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Abstract

The therapeutic alliance has been shown to be integral to treatment outcomes even in forensic settings. There is still a relative dearth of research examining factors related to the formation of the therapeutic alliance in sex offender treatment specifically. Using a sample of 202 incarcerated male sexual offenders participating in sex offender treatment, this study examined whether perceptions of the client–therapist relationship from the perspective of male sexual offenders varied by risk for sexual and general recidivism. Overall, we found a significant negative relationship between risk for sexual recidivism and bond formation. However, when therapist subscale scores on the Working Alliance Inventory were considered by therapist gender, higher risk sexual offenders perceived poorer bonds with their female therapists, relative to their male therapists. Findings are discussed as they pertain to therapeutic relationships and responsivity issues in sex offender treatment.

Keywords

sex offender treatment, Working Alliance Inventory, therapeutic relationship, sex offenders, client–therapist relationship

To date, research overwhelmingly suggests that interventions with the general offender population are most effective at reducing recidivism when they adhere to principles described within the Risk-Need-Responsivity (RNR) framework (Andrews & Bonta,

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2010; Andrews, Bonta, & Hoge, 1990; Andrews & Dowden, 2006; Lowenkamp, Latessa, & Holsinger, 2006). According to the RNR model, those at highest risk of recidivism should receive the most intensive programming, offender programs should target dynamic criminogenic needs, and correctional interventions should be tailored to meet the individual needs of offenders. Evidence suggests that the principles delineated in the RNR framework also apply to treatment outcomes for interventions with sexual offenders. In their meta-analysis of sexual offender recidivism studies, Hanson, Bourgon, Helmus, and Hodgson (2009) found that when sexual offenders participated in treatment programs adhering to principles of the RNR model they were less likely to reoffend sexually. Moreover, their meta-analysis showed that for each additional principle adhered to by programs (e.g., only the risk principle, both the risk and need principle), there was a subsequent increase in program effectiveness as demonstrated by reductions in sexual recidivism (Hanson et al., 2009).

Of the three RNR principles, the responsivity principle has been given the least empirical attention (Andrews & Bonta, 2010). This principle is meant to provide guidance about *how* to treat offenders to effectively reduce risk of reoffending. Andrews and Bonta (2010) divide the responsivity principle in two parts: general responsivity and specific responsivity. The general responsivity principle posits that when cognitive-behavioral treatment (CBT) techniques are used, a program will have increased success at targeting criminogenic needs (Andrews et al., 1990), whereas the specific responsivity principle stipulates that the CBT techniques must be tailored to individual characteristics of offenders. This should include, for example, providing correctional programming that is responsive to learning ability, is sensitive to the treatment setting, and responds to the therapeutic nature of the offender–client relationship. There is also growing evidence that several process-related factors are important, including group composition and therapeutic climate (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005; Harkins & Beech, 2007, 2008). Andrews and Bonta (2010) acknowledge that the specific responsivity principle is underdeveloped and understudied. As a result, clinicians have little empirically supported direction with regard to what it means to adhere to the specific responsivity principle in the process of addressing the criminogenic needs of offenders (Dowden & Andrews, 2004).

This study considers one specific responsivity characteristic—the client–therapist relationship—within a population of incarcerated male sexual offenders. Building on previous research about client–therapist interactions in sex offender treatment, this study examines sexual offenders’ perceptions of the relationship with their therapists as a function of risk.

Client–Therapist Relationships in Sex Offender Treatment

Findings from the general psychotherapy literature have long demonstrated that the client–therapist relationship positively correlates with client outcomes even beyond the specific treatment intervention utilized (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Lambert & Barley, 2001; Murphy, Cramer, & Lillie, 1984; Norcross

& Lambert, 2006). It is estimated that up to 30% of patient improvement in psychotherapy can be attributed to a positive therapeutic relationship between the client and therapist (Lambert & Barley, 2001), and that correlations between the client–therapist relationship and outcomes range from .22 to .26 with the client–therapist relationship explaining about 5% of outcome variance (Baldwin, Wampold, & Imel, 2007; Horvath & Bedi, 2002).

The client–therapist relationship encompasses the feelings and attitudes that a therapist and client have toward one another and how they are expressed (Bordin, 1979; Horvath & Greenberg, 1989; Norcross, 2010). Bordin (1994) defines the working alliance between client and therapist as “a mutual understanding and agreement about change goals and the necessary tasks to move toward these goals along with the establishment of bonds to maintain the partners’ work” (p. 130; Bordin, 1979). He quantified the working alliance (also referred to as the helping alliance or therapeutic alliance by others) by identifying three main dimensions of the collaboration between client and therapist: goals, tasks, and bond. The goals dimension refers to the agreement between the therapist and the client regarding the goals for treatment, the tasks dimension refers to the specific therapeutic interventions utilized in treatment, and the bond dimension refers to the mutual trust, acceptance, and confidence between the client and therapist (Bordin, 1979). Although the concept of the working alliance originated in psychoanalytic theory, it is now considered an integral part of most theoretical orientations, including CBT (Beck, 1976; Wambold, 2010).

The empirically established importance of the client–therapist relationship to positive treatment outcomes with general psychotherapy clients (e.g., Lambert & Barley, 2001; Westen, Novotny, & Thompson-Brenner, 2004) would suggest that the client–therapist relationship would also be important to treatment outcomes with offender populations. However, with the exception of Beech, Fisher, and Beckett (1998), who included group observations in their evaluation of the prison sexual offender treatment program in the United Kingdom, and Marshall and his colleagues, who have focused their work on identifying therapist characteristics and behaviors associated with positive processes and outcomes with sexual offenders in treatment (Fernandez, Marshall, Lightbody, & O’Sullivan, 1999; Marshall, 2005; Marshall et al., 2003; Marshall et al., 2002), the client–therapist relationship has largely been unexamined among justice-involved populations (Kozar & Day, 2012; Magaletta & Verdeyen, 2005).

Marshall and his colleagues (e.g., Marshall, 2005; Marshall & Serran, 2004; Marshall et al., 2003; Marshall et al., 2002) have written extensively on the role of the therapist in sex offender treatment and have described several therapist traits and characteristics that come from the humanistic school of psychology (see Rogers, 1951, 1957), which can positively or, conversely, in their absence, negatively impact the alliance. In one empirical paper, Marshall and his colleagues (2002) conducted a two-part study in an effort first to identify common therapist behaviors and then to examine the relationship between the identified therapist behaviors and client changes in sex offender treatment. Using videotapes of 2-hour group treatment sessions, results showed that across 44 potential treatment targets, four therapist behaviors were associated with the largest number of changes—empathy, warmth, directiveness, and

rewarding behaviors (Marshall et al., 2002). Specifically, when therapists created a supportive and encouraging environment, used a warm and empathic style, and encouraged improvement, the post-treatment functioning of sexual offenders was found to improve (Fernandez et al., 1999; Marshall et al., 2002). Another of their studies, using the same data, found that similar therapist characteristics were associated with positive treatment gain among sexual offenders in three areas—perspective taking, coping skills, and relationship difficulties (Marshall et al., 2003)—which mirror what has been found in the general psychotherapy literature (Nissen-Lie, Monsen, & Ronnestad, 2010).

Client Perceived Relationships in Treatment

Efforts to explain client–therapist relationship factors that contribute to positive outcomes in the sexual offender literature have largely focused on the therapists’ perceptions of the working alliance or the therapists’ behaviors in session as perceived by independent observers (Beech et al., 1998; Fernandez et al., 1999; Marshall, 2005; Marshall et al., 2002; Marshall et al., 2003). However, the general psychotherapy literature suggests some client-based factors such as attachment style (Beech & Mitchell, 2009; Eames & Roth, 2000; Horvath, 2001; Norcross, 2010), socioeconomic status (Hersoug, Hoglend, Havik, Von der Lippe, & Monsen, 2009), and gender-match (Kiesler & Watkins, 1989; Norcross, 2010; Persons, Persons, & Newmark, 1974; Wintersteen, Mensinger, & Diamond, 2005) can influence how clients perceive the relationship with their therapists. The psychological functioning and symptom severity of clients are also often related to the perceived working alliance. Some studies found that clients with lower global functioning, more interpersonal problems, and more symptoms of depression were more likely to perceive a poor working alliance with their therapist (Castonguay, Constantino, & Grosse Holtforth, 2006; Constantino, Arnou, Blasey, & Agras, 2005; Hersoug et al., 2009). In addition, some therapist characteristics have also been found to correlate with client perceptions of the alliance, including gender (Kiesler & Watkins, 1989; Persons et al., 1974; Wintersteen et al., 2005) and age (Connors et al., 2000).

It is likely that many of the client characteristics that have been found to be predictive of perceived working alliance strength in the general psychotherapy literatures would also apply to the treatment of sexual offenders. For example, sexual offenders at higher risk to reoffend generally exhibit more denial and minimization, cognitive distortions, deviant arousal, and low self-esteem (Moster, Wnuk, & Jeglic, 2008; Polaschek & Gannon, 2004), which could be considered analogous to symptom severity and indices of functioning. Therefore, it is plausible that those sexual offenders who are at higher risk to offend as measured by actuarial instruments would exhibit more of these types of behaviors and thus be less likely to form a strong working alliance with their therapists. Nonetheless, to date no one has looked at sexual offender risk for recidivism and how it may impact the therapeutic relationship.

Furthermore, sex offender treatment is unique in that it is often conducted by mixed gender therapist dyads (one male and one female). From a clinical perspective, it is

possible for sexual offenders to observe healthy male–female interactions and practice relating to both male and females in a supervised environment. However, little is known, how, if at all, the gender of the therapist impacts the working alliance. While there is some evidence in the general psychotherapy literature that the gender of the therapist can impact clients' perceptions of the alliance such that matched gender patient–therapist dyads report better working alliances than mixed gender client–therapist dyads (Kiesler & Watkins, 1989; Persons et al., 1974; Wintersteen et al., 2005), it is unclear whether the same holds true in sex offender treatment. One case study reported numerous gender-specific countertransference issues that arose when a female therapist treated a male sexual offender (Mitchell & Melikian, 1995), but it is unclear how much this affected the alliance formation, whether it might generalize across all sexual offenders, and whether risk level would impact this relationship.

Soliciting client perceptions of the client–therapist relationship is integral to understanding how the relationship develops and is maintained in treatment (Bachelor, Meunier, & Laverdière, 2010; Cooley & Lajoy, 1990; Marshall et al., 2003), particularly because client perceptions of the client–therapist relationship and therapist perceptions tend not to converge (Bachelor, 1988, 1991, 1995; Cecero, Fenton, Frankforter, Nich, & Carrol, 2001; Fenton, Cecero, Nich, Frankforter, & Carrol, 2001; Horvath & Marx, 1991; Horvath & Symonds, 1991; Levitt & Rennie, 2004; Taft, Murphy, Musser, & Remington, 2004). Perceptions of the client–therapist relationship as rated by clients correlates more highly with outcomes than ratings completed by both therapists (Bohart, Elliott, Greenburg, & Watson, 2002; Busseri & Tyler, 2004; Zuroff et al., 2000) and independent observers (Bohart et al., 2002).

The Current Study

The extent to which client factors are helpful in explaining variation among ratings of the working alliance by sexual offenders remains underexplored. Many of the factors traditionally associated with sexual offender risk for recidivism could feasibly make perceiving a positive client–therapist relationship difficult (e.g., cognitive distortions such as negative attitudes toward authority or offense–supportive beliefs). Furthermore, many of the behaviors and attitudes specific to sexual offenders may be bothersome to therapists and thus may affect the client–therapist relationship in ways that are unique to sex offender treatment.

Assuming that sexual offenders deemed to be at higher risk of sexual recidivism, as compared with their counterparts at lower risk levels, present with greater pathology and more complex needs, this study examined incarcerated male sexual offenders' perceptions of the client–therapist relationship as a function of risk. Specifically, we first examined the association between sexual offenders' risk for sexual recidivism (as measured by actuarial risk scores) and general recidivism (as measured by risk scores) on their perception of the client–therapist relationship in sex offender treatment. We then examined whether this relationship was impacted by the gender of the therapist. Based upon the extant literature, it was hypothesized that the sexual offenders' perception of the working alliance would be negatively related to their risk level. We also

anticipated that sexual offenders would report a stronger working alliance with male therapists as opposed to female therapists and that this relationship would hold true across risk levels.

Method

Sample and Program Description

Data were collected over a 3-year period from 202 incarcerated male sexual offenders in the United States enrolled in 19 consecutive treatment cohorts and their 10 therapists (one male and one female per group). Of the 202 sexual offenders, 95 successfully completed low intensity programming and 107 successfully completed moderate-high intensity programming. The program was a manualized cognitive-behavioral treatment (CBT) program for sexual offenders conducted in a group format. At the completion of each treatment module, an individual session was scheduled between the sexual offender and both therapists. Attendance in the program was voluntary; however, participation in treatment likely contributed to early release on parole.

Before beginning the treatment program, offender risk was assessed using the Static-99 (Hanson & Thornton, 2000) and Level of Service Inventory-Revised (LSI-R; Andrews & Bonta, 1995). Following Department of Corrections policy, risk for sexual recidivism, as measured by the Static-99, guided group placement. Sexual offenders were placed into one of two groups: low intensity (Static-99 score three or under) or moderate-high intensity (Static-99 score four or above). Policy outlined dynamic risk factors that would warrant the placement of sexual offenders in moderate-high intensity treatment despite scoring three or below on the Static-99.

Low intensity programming was between 12 and 14 months in duration and comprised three modules: (a) responsibility taking, (b) sex education, and (c) relapse prevention and life management plans. Moderate-high intensity programming was between 24 and 30 months in duration and comprised seven modules: (a) responsibility taking, (b) behavioral techniques, (c) emotional wellbeing, (d) victim empathy, (e) anger management, (f) sex education, and (g) relapse prevention and life management plans.

Once enrolled in programming, sexual offenders were asked to rate each of the two therapists (one male, one female) at the completion of Modules 1 and 3 for those in low intensity groups or Modules 1, 3, and 7 for those in moderate-high intensity groups using the Working Alliance Inventory-Client Form (WAI; Horvath & Greenberg, 1989). As the WAI was to be used for research purposes, all sexual offenders completed an informed consent and agreed to have their data used for research purposes. One hundred percent of sexual offenders enrolled in the groups at the time of this study agreed to participate. The study received approval from both the Department of Corrections and affiliated university institutional review board.

Sexual offenders. The sample comprised 202 adult, male sexual offenders¹ sentenced to serve a period in state prison. An additional 4 sexual offenders began treatment but

did not complete the program due to prison transfer, release from prison, and voluntary program drop out. They were not included in the sample because they did not complete the final WAI. The 202 sexual offenders included in the sample ranged in age from 23 to 72 years ($M = 40.87$, $SD = 11.60$) at the start of treatment. Participants were predominantly White, non-Hispanic (51.7%), or Black (42.7%). Approximately half (52%; $n = 121$) of the sexual offenders were deemed between moderate and high risk for sexual recidivism, as determined by Static-99 scores (i.e., scores four and above). The remainder were deemed low or low-moderate risk (i.e., scores three and below). With regard to officially sanctioned criminal justice involvement, 22.9% of participants were previously convicted as an adult for a sexual offense and 47.6% for a violent offense. Almost half of the offenders had a history of juvenile conviction (48.5%), with 9.0% having a previous conviction as a juvenile for a sexually related offense and 39.5% a nonsexual offense. With regard to the offenders' relationship to their victim(s) in their index offenses, 66 sexually abused stranger victims, 84 sexual offenders had victims who were considered acquaintances, 15 sexually abused wives or girlfriends, and the remainder ($n = 37$) offended against related victims. The number of victims ranged from 1 to 15² ($M = 1.61$, $SD = 1.35$) with the majority of sexual offenders having 1 victim ($n = 133$). Considering the sample by victim type, 113 of the sexual offenders' index offenses involved solely child victims, 81 solely adult victims, and 8 abused both adult and child victims as part of their index offenses.

Therapists. Over the study period, a total of 10 therapists (5 female, 5 male) facilitated groups. The average age of the therapists at the start of treatment was 39.94 years (range = 26-64, $SD = 9.61$), with female therapists on average approximately 5 years older than male therapists ($M = 33.17$, $SD = 5.79$ vs. $M = 27.81$ years, $SD = 10.35$). A majority of both female and male therapists were White, non-Hispanic (3 female, 4 male). All therapists were required to have a graduate degree in a human services field. In all, 2 were licensed psychologists with doctorate degrees, 1 a psychiatrist, and 7 were masters-level clinicians. A majority were trained in graduate school to provide cognitive-behavioral treatment; however, 1 therapist was a social worker (Licensed Clinical Social Worker [LCSW]) and identified with the humanistic orientation. All therapists were trained to provide the manualized program at a 5-day intensive training. Following training, therapists were required to observe the groups of previously trained therapists who had been facilitating the manualized program (for no less than 1 year) prior to leading their own groups. As a job requirement all therapists participated in a weekly supervision group. The therapists who were part of this study had a minimum of 3 years prior experience conducting manualized group interventions with sexual offender and general offender populations.

Measures

Working Alliance Inventory (WAI). The WAI (Form C; Horvath & Greenberg, 1989) was designed to measure the quality of the therapeutic alliance between the therapist and client from the perspective of the client. Form C of the WAI comprises 36 items total, which include three subscales with 12 items in each subscale. The subscales measure

distinct features of the therapeutic relationship: the therapeutic bond (e.g., “I appreciate my therapist as a person”), task agreement (e.g., “My therapist and I agree about the steps to be taken to improve my situation”), and agreement on the goals (e.g., “I have doubts about what we are trying to accomplish in counseling”). These subscales are operationalized following Bordin’s (1979, 1994) theoretical conceptualization of the working alliance. Each question is rated on a 7-point Likert-type scale (1 = *never*, 2 = *rarely*, 3 = *occasionally*, 4 = *sometimes*, 5 = *often*, 6 = *very often*, and 7 = *always*). The WAI has been heavily grounded in empirical research over the past 30 years. This measure has demonstrated good convergent and discriminant validity, as shown by high correlations with other alliance measures, overlap with other measures of the therapeutic relationships, and little overlap with unrelated concepts (see Horvath & Greenberg 1994 for a review). Cronbach’s alpha for the WAI in this sample was .89. For this study, sum ratings on the WAI at the completion of treatment and total scores on the three subscales at the completion of treatment were of interest.

Static-99. The Static-99 (Hanson & Thornton, 2000) is a measure of actuarial risk that was derived by combining the four items from the RRASOR (Hanson, 1997) with six additional items from the Structured Anchored Clinical Judgment. This tool places offenders in one of four risk categories: (a) low, with scores of zero and one; (b) moderate-low, with scores of two and three; (c) moderate-high, with scores of four and five; and (d) high, with scores of six and above. Studies find that this actuarial risk assessment tool demonstrates moderate accuracy in predicting both sexual and violent recidivism (Barbaree, Seto, Langton, & Peacock, 2001; Hanson & Thornton, 1999, 2000; Nunes et al., 2002). The Static-99 is routinely used for treatment placement (McGrath, Cumming, & Burchard, 2003). This risk assessment tool was used to assess sex-offense-specific risk in the current study. Offenders were compared on total Static-99 scores.

LSI-R. This offender assessment tool uses static and dynamic factors as the basis for assessment. The LSI-R (Andrews & Bonta, 1995) contains 54 items grouped into Criminal History, Education/Employment, Financial, Family/Marital, Accommodation, Companions, Alcohol/Drug Problems, Emotional/Personal, and Attitudes/Orientation. The LSI-R has been widely used and researched in many jurisdictions, including the United States, Canada, Australia, and England. The LSI-R is also a strong predictor of general recidivism for the offender population (Gendreau, Goggin, & Smith, 2002). This risk assessment tool was used to assess for risk for general recidivism in the current study. Sexual offenders were compared on total LSI-R scores.

Analytic Plan

We first assessed the relationship between risk for sexual recidivism, as measured by actuarial risk scores, and the averaged ratings of sexual offenders’ WAI and WAI subscales completed on the collapsed scores of their female and male therapists at the completion of sex offender treatment. We were then interested in whether results were

Table 1. Summary Statistics of Working Alliance Inventory (WAI) Scores (*SDs* in Brackets).

Group	Goals	Tasks	Bond	Total
Sample	69.28 (11.24)	69.77 (10.77)	68.74 (11.56)	206.82 (31.38)
Female therapists	67.77 (11.12)	68.64 (12.07)	67.21 (12.40)	203.14 (33.60)
Male therapists	69.13 (11.97)	69.31 (11.06)	69.04 (11.63)	207.74 (32.01)
By treatment category				
Low-moderate	70.28 (11.41)	70.31 (11.16)	70.62 (10.73)	211.18 (31.36)
Female therapist	69.32 (10.97)	69.54 (11.45)	69.61 (11.65)	208.47 (31.88)
Male therapist	70.30 (12.46)	70.66 (11.33)	70.98 (11.18)	211.94 (32.42)
Moderate-high	63.94 (12.38)	64.47 (12.23)	65.11 (13.51)	192.33 (37.59)
Female therapist	62.75 (12.78)	65.15 (12.55)	62.70 (13.58)	191.75 (38.08)
Male therapist	65.64 (11.89)	65.69 (13.11)	64.74 (13.25)	194.38 (37.63)

Note. Number of sexual offenders = 202 (low-moderate = 95, moderate-high = 107); number of therapists = 10 (5 female, 5 male).

the same when ratings of co-facilitators were not averaged, but rather considered as gender-specific models while controlling for other potentially influential demographics (i.e., age and race). We then repeated the analyses to examine the relationship between risk for general recidivism and the client–therapist relationship.

Results

Means and standard deviations for WAI ratings among the sample and WAI ratings by treatment placement category are shown in Table 1. Among the sexual offenders in the sample, the mean sum rating on the WAI was 206.82 ($SD = 31.38$; Goals subscale = 69.27, $SD = 11.24$; Tasks subscale = 69.77, $SD = 10.77$; and Bond subscale = 68.74, $SD = 11.56$). Ratings were comparable with those reported at treatment completion across a range of client types; cf. Busseri and Tyler (2003) and Saffran and Wallner (1991).

WAI and Sexual Recidivism Risk

For the first set of analyses, WAI ratings were collapsed across both therapists to assess the relationship between WAI ratings and risk for sexual recidivism (Static-99 scores). Considered across Static-99 scores, the mean sum WAI ratings were as follows: (a) score of zero = 215.23 ($SD = 32.19$), (b) score of one = 216.17 ($SD = 35.61$), (c) score of two = 213.92 ($SD = 24.04$), (d) score of three = 207.34 ($SD = 31.84$), (e) score of four = 202.90 ($SD = 38.44$), (f) score of five = 215.86 ($SD = 25.70$), (g) score of six = 198.25 ($SD = 29.27$), and (e) score of seven = 198.42 ($SD = 27.34$). Sexual offenders deemed high risk had lower mean alliance ratings.

As seen in Table 2, correlations between Static-99 scores and overall WAI ratings and subscale ratings showed no significant relationship between Static-99 scores and

Table 2. Correlation Matrix Including Static-99, LSI-R, and WAI Scores.

Measure	1	2	3	4	5	6
1. Static-99	—	.05	-.19	-.12	-.24*	-.21
2. LSI-R	.05	—	.16	.13	.10	.16
3. Goals subscale	-.19	.16	—	.88**	.82**	.96**
4. Tasks subscale	-.12	.13	.88**	—	.74**	.92**
5. Bond subscale	-.24*	.10	.82**	.74**	—	.91**
6. WAI score	-.21	.16	.96**	.92**	.91**	—

Note. Number of sexual offenders = 202; number of therapists = 10. LSI-R = Level of Service Inventory-Revised; WAI = Working Alliance Inventory.

* $p < .05$. ** $p < .001$.

Table 3. Multiple Regression for Models Assessing Sexual Recidivism Risk and Sexual Offender Collapsed Ratings of Their Therapists While Controlling for Demographics.

	WAI		Goals		Task		Bond	
	β	<i>b</i>	β	<i>b</i>	β	<i>b</i>	β	<i>b</i>
Static-99	-.19	-3.78	-.13	-0.90	-.12	-0.76	-.26	-1.90
Female age	-.09	-0.42	.05	0.09	-.08	-0.14	-.01	-0.01
Female race	.10	6.94	-.09	-2.19	.18	-0.37	.17	4.29
Male age	-.07	-0.22	-.13	-0.13	.08	0.09	-.23	-0.28
Male race	.05	2.92	.03	0.65	-.06	-1.28	.15	3.48
Sexual offender age	-.18	-0.49	-.22	-0.21	-.07	-0.07	-.13	-0.13
Sexual offender race	.11	6.81	.09	1.92	.18	3.74	.01	0.23
Constant	259.38		83.53		74.74		90.81	
R^2	.081		.099		.050		.099	

Note. Race variables were dichotomized with 0 = Black and 1 = Other. Number of sexual offenders = 202; number of therapists = 10. WAI = Working Alliance Inventory.

* $p < .05$. ** $p < .001$.

overall ratings on the WAI. As for the subscale ratings, the results suggested that only one subscale rating was significantly correlated with Static-99 scores, the Bond subscale, $r = -.27$, $p < .001$. The Goals and Tasks subscales did not show a significant relationship with the Static-99 scores.

For the initial set of multiple regressions, the β weights in Table 3 show that Static-99 scores were not significantly related to total WAI ratings or WAI subscale ratings when collapsed across therapists and demographics were controlled.

WAI by Gender and Risk for Sexual Recidivism

Because groups were facilitated by one female and one male therapist and because there is some evidence in the general therapy literature that the gender of the therapist can impact clients' perceptions of the therapeutic alliance (Kiesler & Watkins, 1989;

Table 4. Multiple Regression for Models Assessing Sexual Recidivism Risk and Sexual Offender Ratings of Therapists by Gender.

	WAI		Goals		Task		Bond	
	β	<i>b</i>	β	<i>b</i>	β	<i>b</i>	β	<i>b</i>
Female therapist								
Static-99	-.19	-3.74	-.10	-0.65	-.08	-0.62	-.24	-1.80
Therapist age	-.24	-1.20	-.07	-0.12	-.06	-0.10	-.56	-1.05
Therapist race	.26	18.93	-.03	-0.82	.06	1.59	.63	17.12
Sexual offender age	-.24	-1.20	-.25	-0.23	-.15	-0.15	.09	2.12
Sexual offender race	.16	10.76	.12	2.31	.18	4.21	-.22	-0.23*
Constant	286.58		82.82		78.00		112.98	
R ²	.095		.105		.044		.092	
Male therapist								
Static-99	-.20	-4.01	-.16	-1.18	-.20	-1.35	-.23	-1.66
Therapist age	.05	0.16	.04	0.04	.16	0.17	-.01	-0.01
Therapist race	.12	7.83	-.11	-2.69	-.18	-4.10	.06	1.46
Sexual offender age	-.11	-0.30	-.20	-0.21	-.05	-0.05	-.05	-0.05
Sexual offender race	.12	7.83	.12	2.82	.23	4.93	.03	0.72
Constant	226.84		80.14		68.19		75.96	
R ²	.066		.088		.092		.063	

Note. Race variables were dichotomized with 0 = Black and 1 = Other. Number of sexual offenders = 202; number of therapists = 10. WAI = Working Alliance Inventory.

* $p < .05$.

Persons et al., 1974; Wintersteen et al., 2005), we decided to then examine the relationship between WAI ratings and Static-99 scores by gender. Age and race of the therapist and sexual offenders were controlled. Means (*SDs*) for WAI scores by gender are shown in Table 1.

Table 4 shows results for the regression models with overall WAI and subscale ratings by gender. With regard to female therapist models, the Bond subscale was the only variable related to Static-99 scores ($\beta = -.23$, $p < .05$). This model explained a total of 9% of the variance. As for male therapists, the results suggested the Static-99 scores were not related to WAI ratings by sexual offenders.

WAI Risk for General Recidivism

Finally, we were interested in whether risk for general recidivism showed a similar pattern of results. As shown in Table 2, the relationship between LSI-R scores among the sexual offenders in the sample and their WAI ratings was not significant. The same was true in comparing the relationship between risk for general recidivism (LSI-R scores) and each of the subscale ratings. Next, a series of regression models was carried out to explore whether the LSI-R score was associated with WAI ratings. Results showed that general recidivism risk was not significantly predictive of total WAI ratings or subscale ratings when collapsed across therapists or considered by gender of the therapist.

Discussion

Despite its critical importance to positive treatment outcomes in general psychotherapy, relatively little empirical attention has been given to the client–therapist relationship with justice-involved populations. To examine this specific responsiveness component in sex offender treatment, we assessed the effect of sexual offenders' risk for recidivism on their WAI (Horvath & Greenberg, 1989) ratings of their therapists. Overall, we found that sexual offenders' risk for sexual recidivism was negatively correlated with perceived bonds. When we assessed the models by gender of the therapist we found that risk was negatively related to perceived bonds with female therapists, but not male therapists. Sexual offenders' self-reported agreement with their therapists on the goals and tasks of treatment were not related to risk for sexual recidivism. No relationship was found between risk for general recidivism and the perceived client–therapist relationship.

The WAI mean rating and ratings on subscale scores of the sexual offenders in the sample were equivalent to those reported at treatment completion across an array of client types; cf. Busseri and Tyler (2003) and Saffran and Wallner (1991). This suggests sexual offenders are able to perceive a working alliance with their therapists comparable with other client groups.

It was conceptualized that risk for recidivism could be analogous to measures of symptom severity or global functioning, which in the general psychotherapy literature were found to be negatively related with the client's ability to form a working alliance with their therapist (Castonguay et al., 2006; Constantino et al., 2005; Hersoug et al., 2009). Typically, sexual offenders at higher risk to recidivate exhibit more symptoms of denial, minimization, and cognitive distortions, among others. We anticipated therefore that these characteristics would be more prevalent in higher risk sexual offenders and impede formation of the therapeutic alliance. Overall, this hypothesis was only partially supported. The overall WAI ratings were not related to risk of sexual recidivism. With regard to subscale ratings, one subscale, the Bond Formation, demonstrated a significant relationship with risk of sexual recidivism.

We were further interested in exploring whether certain therapist characteristics found to be associated with the client perceived working alliance in general psychotherapy were influential when considering the relationship between sexual recidivism risk and sexual offenders' perceived client–therapist relationship (Connors et al., 2000; Kiesler & Watkins, 1989; Persons et al., 1974; Wintersteen et al., 2005). To do so, we created gender-specific models. Of the three subscales on the WAI, Static-99 scores were predictive of the perceived bonds sexual offenders had with their female therapists only, highlighting a potential responsiveness issue. It may be that higher risk sexual offenders present with increased cognitive distortions pertaining to women, subsequently influencing ratings of the client–therapist relationship with female therapists. Evidence from the general offender literature suggests that certain subgroups of offenders are more likely to present with increased distortions or types of distortions. For example, in their study of male violent offenders, Polaschek and colleagues (2004) found that violent offenders endorsed higher criminal attitudes than their nonviolent

counterparts. Cognitive processes in sex offender treatment focus on changing offense-supportive beliefs, and therefore, the same beliefs a sexual offender had about his victim (Polaschek & Ward, 2002; Ward, 2000; Ward & Keenan, 1999) could be those he has about his therapist—thus making the development of a relationship difficult. For example, a rapist who believes that women exist to meet the needs of men may find it difficult to collaborate with his female therapist, or may resist efforts to collaborate.

Turning to rapists specifically, it is likely that many of the schemas and cognitive distortions of rapists are centered on beliefs and attitudes about women (Malamuth & Brown, 1994; Polaschek & Gannon, 2004; Polaschek & Ward, 2002). It is possible that rapists interpret the behaviors of their female therapists according to their own gender-related cognitions making bond formation difficult. Gender-related cognitions refer to “rape myth acceptance, hostility towards women, traditional gender role adherence, and hypermasculinity” (Teten Tharp et al., 2013, p. 140). For example, Scott and Tetreault (1987) administered the Attitudes Toward Women Scale (AWS; Spence, Helmreich, & Stapp, 1973) to a sample of convicted rapists, a sample of convicted violent, nonsexual offenders, and a sample of noncriminal individuals. Results from the AWS, designed to measure attitudes toward the rights and roles of women, found that convicted rapists, as compared with nonsexual offenders and a noncriminal sample, showed increased negative attitudes toward the growing equality of women in the marketplace and strongly supported the subservient, stereotypical, passive roles for women in male–female relationships. Given these results, it could be that the mere presence of a woman in a facilitator role is difficult for rapists, setting the stage for difficult bond formation over the course of treatment.

Finally, it was intriguing that there was not a significant relationship between the working alliance and the sexual offenders’ general recidivism risk. Some recent work by criminologists has shown that programs adhering to the RNR model, while effective at reducing crime days, are not effective at reducing drug use outcomes following incarceration (Prendergast, Pearson, Podus, Hamilton, & Greenwell, 2013; Wooditch, Tang, & Taxman, 2014). These findings suggest that when an offender’s pathway to offending is by way of drug use, participating in a program targeting crime involvement (e.g., criminal thinking) will likely not result in reductions in drug use and subsequent offending. Findings from the current study suggest that there are *specific* responsivity components unique to certain sexual offender groups. To date, evidence for the efficacy of the RNR model at reducing recidivism with sexual offender populations has largely been derived from meta-analyses that consider *general* responsivity, or adhering to the CBT model (e.g., Hanson et al., 2009).

Limitations and Conclusion

When interpreting the findings of this study, it is important to consider the potential limitations. The group of sexual offenders examined here may not be representative of all sexual offenders who present for treatment. While some research suggests there are minimal differences between voluntary and mandated sex offender treatment

participants (see Grady, Edwards, Pettus-Davis, & Abramson, 2013), given that this study focused specifically on client–therapist relationships, it is important to keep in mind when interpreting the results that the sexual offenders who were part of this study volunteered to participate in treatment. Future studies can examine the role of therapeutic alliance in groups of offenders who are mandated to participate in treatment to examine whether nonvoluntary participation impacts the client–therapist relationship.

For the current study, it was conceptualized that the risk of recidivism was analogous to measures of symptom severity or global functioning (e.g., symptoms of denial, minimization, and cognitive distortions). While it was not possible to do so in the current study, future research could consider specific symptoms when assessing the role of the therapeutic alliance in sex offender treatment.

Results from this study showed that perceived bonds with female therapists were related to risk; however, risk was not an effect of agreement on goals and tasks. Theoretically, it would be interesting for future work to explore which dimensions of the client–therapist relationship are associated with posttreatment outcomes, such as retention of treatment materials or rearrest. Perhaps perceiving a strong bond is not as important for sexual offenders as long as they perceive agreement on goals and tasks of treatment.

The findings from this study offer some meaningful results about the client–therapist relationship as perceived by a group of male sexual offenders. First and foremost, these findings underscore the need for further investigation. While risk and therapist gender account for some part of the variance in the perceived working alliance in the current study, it appears there are other demographic and personality factors that also contribute; more research is needed. This work also highlights that it is likely not enough to generically consider the client–therapist relationship as important to outcomes, but rather further research should investigate the client factors that could moderate the perceived client relationship and consider under what circumstances these factors are important to treatment outcomes. Building on research in this area would also contribute to empirical findings on the specific responsivity principle and in turn contribute to effective treatment implementation with sexual offender populations.

Second, it would be incorrect to assume that these findings translate to male therapists being more effective in working with sexual offenders than female therapists. Rather, what is important to consider is that training for individuals working with higher risk sexual offenders should emphasize that even when therapists are highly trained and are considered as acting “appropriately” in their therapeutic interactions, therapist behaviors may be but one element that contributes to the formation of the therapeutic alliance. It seems likely that higher risk sexual offenders present with increased pathology and criminogenic needs, many of which could influence how women are perceived in general. These views and perspectives could be transferred onto the relationship with their therapist. In as much as these views may impact the therapeutic relationship, they offer an invaluable opportunity as treatment targets as there is some evidence suggesting that rapists hold more negative attitudes toward

women (Scott & Tetreault, 1987) and thus could be a criminogenic risk factor. Therefore, these attitudes could be explored in treatment using interactions with the female therapist as a proxy.

It may also be the case that female therapists have the opportunity to influence treatment outcomes as a result of the difficult bond formation process. Studies from the general psychotherapy literature suggest when therapists are able to appropriately address a rupture in the client–therapist relationship by responding nondefensively, adjusting their behavior, and addressing strains in the relationship as they occur, the therapeutic bond can improve (Foreman & Marmar, 1985; Lansford, 1986; Rhodes, Hill, Thompson, & Elliott, 1994) and even result in better treatment outcomes than would have been expected from a steady and healthy therapeutic bond development (Bordin, 1980). If female therapists respond appropriately to alliance ruptures, it may serve to counter a sexual offender’s attitudes and beliefs, particularly about women (e.g., the expectation of a negative reaction).

While it could be that many of the skills and techniques that have been found to promote a positive therapeutic alliance in the general psychotherapy literature would also be applicable when working with sexual offenders, we know little, empirically, about under what circumstance this is true. It is vital to conduct more research to examine mechanisms of change in sex offender treatment, with a special emphasis on understanding the factors related to sexual offenders’ perceptions of the client–therapist relationship as a vehicle for change (e.g., attachment style, levels of denial, schemas). Under what circumstances higher risk sexual offenders perceive a positive client–therapist relationship with female therapists, which aspects of the client–therapist relationship (e.g., agreement on goals, agreement on tasks, and formation of a bond) are important for different posttreatment outcomes, and which populations of sexual offenders experience difficulty forming a bond with their female therapists are all important questions that can have implications for the prevention of future sexual assaults.

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Authors’ Note

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Notes

1. The sample included developmentally disabled sexual offender groups ($n = 2$) and deaf sexual offender groups ($n = 3$).
2. One individual had 15 child victims who he abused (contact offending) while creating child pornography.

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