x
- Critchfield, K.L., & Benjamin, L.S. (2006). Principles for psychosocial treatment of personality disorder: Summary of the APA Division 12 Task Force/NASPR review. *Journal of Clinical Psychology, 62*, 661-674. doi:10.1002/jclp.20255
- Crits-Christoph, P., Hamilton, J.L., Ring-Kurtz, S., Gallop, R., McClure, B., Kulaga, A., & Rotrosen, J. (2011). Program, counselor, and patient variability in the alliance: A multilevel study of the alliance in relation to substance use outcomes. *Journal of Substance Abuse Treatment, 40*, 405-413. doi:10.1016/j.jsat.2011.01.003
- Daffern, M., Duggan, C., Huband, N., & Thomas, S. (2008). The impact of interpersonal style on aggression and treatment non-completion in patients with personality disorder admitted to a medium secure psychiatric unit. *Psychology, Crime & Law, 14*, 481-492. doi:10.1080/10683160801948717
- Daffern, M., Duggan, C., Huband, N., & Thomas, S. (2010). Staff and patient's perceptions of each other's interpersonal style: Relationship with severity of personality disorder. *International Journal of Offender Therapy and Comparative Criminology, 54*, 611-624. doi:10.1177/0306624X09335111
- Daffern, M., Thomas, S., Ferguson, M., Podubinski, T., Hollander, Y., Kulkhani, J., . . . Foley, F. (2010). The impact of psychiatric symptoms, interpersonal style, and coercion on aggression and self-harm during psychiatric hospitalization. *Psychiatry: Interpersonal and Biological Processes, 73*, 365-381. doi:10.1521/psyc.2010.73.4.365

- Daffern, M., Thomas, S.D.M., Podubinski, P., Hollander, Y., Kulkarni, J., de Castella, A., et al. (2010b). The impact of psychiatric symptoms, interpersonal style and coercion on aggression during psychiatric hospitalization. *Psychiatry and Biological Processes*, *73*, 365–382.
doi:10.1521/psyc.2010.73.4.365
- Daffern, M., Tonkin, M., Howells, K., Krishnan, G., Ijomah, G., & Milton, J. (2010a). The impact of interpersonal style and perceived coercion on aggression and self-harm in personality-disordered patients admitted to a secure psychiatric hospital. *Journal Of Forensic Psychiatry & Psychology*, *21*, 426-445. doi:10.1080/14789940903505951
- Davis, L.W., & Lysaker, P.K. (2007). Therapeutic alliance and improvements in work performance over time in patients with schizophrenia. *Journal of Nervous and Mental Disease*, *195*, 353-357.
doi:10.1097/01.nmd.0000261954.36030.a1
- Day, A., Bryan, J., Davey, L., & Casey, S. (2006). The process of change in offender rehabilitation programmes. *Psychology, Crime & Law*, *12*, 473-487.
doi:10.1080/10683160500151209
- Day, A., Casey, S., Ward, T., Howells, K., & Vess, J. (2010). *Transitions to Better Lives: Offender Readiness and Rehabilitation*. Devon, UK: Willan Publishing.
- Day, A., Howells, K., Casey, S., Ward, T., Chambers, J. C., & Birgden, A. (2009). Assessing treatment readiness in violent offenders. *Journal of Interpersonal Violence*, *24*, 618-635. doi:10.1177/0886260508317200

- Department of Justice (2012). *Sex Offender Programs MMIP Information Sheet*. Retrieved from http://assets.justice.vic.gov.au/corrections/resources/d8549507-a6ee-483f-9f37-750d3639b9a5/modular+management+intervention+program+_mmip_.pdf
- Derks, F.C.H. (1996). A forensic day treatment program for personality disordered criminal offenders. *International Journal of Offender Therapy and Comparative Criminology*, 40, 123–134. doi:10.1177/0306624X96402005
- Diener, M.J., & Monroe, J.M. (2011). The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: A meta-analytic review. *Psychotherapy*, 48, 237-248. doi:10.1037/a0022425
- Dowden, C., & Andrews, D. (2000). Effective correctional treatment and violent reoffending: A meta-analysis. *Canadian Journal of Criminology*, 42, 449-467. Retrieved from <http://web.b.ebscohost.com.ezproxy.lib.monash.edu.au/ehost/pdfviewer/pdfviewer?sid=c9cc8476-a707-4d54-bf25-813669a084e5%40sessionmgr115&vid=3&hid=124>
- Doyle, M., & Dolan, M. (2006). Evaluating the validity of anger regulation problems, interpersonal style, and disturbed mental state for predicting inpatient violence. *Behavioral Sciences & the Law*, 24, 783-798. doi:10.1002/bsl.739
- Drapeau, M. (2005). Research on the processes involved in treating sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 17, 117-125. doi:10.1177/107906320501700203

- Drieschner, K.H., & Boomsma, A. (2008). The Treatment Engagement Rating scale (TER) for forensic outpatient treatment: Description, psychometric properties, and norms. *Psychology, Crime & Law, 14*, 299-315.
doi:10.1080/10683160701858206
- Drieschner, K.H., Lammers, S.M., & van der Staak, C.P. (2004). Treatment motivation: An attempt for clarification of an ambiguous concept. *Clinical Psychology Review, 23*, 1115-1137. doi:10.1016/j.cpr.2003.09.003
- Dryer, D., & Horowitz, L.M. (1997). When do opposites attract? Interpersonal complementarity versus similarity. *Journal of Personality and Social Psychology, 72*, 592-603. doi:10.1037/0022-3514.72.3.592
- Duggan, C. (2009). A treatment guideline for people with antisocial personality disorder: Overcoming attitudinal barriers and evidential limitations. *Criminal Behaviour and Mental Health, 19*, 219-223. doi:10.1002/cbm.726
- Dunkle, J.H. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology, 43*, 456-460.
doi:10.1037/0022-0167.43.4.456
- Eames, V., & Roth, A. (2000). Patient attachment orientation and the early working alliance: A study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research, 10*, 421-434. doi:10.1093/ptr/10.4.421
- Edens, J.F. (2009). Interpersonal characteristics of male criminal offenders: Personality, psychopathological, and behavioral correlates. *Psychological Assessment, 21*, 89-98. doi:10.1037/a0014856
- Elkin, I., Yamaguchi, J.L., Arnkoff, D.B., Glass, C.R., Sotsky, S.M., & Krupnick, J. L. (1999). "Patient-treatment fit" and early engagement in therapy. *Psychotherapy Research, 9*, 437-451. doi:10.1080/10503309912331332851

- Estroff, S.D., & Nowicki, S. (1992). Interpersonal complementarity, gender of interactants, and performance on puzzle and word tasks. *Personality and Social Psychology Bulletin*, *18*, 351-356. doi:10.1177/0146167292183012
- Fishbein, D., Sheppard, M., Hyde, C., Hubal, R., Newlin, D., Serin, R., . . . Alesci, S. (2009). Deficits in behavioral inhibition predict treatment engagement in prison inmates. *Law and Human Behavior*, *33*, 419-435. doi:10.1007/s10979-008-9163-7
- Flückiger, C., Del Re, A.C., Wampold, B.E., Symonds, D., & Horvath, A.O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology*, *59*, 10-17. doi:10.1037/a0025749
- Frost, A., & Connolly, M. (2004). Reflexivity, reflection, and the change process in offender work. *Sexual Abuse: Journal of Research and Treatment*, *16*, 365–380. doi:10.1177/107906320401600408
- Gallagher, C.A., Wilson, D.B., Hirschfield, P., Coggeshall, M.B., & MacKenzie, D.L. (1999). A quantitative review of the effects of sex offender treatment on sexual reoffending. *Corrections Management Quarterly*, *3*, 19–29. Recovered from <http://search.proquest.com.ezproxy.lib.monash.edu.au/docview/214564784?accountid=12528>
- Gallo, L.C., Smith, T.W., & Ruiz, J.M. (2003). An interpersonal analysis of adult attachment style: Circumplex descriptions, recalled developmental experiences, self-representations and interpersonal functioning in adulthood. *Journal of Personality*, *71*, 141-181. doi:10.1111/1467-6494.7102003
- Garner, B.R., Godley, S.H., & Funk, R.R. (2008). Predictors of early therapeutic alliance among adolescents in substance abuse treatment. *Journal of Psychoactive Drugs*, *40*, 55-65. doi:10.1080/02791072.2008.10399761

- Gelb, K. (2007). *Recidivism of Sex Offenders Research Paper*. Sentencing Advisory Council. Melbourne: Victoria.
- Gretton, H.M., McBride, M., Hare, R.D., O' Shaughnessy, R., & Kumka, G. (2001). Psychopathy and recidivism in adolescent sex offenders. *Criminal Justice and Behavior, 28*, 427-449. doi:10.1177/009385480102800403
- Hall, G.C.N. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. *Journal of Consulting and Clinical Psychology, 6*, 802–809. doi:10.1037/0022-006X.63.5.802
- Hanson, R., Bourgon, G., Helmus, L., & Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior, 36*, 865-891. doi:10.1177/0093854809338545
- Hanson, R.K., & Bussière, M.T. (1996). *Predictors of Sexual Offender Recidivism: A Meta-Analysis. (User Report 96-04)*. Ottawa: Department of the Solicitor General of Canada.
- Hanson, R.K., & Bussière, M.T. (1998). Predicting relapse: a meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*, 348-362. doi:10.1037/0022-006X.66.2.348
- Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V.L., et al. (2002). First report of the Collaborative Outcome Project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*, 169– 194. doi:10.1177/107906320201400207

- Hardy, G.E., Cahill, J., Shapiro, D.A., Barkham, M., Rees, A., & Macaskill, N. (2001). Client interpersonal and cognitive styles as predictors of response to time-limited cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 69*, 841-845. doi:10.1037/0022-006X.69.5.841
- Hardy, G.E., Stiles, W.B., Barkham, M., & Startup, M. (1998). Therapist responsiveness to client interpersonal styles during time-limited treatments for depression. *Journal of Consulting and Clinical Psychology, 66*, 304-312. doi:10.1037/0022-006X.66.2.304
- Hare, R.D. (1991). *The Hare Psychopathy Checklist—Revised*. Toronto: Multi-Health Systems.
- Hare, R.D. (2003). *Hare Psychopathy Checklist—Revised: 2nd ed. (PCL-R 2nd ed.)*. Toronto, Ontario, Canada: Multi-Health Systems.
- Hare, R.D., Clarke, D., Grann, M., & Thornton, D. (2000). Psychopathy and the predictive validity of the PCL-R: An international perspective. *Behavioral Sciences and the Law, 18*, 623–645. doi:10.1002/1099-0798(200010)18:5<623::AID-BSL409>3.0.CO;2W
- Hart, S.D., Cox, D.N., & Hare, R.D. (1995). *The Hare Psychopathy Checklist: Screening Version (1st ed.)*. Toronto, Ontario, Canada: Multi-Health Systems.
- Hatcher, R.L., Barends, A.W., Hansell, J., & Gutfreund, M.J. (1995). Patients' and therapists' shared and unique views of the therapeutic alliance: An investigation using confirmatory factor analysis in a nested design. *Journal of Consulting and Clinical Psychology, 63*, 636–643. doi:10.1037/0022-006X.63.4.636
- Hemphill, J.F., & Hart, S.D. (2002). Motivating the unmotivated: Psychopathy, treatment, and change. In M. McMurrin (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy*. John Wiley and Sons Ltd.

- Heseltine, K., Sarre, R., & Day, A. (2011). Prison-based correctional rehabilitation: An overview of intensive interventions for moderate to high-risk offenders. *Trends and Issues in Crime and Criminal Justice*, 412, 401-420. Retrieved from <http://aic.gov.au/publications/current%20series/tandi/401-420/tandi412.html>
- Hill, C.E., & Corbett, M.M. (1993). A perspective on the history of process and outcome research in counseling psychology. *Journal of Counseling Psychology*, 40, 3-24. doi:10.1037/0022-0167.40.1.3
- Hill, C.E., Kellems, I.S., Kolchakian, M.R., Wonnell, T.L., Davis, T.L., & Nakayama, E.Y. (2003). The therapist experience of being the target of hostile versus suspected-unasserted client anger: Factors associated with resolution. *Psychotherapy Research*, 13, 475-491. doi:10.1093/ptr/kpg040
- Hill, C.E., & Knox, S. (2009). Processing the Therapeutic Relationship. *Psychotherapy Research*, 19, 13-29. doi:10.1080/10503300802621206
- Hillege, S., Das, J., & de Ruiter, C. (2010). The Youth Psychopathic Traits Inventory: Psychometric properties and its relation to substance use and interpersonal style in a Dutch sample of non-referred adolescents. *Journal of Adolescence*, 33, 83-91. doi:10.1016/j.adolescence.2009.05.006
- Hiller, M.L., Knight, K., Leukefeld, C., & Simpson, D. (2002). Motivation as a predictor of therapeutic engagement in mandated residential substance abuse treatment. *Criminal Justice and Behavior*, 29, 56-75. doi:10.1177/0093854802029001004
- Hilsenroth, M.J., Menaker, J., Peters, E.J., & Pincus, A. L. (2007). Assessment of borderline pathology using the Inventory of Interpersonal Problems Circumplex Scales (IIP-C): A comparison of clinical samples. *Clinical Psychology & Psychotherapy*, 14, 365-376. doi:10.1002/cpp.549

- Hobson, J., Shine, J., & Roberts, R. (2000). How do psychopaths behave in a prison therapeutic community? *Psychology, Crime, and Law*, *6*, 139–154.
doi:10.1080/10683160008410838
- Holdsworth, E., Bowen, E., Brown, S., & Howat, D. (2014). Offender engagement in group programs and associations with offender characteristics and treatment factors: A review. *Aggression and Violent Behavior*, *19*, 102–121.
doi:10.1016/j.avb.2014.01.004
- Holtforth, M.G., & Castonguay, L.G. (2005). Relationship and techniques in cognitive-behavioral therapy – a motivational approach. *Psychotherapy: Theory, Research, Practice, Training*, *42*, 443-455. doi:10.1037/0033-3204.42.4.443
- Horowitz, L.M., Locke, K.D., Morse, M.B., Waikar, S.V., Dryer, D., Tarnow, E., & Ghannam, J. (1991). Self-derogations and the interpersonal theory. *Journal of Personality and Social Psychology*, *61*, 68-79. doi:10.1037/0022-3514.61.1.68
- Horowitz, L.M., Wilson, K.R., Turan, B., Zolotsev, P., Constantino, M.J., & Henderson, L. (2006). How interpersonal motives clarify the meaning of interpersonal behavior: A revised circumplex model. *Personality and Social Psychology Review*, *10*, 67-86. doi:10.1207/s15327957pspr1001_4
- Horvath, A.O. (2000). The therapeutic relationship: From transference to alliance. *Journal of Clinical Psychology*, *56*, 163–173. doi:10.1002/(SICI)1097-4679(200002)56:2<163::AID-JCLP3>3.0.CO;2-D
- Horvath, A.O., Del Re, A.C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, *48*, 9-16. doi:10.1037/a0022186

- Horvath, A.O., & Greenberg, L.S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233. doi:10.1037/0022-0167.36.2.223
- Horvath, A.O., & Luborsky, L. (1993). The role of therapeutic alliance in psychotherapy. *Journal of Consulting Psychology, 61*, 561-573. doi:10.1037/0022-006X.61.4.561
- Horvath, A.O., & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139–149. doi:10.1037/0022-0167.38.2.139
- Howells, K. (2004). Anger and its links to violent offending. *Psychiatry, Psychology and Law, 11*, 189-196. doi:10.1375/pplt.2004.11.2.189
- Howells, K., & Day, A. (2003). Readiness for anger management: Clinical and theoretical issues. *Clinical Psychology Review, 23*, 319-337. doi:10.1016/S0272-7358(02)00228-3
- Howells, K., & Day, A. (2006). Affective determinants of treatment engagement in violent offenders. *International Journal of Offender Therapy and Comparative Criminology, 50*, 174-186. doi:10.1177/0306624X05281336
- Hudson, S.M., Ward, T., & McCormack, J.C. (1999). Offense pathways in sexual offenders. *Journal of Interpersonal Violence, 14*, 779– 798. doi:10.1177/088626099014008001
- Jaccard, J., Wan, C.K., & Turrisi, R. (1990). The detection and interpretation of interaction effects between continuous variables in multiple regression. *Multivariate Behavioral Research, 25*, 467-478. doi:10.1207/s15327906mbr2504_4

- Joe, G.W., Simpson, D., & Broome, K.M. (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction, 93*, 1177-1190. doi:10.1046/j.1360-0443.1998.93811776.x
- Johansen, R., Melle, I., Iversen, V.C., & Hestad, K. (2013). Personality traits, interpersonal problems and therapeutic alliance in early schizophrenia spectrum disorders. *Comprehensive Psychiatry, 54*, 1169-1176. doi:10.1016/j.comppsy.2013.05.016
- Karver, M.S., Handelsman, J.B., Fields, S., & Bickman, L. (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research, 7*, 35–51. doi:10.1007/s11020-005-1964-4
- Katz, E.C., King, S.D., Schwartz, R.P., Weintraub, E., Barksdale, W., Robinson, R., & Brown, B.S. (2005). Cognitive ability as a factor in engagement in drug abuse treatment. *The American Journal of Drug and Alcohol Abuse, 31*, 359-369. doi:10.1081/ADA-200056767
- Kiesler, D.J. (1983). The 1982 Interpersonal Circle: A taxonomy for complementarity in human transactions. *Psychological Review, 90*, 185-214. doi:10.1037/0033-295X.90.3.185
- Kiesler, D.J. (1987). *Manual for the Impact Message Inventory*. CA: Consulting Psychologists Press, Inc.
- Kiesler, D.J., & Auerbach, S.M. (2003). Integrating measurement of control and affiliation in studies of physician-patient interaction: The interpersonal circumplex. *Social Science & Medicine, 57*, 1707-1722. doi:10.1016/S0277-9536(02)00558-0

- Kiesler, D.J., & Schmidt, J.A. (2006). *The Impact Message Inventory–Circumplex (IMI–C) Manual: Sampler set, manual, test booklet, scoring key, work sheets*. CA: Mind Garden.
- Kiesler, D.J., Schmidt, J.A., & Wagner, C.C. (1997). A circumplex inventory of impact messages: An operational bridge between emotion and interpersonal behavior. In R. Plutchik & H.R. Conte (Eds.), *Circumplex Models of Personality and Emotions*. Washington, DC, US: American Psychological Association
- Kiesler, D.J., & Watkins, L.M. (1989). Interpersonal complementarity and the therapeutic alliance: A study of the relationship in psychotherapy. *Psychotherapy, 26*, 183–194. doi:10.1037/h0085418
- Kirsch, L.G., & Becker, J.V. (2006). Sexual offending: Theory of problem, theory of change, and implications for treatment effectiveness. *Aggression and Violent Behavior, 11*, 208– 224. doi:10.1016/j.avb.2005.08.001
- Klag, S. M.-L., Creed, P., & O'Callaghan, F. (2010). Early motivation, well-being, and treatment engagement of chronic substance users undergoing treatment in a therapeutic community setting. *Substance Use and Misuse, 45*, 1112-1130. doi:10.3109/10826080903499562
- Klepfisz, G., O'Brien, K., & Daffern, M. (2014). Violent offenders' within-treatment change in anger, criminal attitudes, and violence risk: Associations with violent recidivism. *International Journal of Forensic Mental Health, 13*, 348-362. doi:10.1080/14999013.2014.951107
- Kozar, C. (2010). Treatment readiness and the therapeutic alliance. In A. Day, S. Casey, T. Ward, K. Howells & J. Vess (Eds.), *Transitions to Better Lives: Offender Readiness and Rehabilitation*. Devon: UK: Willan Publishing.

- Kozar, C.J., & Day, A. (2012). The therapeutic alliance in offending behavior programs: A necessary and sufficient condition for change? *Aggression and Violent Behavior, 17*, 482–487. doi:10.1016/j.avb.2012.07.004
- Kreyenbuhl, J., Nossel, I.R., & Dixon, L.B. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *Schizophrenia Bulletin, 35*, 696-703. doi:10.1093/schbul/sbp046
- Långström, N., Enebrink, P., Laurén, E.M., Lindblom, J., Werkö, S., & Hanson, R.K. (2013). Preventing sexual abusers of children from reoffending: Systematic review of medical and psychological interventions. *BMJ, 347*, 1-11. doi:10.1136/bmj.f4630
- Langton, C.M., Barbaree, H.E., Harkins, L., & Peacock, E.J. (2006). Sexual offenders' response to treatment and its association with recidivism as a function of psychopathy. *Sexual Abuse: A Journal of Research and Treatment, 18*, 99–120. doi:10.1177/107906320601800107
- Larke, J. (1985). Compulsory treatment: Some practical methods of treating the mandated client. *Psychotherapy: Theory, Research, Practice, Training, 22*, 262-268. doi:10.1037/h0085504
- Laws, D. R., & Marshall, W. L. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offenders: Part 1. Early developments. *Sexual Abuse: A Journal of Research and Treatment, 15*, 75–92. doi:10.1023/A:1022325231175
- Leary, T. (1957). *Interpersonal diagnosis of personality*. New York: Ronald Press.

- Lecomte, T., Spidel, A., Leclerc, C., MacEwan, G., Greaves, C., & Bentall, R.P. (2008). Predictors and profiles of treatment non-adherence and engagement in services problems in early psychosis. *Schizophrenia Research, 102*, 295-302. doi:10.1016/j.schres.2008.01.024
- Levenson, J.S., & Macgowan, M.J. (2004). Engagement, denial, and treatment progress among sex offenders in group therapy. *Sexual Abuse: A Journal of Research and Treatment, 16*, 49-63. doi:10.1023/B:SEBU.0000006284.33837.d7
- Levenson, J.S., Macgowan, M.J., Morin, J.W., & Cotter, L.P. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: Journal of Research and Treatment, 21*, 35–56. doi:10.1177/1079063208326072
- Levenson, J.S., Prescott, D.S., & D'amora, D.A. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology, 54*, 307-326. doi:10.1177/0306624X08328752
- Lievore, D. (2004). *Recidivism of Sexual Assault Offenders: Rates, Risk Factors and Treatment Efficacy* (Vol. 80). Canberra, ACT: Australian Institute of Criminology.
- Lillie, R. (2007). Getting clients to hear: Applying principles and techniques of Kiesler's Interpersonal Communication Therapy to assessment feedback. *Psychology and Psychotherapy: Theory, Research and Practice, 80*, 151-163. doi:10.1348/147608306X115198

- Lipsey, M.W., & Cullen, F.T. (2007). The effectiveness of correctional rehabilitation: A review of systematic reviews. *Annual Review Law Social Sciences*, 3, 297-320. doi:10.1146/annurev.lawsocsci.3.081806.112833
- Littrell, J.H., & Girvin, H. (2002). Stages of change: A critique. *Behavior Modification*, 26, 223-273. doi:10.1177/0145445502026002006
- Loeffler-Stastka, H., & Blueml, V. (2010). Assessment tools for affect regulation and quality of object relations in personality disorders: The predictive impact on initial treatment engagement. *Bulletin of the Menninger Clinic*, 74, 29-44. doi:10.1521/bumc.2010.74.1.29
- Looman, J., Abracen, J., Serin, R., & Marquis, P. (2005). Psychopathy, treatment change, and recidivism in high-risk, high-need sexual offenders. *Journal of Interpersonal Violence*, 20, 549-568. doi:10.1177/0886260504271583
- Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, 1, 117-146. doi:10.1007/s11292-004-6466-7
- Mallinckrodt, B. (1991). Clients' representations of childhood emotional bonds with parents, social support, and formation of the working alliance. *Journal of Counseling Psychology*, 38, 401-409. doi:10.1037/0022-0167.38.4.401
- Mallinckrodt, B., Porter, M.J., & Kivlighan, D.M., Jr. (2005). Client attachment to therapist, depth of in-session exploration, and object relations in brief psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 42, 85-100. doi:10.1037/0033-3204.42.1.85
- Mann, J. (1973). *Time Limited Psychotherapy*. Cambridge, Massachusetts & London, England: Harvard University Press.

- Marshall, W.L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment*, *17*, 109-116. doi:10.1177/107906320501700202
- Marshall, W.L., & Burton, D.L. (2010). The importance of group processes in offender treatment. *Aggression and Violent Behavior*, *15*, 141–149. doi:10.1016/j.avb.2009.08.008
- Marshall, W.L., & Laws, D.R. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offenders: Part 2. The modern era. *Sexual Abuse: A Journal of Research and Treatment*, *15*, 93– 120. doi:10.1023/A:1022389915245
- Marshall, W.L., Serran, G., Fernandez, Y.M., Mulloy, R., Mann R., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression*, *9*, 25-30. doi:10.1080/355260031000137940
- Marshall, W.L., Serran, G., Moulden, H., Mulloy, R., Fernandez, Y.M., Mann R., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clinical Psychology and Psychotherapy*, *9*, 395–405. doi:10.1002/cpp.335
- Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *68*, 438–450. doi:10.1037//0022-006X.68.3.438
- Martinson, R. (1974). What works? Questions and answers about prison reform. *The Public Interest*, *35*, 22-54. Retrieved from <http://search.proquest.com/docview/1298113963?accountid=12528>

- Marques, J.K., Wiederanders, M., Day, D.M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment, 17*, 79–107. doi:10.1007/s11194-005-1212-x
- McCarthy, L., & Duggan, C. (2010). Engagement in a medium secure personality disorder service: A comparative study of psychological functioning and offending outcomes. *Criminal Behaviour and Mental Health, 20*, 112–128. doi:10.1002/cbm.758
- McMurrin, M., Huband, N., & Duggan, C. (2008). A comparison of treatment completers and non-completers of an in-patient treatment programme for male personality disordered offenders. *Psychology and Psychotherapy: Theory, Research and Practice, 81*, 193–198. doi:10.1348/147608308X288762
- McMurrin, M., & Theodosi, E. (2007). Is treatment non-completion associated with increased reconviction over no treatment? *Psychology, Crime & Law, 13*, 333-343. doi:10.1080/10683160601060374
- McMurrin, M., & Ward, T. (2010). Treatment readiness, treatment engagement and behaviour change. *Criminal Behaviour and Mental Health, 20*, 75-85. doi:10.1002/cbm.762
- Meier, P.S., & Donmall, M.C. (2006). Differences in client and therapist views of the working alliance in drug treatment. *Journal of Substance Use, 11*, 73-80. doi:10.1080/14659890500137004

- Meier, P.S., Donmall, M.C., McElduff, P., Barrowclough, C., & Heller, R.F. (2006).
The role of the early therapeutic alliance in predicting drug treatment dropout.
Drug and Alcohol Dependence, 83, 57-64.
doi:10.1016/j.drugalcdep.2005.10.010
- Morgan, R., Luborsky, L., Crits-Christoph, P., Curtis, H., & Solomon, J. (1982).
Predicting outcomes of psychotherapy by the Penn Helping Alliance Rating
Method. *Archives of General Psychiatry*, 39, 397-402.
doi:10.1001/archpsyc.1982.04290040013002
- Mullen, P., & Ogloff, J. (2009) Providing mental health services to adult offenders in
Victoria, Australia: Overcoming barriers. *European Psychiatry*, 24, 395-400,
doi:10.1016/j.eurpsy.2009.07.003
- Muran, J., Safran, J.D., Gorman, B.S., Samstag, L.W., Eubanks-Carter, C., &
Winston, A. (2009). The relationship of early alliance ruptures and their
resolution to process and outcome in three time-limited psychotherapies for
personality disorders. *Psychotherapy: Theory, Research, Practice, Training*,
46, 233-248. doi:10.1037/a0016085
- Muran, J.C., Safran, J.D., Samstag, L.W., & Winston, A. (1992). *Patient and
Therapist Postsession Questionnaires, Version 1992*. Beth Israel Medical
Center, NY.
- Muran, J., Segal, Z.V., Samstag, L.W., & Crawford, C.E. (1994). Patient
pretreatment interpersonal problems and therapeutic alliance in short-term
cognitive therapy. *Journal of Consulting and Clinical Psychology*, 62, 185-
190. doi:10.1037/0022-006X.62.1.185

- Newman, C.F. (1998). The therapeutic relationship and alliance in short-term cognitive therapy. In J. Safran & C.J. Muran (Eds.), *The Therapeutic Alliance in Brief Psychotherapy*. Washington, DC, US: American Psychological Association
- Ogrodniczuk, J.S., Piper, W.E., Joyce, A.S., Steinberg, P.I., & Duggal, S. (2009). Interpersonal problems associated with narcissism among psychiatric outpatients. *Journal of Psychiatric Research*, *43*, 837-842.
doi:10.1016/j.jpsychires.2008.12.005
- Olver, M.E., Beggs Christofferson, S.M., Grace, R.C., & Wong, S.C.P. (2014b). Incorporating change information into sexual offender risk assessments using the violence risk scale-sexual offender version. *Sexual Abuse: A Journal of Research and Treatment*, *26*, 472–499. doi:10.1177/1079063213502679
- Olver, M.E., Beggs Christofferson, S.M., & Wong, S.C.P. (2015). Evaluation and applications of the clinically significant change method with the Violence Risk Scale-Sexual Offender Version: Implications for risk-change communication. *Behavioral Sciences and the Law*, *33*, 92-110.
doi:10.1002/bsl.2159
- Olver, M.E., Kingston, D.A., Nicholaichuk, T.P., & Wong, S.C.P. (2014). A psychometric examination of treatment change in a multisite sample of treated Canadian federal sexual offenders. *Law and Human Behavior*, *38*, 544-559.
doi:10.1037/lhb0000086
- Olver, M.E., Nicholaichuk, T.P., & Wong, S.C.P. (2014a). The predictive and convergent validity of a psychometric battery used to assess sex offenders in a treatment program: An 18-year follow-up. *Journal of Sexual Aggression*, *20*, 216–239. doi:10.1080/13552600.2013.816791

- Olver, M.E., Sewall, L.A., Sarty, G.E., Lews, K., & Wong, S. (2015). A cluster analytic examination and external validation of psychopathic offender subtypes in a multisite sample of Canadian federal offenders. *Journal of Abnormal Psychology, 124*, 355-371. doi:10.1037/abn0000038
- Olver, M.E., Stockdale, K.C., & Wormith, J. (2011). A meta-analysis of predictors of offender treatment attrition and its relationship to recidivism. *Journal of Consulting and Clinical Psychology, 79*, 6-21. doi:10.1037/a0022200
- Olver, M.E., & Wong, S.C. (2006). Psychopathy, sexual deviance, and recidivism among sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 18*, 65-82. doi:10.1007/s11194-006-9006-3
- Olver, M.E., & Wong, S. (2011). Predictors of sex offender treatment dropout: Psychopathy, sex offender risk, and responsivity implications. *Psychology, Crime & Law, 17*, 457-471. doi:10.1080/10683160903318876
- Olver, M.E., Wong, S.C., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the Violence Risk Scale Sexual Offender version: Assessing sex offender risk and evaluating therapeutic change. *Psychological Assessment, 19*, 318-29. doi:10.1037/1040-3590.19.3.318
- Pereira, S., & Woollaston, K. (2007). Therapeutic engagement in acute psychiatric inpatient services. *Journal of Psychiatric Intensive Care, 3*, 3-11. doi:10.1017/S1742646407001057
- Polaschek, D.L. (2014). Adult criminals with psychopathy: Common beliefs about treatability and change have little empirical support. *Current Directions in Psychological Science, 23*, 296-301. doi:10.1177/0963721414535211

- Polaschek, D.L., & Daly, T.E. (2013). Treatment and psychopathy in forensic settings. *Aggression and Violent Behavior, 18*, 592-603.
doi:10.1016/j.avb.2013.06.003
- Polaschek, D.L., & Ross, E.C. (2010). Do early therapeutic alliance, motivation, and stages of change predict therapy change for high-risk, psychopathic violent prisoners? *Criminal Behaviour and Mental Health, 20*, 100-111.
doi:10.1002/cbm.759
- Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*, 1102-1114. doi:10.1037/0003-066X.47.9.1102
- Raue, P.J., & Sirey, J.A. (2011). Designing personalized treatment engagement interventions for depressed older adults. *Psychiatric Clinics of North America, 34*, 489-500. doi:10.1016/j.psc.2011.02.011
- Rhodes, R.H., Hill, C.E., Thompson, B.J., & Elliot, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counseling Psychology, 41*, 473-483. doi:10.1037//0022-0167.41.4.473
- Rice, M.E., Harris, G.T., & Cormier, C.A. (1992). An evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered offenders. *Law and Human Behavior, 16*, 399-412.
doi:10.1007/BF02352266
- Rice, M.E., Quinsey, V.L., & Harris, G.T. (1991). Sexual recidivism among child molesters released from a maximum security psychiatric institution. *Journal of Consulting and Clinical Psychology, 59*, 381-386. doi:10.1037/0022-006X.59.3.381

- Ross, E.C., Polaschek, D.L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior, 13*, 462-480. doi:10.1016/j.avb.2008.07.003
- Ross, S., & Guarnieri, T. (1996). Recidivism rates in a custodial population: The influence of criminal history, offence and gender factors. *Report to the Criminology Research Council*. Retrieved from <http://www.criminologyresearchcouncil.gov.au/reports/35-89.pdf>
- Rossi, A., Amaddeo, F., Sandri, M., Marsilio, A., Bianco, M., & Tansella, M. (2008). What happens to patients seen only once by psychiatric services: Findings from a follow-up study. *Psychiatry Research, 157*, 53-65. doi:10.1016/j.psychres.2006.05.023
- Ruggeri, M., Salvi, G., Bonetto, C., Lasalvia, A., Allevi, L., Parabiaghi, A., . . . Tansella, M. (2007). Outcome of patients dropping out from community-based mental health care: A 6-year multiwave follow-up study. *Acta Psychiatrica Scandinavica, 116*, 42-52. doi:10.1111/j.1600-0447.2007.01092.x
- Safran, J.D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy, 27*, 154-165. doi:10.1037/0033-3204.27.2.154
- Safran, J.D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy, 3*, 381-387. doi:10.1037/a0036815
- Safran, J.D., & Muran, J.C. (2006). Has the concept of alliance outlived its usefulness? *Psychotherapy: Theory, Research, Practice, Training, 43*, 286-291. doi:10.1037/0033-3204.43.3.286

- Safran, J.D., Muran, J., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48*, 80-87. doi:10.1037/0033-3204.38.4.406
- Safran, J.D., Muran, J.C., & Rothman, M. (2006). The therapeutic alliance: Cultivating and negotiating the therapeutic relationship. In W. O'Donohue, N.A. Cummings, & J.L. Cummings (Eds.), *Clinical Strategies for Becoming a Master Psychotherapist*. Amsterdam. Boston: Elsevier Academic Press.
- Samstag, L.W., Muran, J.C., Wachtel, P.L., Slade, A., Safran, J.D., & Winston, A. (2008). Evaluating negative process: A comparison of working alliance. *American Journal of Psychotherapy, 62*, 165-194. Retrieved from <http://search.proquest.com/docview/1441834817?accountid=12528>
- Scalora, M. J., & Garbin, C. (2003). A multivariate analysis of sex offender recidivism. *International Journal of Offender Therapy and Comparative Criminology, 47*, 309-323. doi:10.1177/0306624X03252396
- Schmidt, J.A., Wagner, C.C., & Kiesler, D.J. (1999). Psychometric and circumplex properties of the octant scale Impact Message Inventory (IMI-C): A structural evaluation. *Journal of Counseling Psychology, 46*, 325-334. doi:10.1037/0022-0167.46.3.325
- Schneider, S.L., & Wright, R.C. (2004). Understanding denial in sexual offenders: A review of cognitive and motivational processes to avoid responsibility. *Trauma, Violence & Abuse, 5*, 3-20. doi:10.1177/1524838003259320
- Steering Committee for the Review of Government Services. (SCRGS; 2006). *Report on government services 2005*. Retrieved 6 Jan 2011, 2011, from <http://www.pc.gov.au/gsp/reports/rogs/2005>
- SCRGS. (2010). *Report on government services 2011*. Retrieved 6 Jan 2011, 2011, from <http://www.pc.gov.au/gsp/reports/rogs/2011>

- Serin, R.C., & Kennedy, S. (1997). *Treatment Readiness Responsivity: Contributing to Effective Correctional Programming (Research Report R-54)*. Ottawa, ON: Correctional Service of Canada.
- Serin, R.C., Kennedy, S., & Mailloux, D.L. (2005). *Manual for the Treatment Readiness, Responsivity, and Gain Scale: Short Version (TRRG:SV)*. Carlton University, Ontario Canada.
- Serin, R.C., Kennedy, S.M., Mailloux, D.L., & Hanby, L.J. (2010). The origins of treatment readiness. In A. Day, S. Casey, T. Ward, K. Howells & J. Vess (Eds.), *Transitions to Better Lives: Offender Readiness and Rehabilitation*. Devon, UK: Willan Publishing.
- Serin, R.C., & Lloyd, C.D. (2009). Examining the process of offender change: The transition to crime desistance. *Psychology, Crime & Law, 15*, 347-364.
doi:10.1080/10683160802261078
- Serran, G., Fernandez, Y., Marshall, W., & Mann, R. (2003). Process issues in treatment: Application to sexual offender programs. *Professional Psychology: Research and Practice, 34*, 368-374. doi:10.1037/0735-7028.34.4.368
- Seto, M.C., & Barbaree, H.E. (1999). Psychopathy, treatment behavior, and sex offender recidivism. *Journal of Interpersonal Violence, 14*, 1235-1248.
doi:10.1177/088626099014012001
- Sharf, J., Primavera, L.H., & Diener, M.J. (2010). Dropout and therapeutic alliance: A meta-analysis of adult individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 47*, 637-645. doi:10.1037/a0021175
- Shean, G., & Uchenwa, U. (1990). Interpersonal style and anxiety. *Journal of Psychology: Interdisciplinary and Applied, 124*, 403-408.
doi:10.1080/00223980.1990.10543235

- Sheldon, K., & Tennant, A. (2011). Considerations for working with personality-disordered patients. *The British Journal of Forensic Practice*, *13*, 44-53. doi:10.5042/bjfp.2011.0049
- Shine, J., & Hobson, J. (1997). Construct validity of the Hare Psychopathy Checklist, Revised, on a UK prison population. *Journal of Forensic Psychiatry*, *8*, 546–561. doi:10.1080/09585189708412275
- Simpson, D., & Joe, G.W. (1993). Motivation as a predictor of early dropout from drug abuse treatment. *Psychotherapy: Theory, Research, Practice, Training*, *30*, 357-368. doi:10.1037/0033-3204.30.2.357
- Simpson, D., & Joe, G.W. (2004). A longitudinal evaluation of treatment engagement and recovery stages. *Journal of Substance Abuse Treatment*, *27*, 89-97. doi:10.1016/j.jsat.2004.03.001
- Simpson, D.D., Joe, G.W., Knight, K., Rowan-Szal, G., & Gray, J. S. (2012). Texas Christian University (TCU) short forms for assessing client needs and functioning in addiction treatment. *Journal of Offender Rehabilitation*, *51*, 34–56. doi:10.1080/10509674.2012.633024.
- Skeem, J.L., Louden, J.E., Polaschek, D., & Camp, J. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment*, *19*, 397-410. doi:10.1037/1040-3590.19.4.397
- Skeem, J.L., Monahan, J., & Mulvey, E.P. (2002). Psychopathy, treatment involvement, and subsequent violence among civil psychiatric patients. *Law and Human Behavior*, *26*, 577-603. doi:10.1023/A:1020993916404

- Staton-Tindall, M., Garner, B.R., Morey, J.T., Leukefeld, C., Krietemeyer, J., Saum, C.A., & Oser, C.B. (2007). Gender differences in treatment engagement among a sample of incarcerated substance abusers. *Criminal Justice and Behavior, 34*, 1143-1156. doi:10.1177/0093854807304347
- Stevens, C.L., Muran, J., Safran, J.D., Gorman, B.S., & Winston, A. (2007). Levels and patterns of the therapeutic alliance in brief psychotherapy. *American Journal of Psychotherapy, 61*, 109-129. Retrieved from http://www.researchgate.net/profile/John_Muran/publication/6080621_Levels_and_patterns_of_the_therapeutic_alliance_in_brief_psychotherapy/links/0046351a632f9ddfc5000000.pdf
- Stiles, W.B., Glick, M.J., Osatuke, K., Hardy, G.E., Shapiro, D.A., Agnew-Davies, R., . . . Barkham, M. (2004). Patterns of alliance development and the rupture-repair hypothesis: Are productive relationships U-shaped or V-shaped? *Journal of Counseling Psychology, 51*, 81-92. doi:10.1037/0022-0167.51.1.81
- Strauss, J. L., Hayes, A.M., Johnson, S.L., Newman, C.F., Brown, G.K., Barber, J.P., . . . Beck, A.T. (2006). Early alliance, alliance ruptures, and symptom change in a nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology, 74*, 337-345. doi:10.1037/0022-006X.74.2.337
- Sullivan, D.H., Mullen, P.E., & Pathé, M.T. (2005). Legislation in Victoria on sexual offenders: Issues for health professionals. *Medical Journal of Australia, 183*, 318-320. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.151.6410&rep=rep1&type=pdf>

- Taft, C.T., & Murphy, C.M. (2007). The working alliance in intervention for partner violence perpetrators: Recent research and theory. *Journal of Family Violence, 22*, 11-18. doi:10.1007/s10896-006-9053-z
- Taft, C.T., Murphy, C.M., Musser, P.H., & Remington, N.A. (2004). Personality, interpersonal, and motivational predictors of the working alliance in group cognitive-behavioral therapy for partner violent men. *Journal of Consulting and Clinical Psychology, 72*, 349-354. doi:10.1037/0022-006X.72.2.349
- Tichenor, V., & Hill, C. (1989). A comparison of six measures of working alliance. *Psychotherapy, 26*, 195-199. doi:10.1037/h0085419
- Tracey, T.J., & Kokotovic, A.M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1*, 207–210. doi:10.1037/1040-3590.1.3.207
- Tufekcioglu, S., Muran, J.C., Safran, J.D., & Winston A. (2013). Personality disorder and early therapeutic alliance in two time-limited therapies. *Psychotherapy Research, 6*, 646-657. doi:10.1080/10503307.2013.843803
- Van Buren, A., & Nowicki, S., Jr. (1997). Awareness of interpersonal style and self-evaluation. *The Journal of Social Psychology, 137*, 429-434. doi:10.1080/00224549709595458
- Wakeling, H., Beech, A.R., & Freemantle, N. (2013). Investigating treatment change and its relationship to recidivism in a sample of 3773 sex offenders in the UK. *Psychology, Crime & Law, 19*, 233–252. doi:10.1080/1068316x.2011.626413
- Ward, T. (2002). Good lives and the rehabilitation of offenders: Promises and problems. *Aggression and Violent Behavior, 7*, 513-528. doi:10.1016/S1359-1789(01)00076-3

- Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and Violent Behavior, 9*, 645-673.
doi:10.1016/j.avb.2003.08.001
- Ward, T., Yates, P.M., & Willis, G.M. (2012). The good lives model and the risk need responsivity model: A critical response to Andrews, Bonta, and Wormith (2011). *Criminal Justice and Behavior, 39*, 94-110.
doi:10.1177/0093854811426085
- Ware, J., & Bright, D.A. (2008). Evolution of a treatment programme for sex offenders: Changes to the NSW Custody-Based Intensive Treatment (CUBIT). *Psychiatry, Psychology and Law, 15*, 340-349.
doi:10.1080/13218710802014543
- Welsh, W.N., & McGrain, P.N. (2008). Predictors of therapeutic engagement in prison-based drug treatment. *Drug and Alcohol Dependence, 96*, 271-280.
doi:10.1016/j.drugalcdep.2008.03.019
- Westra, H.A., Constantino, M.J., & Aviram, A. (2011). The impact of alliance ruptures on client outcome expectations in cognitive behavioral therapy. *Psychotherapy Research, 21*, 472-481. doi:10.1080/10503307.2011.581708

Appendices

Appendix A - Ethics



Department of Justice

Justice Human Research Ethics Committee

Innovation and Strategy Unit
Level 21
121 Exhibition Street
Melbourne, Victoria 3000
GPO Box 123A
Melbourne, Victoria 3001

DX 210077

5 June 2012

Reference: CF/12/8098

Dr. Stuart Thomas
C/o Dr. Stuart Thomas
Monash University

Re: Treatment Readiness, Interpersonal Style and the Therapeutic Alliance in Offender Populations

Dear Dr. Thomas,

I am happy to inform you that the Department of Justice Human Research Ethics Committee (JHREC) considered your resubmission in relation to the project *Treatment Readiness, Interpersonal Style and the Therapeutic Alliance in Offender Populations* at its meeting on 29 May 2012 and granted **full approval** for the duration of the investigation. The Department of Justice reference number for this project is CF/12/8098. Please note the following requirements:

- To remove the JHREC office address from the research material. Only the telephone and email address are required.
- To confirm JHREC approval sign the Undertaking form attached and provide both an electronic and hardcopy version within ten business days.
- The JHREC is to be notified immediately of any matter that arises that may affect the conduct or continuation of the approved project.
- You are required to provide an Annual Report every 12 months (if applicable) and to provide a completion report at the end of the project (see the Department of Justice Website for the forms).
- Note that for long term/ongoing projects approval is only granted for three years, after which time a completion report is to be submitted and the project renewed with a new application.
- The Department of Justice would also appreciate receiving copies of any relevant publications, papers, theses, conferences presentations or audiovisual materials that result from this research.
- All future correspondence regarding this project must be sent electronically to [REDACTED] and include the reference number and the project title. Hard copies of signed documents or original correspondence are to be sent to The Secretary, JHREC, Level 21, 121 Exhibition St, Melbourne, VIC 3000.

If you have any queries regarding this application you are welcome to contact me [REDACTED]

Yours sincerely,

Mr Jonathan Clark
Secretary,
Department of Justice Human Research Ethics Committee



Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

Date: 21 June 2012

Project Number: CF12/1766 - 2012000959

Project Title: Treatment readiness, interpersonal style and the therapeutic alliance in offender populations

Chief Investigator: Assoc Prof Stuart Thomas

Approved: From 21 June 2012 to 21 June 2017

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. **Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research.**
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. **Complaints:** The researchers are required to inform MUHREC promptly of any complaints made about the project, whether the complaint was made directly to a member of the research team or to the primary HREC.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.



Professor Ben Canny
Chair, MUHREC

Cc: Ms Rachael Watson; Assoc Prof Michael Daffern

Appendix B - Integrated Discussion Analyses

Approach to Analyses

An individual regression analysis was run to determine whether early therapist ratings of the therapeutic alliance predicted treatment gain. Descriptive statistics pertaining to the IMI *Control* axis were calculated for both offenders and therapists. The *Control* axis was determined based on instructions from the IMI-C manual (Kiesler & Schmidt, 2006) by combining dimensions of dominance and control. An ANOVA was conducted to determine whether level of treatment gain differed for those offender who experienced an improvement of therapeutic alliance over time, compared to those who experienced a reduction in the therapeutic alliance over time. Finally, a bivariate correlation analysis was computed to assess the relationship between treatment readiness and the therapeutic alliance.

Results

It was found that early therapist therapeutic alliance ratings significantly predicted treatment gain ($F(1, 58) = 6.33, p = .02, R = .32, R^2 = .10$). Late offender therapeutic alliance ratings had an effect size of $r = .30$ and explained 9% of variance in treatment gain, with offender treatment gain ratings increasing 0.13 points for every one-point increase in early therapist therapeutic alliance ratings. In addition, early therapist-rated therapeutic alliance rating significantly differed from late offender-rated therapeutic alliance (see Table 1).

Table 1

Early Therapist-Rated Therapeutic Alliance and Late Offender-Rated Therapeutic Alliance

| | n | M | SD | <i>t</i> (122) |
|--------------------------|----|-------|-------|----------------|
| Early Therapist-Rated TA | 60 | 51.42 | 10.96 | 8.26** |
| Late Offender-Rated TA | 54 | 68.31 | 10.84 | - |

* $p < .05$ (two-tailed). ** $p < .01$ (two-tailed)

Table 2 shows the means and standard deviations of the IMI Control Axis. The average therapist ratings sit within the middle of the axis (between submission and dominance), whereas the offender ratings average falls towards the submissive end of the axis.

Table 2
*Means and Standard Deviations of Therapist
and Offender Impact Message Inventory-Control
Axis*

| | M | SD |
|------------------------|------|------|
| Therapist Control Axis | .03 | .72 |
| Offender Control Axis | -.33 | 2.38 |

A significant difference in offender treatment gain was found for those offenders whose ratings of the therapeutic alliance improved over time, to those offenders whose ratings of the therapeutic alliance decreased over time ($F(1, 51) = 6.53, p = .02$). The average reduction in therapeutic alliance was $M = 9.60$ ($SD = 5.58$), with average improvement in therapeutic alliance, $M = 13.27$ ($SD = 4.30$).

Offender treatment readiness was found to be significantly related to the therapeutic alliance (see Table 3).

Table 3
*Correlations between Treatment Readiness, Treatment Gain and
Offenders' and Therapists' Ratings of the Therapeutic Alliance*

| | Readiness Total | Treatment Gain |
|--------------------------|-----------------|----------------|
| Early offender rated TA | .29* | .05 |
| Early therapist rated TA | .33* | .32* |
| Late Offender rated TA | .36** | .30* |

* $p < .05$ (two-tailed). ** $p < .01$ (two-tailed)