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FACTORS WHICH INFLUENCE THE DECISION OF SEXUAL OFFENDERS AGAINST CHILDREN TO ATTEND A SEX OFFENDER TREATMENT PROGRAMME AT TE PIRITI OR KIA MARAMA

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ABSTRACT

FACTORS WHICH INFLUENCE THE DECISION OF SEXUAL OFFENDERS AGAINST CHILDREN TO ATTEND A SEX OFFENDER TREATMENT PROGRAMME AT TE PIRITI OR KIA MARAMA

Treatment of individuals who sexually offend against children has been shown to be associated with reductions in recidivism both in New Zealand, (Johnston, 1996) and overseas (Gendreau, 1996). Laven (1993) and Jury (1993) found in two New Zealand studies of incarcerated child sex offenders that when they were offered treatment to help them address their offending they more often than not declined. Barbaree (1991) noted that offenders often present as denying, minimising, rationalising or being vague about their sexual offending behaviours. Treatment for incarcerated individuals who have sexually offended against children is provided by the New Zealand Department of Corrections Psychological Service specialist prison-based Child Sex Offender Treatment Programme at Auckland (Te Piriti) and Christchurch (Kia Marama). However, participation in the programme is voluntary.

The main purpose of the study was to examine the effects of a motivational and educational pretherapy intervention, First Step, on factors such as Stage of Change and Victim Empathy which were believed to be associated with the decision to seek entry to the Sex Offender Treatment Programme. A secondary purpose was to investigate which factors the child sex offenders considered while making their decision to seek or decline treatment in the programme.

The subjects were 104 male incarcerated offenders convicted of sexual offences against children under the age of sixteen years. They were resident in one of three minimum security prisons, Tongariro/Rangipo, Ohura and Waikeria, New Zealand. All of the subjects were referred by the prison Case

Management Committee to Department of Corrections, Psychological Service for assessment when they arrived in the prison. Of the total of 104 participants, 39 attended First Step. The other 65 were involved in a related study (Knowles, 1997) at Waikeria Prison. They were included to provide additional information on select issues related to helpseeking.

Participation was voluntary and access to the First Step programme was not contingent on participation in the study. Also, there were no custodial consequences (e. g., temporary paroles or early release) contingent on participation in the study.

The design for the treatment portion of the study was a two by two factorial, repeated measures design with two conditions, a wait-list control and a treatment condition (First Step). An assessment of treatment readiness and victim-specific empathy was made using the University of Rhode Island Change Assessment (URICA) questionnaire based on Prochaska, DiClemente et al's (1982, 1985, 1989, 1991, 1995) Transtheoretical Stages of Change model and Marshall et al's (1995) Person Specific Empathy Scale which were administered at pre and post wait-list and treatment conditions.

The results of this study provide important data for enhancing our understanding of the effects of a pre therapy intervention on motivation and of the factors that influence the incarcerated child sex offender's decision to seek entry to a Sex Offender Treatment Programme.

There was evidence that the motivational and educational intervention, the First Step programme, had an influence on the way that the offenders thought about their offending behaviour. In particular, this was supported by a general pattern of movement through the Stages of Change as illustrated by changes in the numbers of offenders in identified Stages of Change clusters. The support for First Step further buttresses Barbaree (1991) and O'Donohue and LeTourneau (1993) proposals for the necessity, particularly in cases where the problem is denied, for a pre-treatment intervention designed to

encourage a frame of mind that is more amenable to treatment entry and compliance. Some positive treatment produced changes were also noted on the empathy scale.

Apart from a motivational intervention, other factors identified by the sample as being influential in the treatment-seeking decision-making process included both internal (e. g., desire for self improvement, acceptance of responsibility for the offending, denial of offending, fear and shame) and external (e. g., awareness of treatment procedures at the Sex Offender Treatment Programme, family support and custody conditions) factors. The discussion focuses on future use of pretherapy, motivational interventions and the integration of such factors.

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CHAPTER 1

INTRODUCTION

Sexual Offending Against Children

Sexual victimization is a serious social problem. The rate of sexual victimization among children has been shown to be high and is, therefore, suggestive of a significant number of sexual offenders against children. The size of this group of offenders, also known as child sex offenders, child molesters or paedophiles, and the damage they do to our community's well being raises important public policy questions concerning how such offenders should be managed and treated by the criminal justice and mental health systems (Hanson & Bussiere, 1996). In terms of treatment, cognitive behavioural interventions with child sex offenders have been found to effectively reduce recidivism of the offence (Johnston, 1996). However, in New Zealand, offenders can not be compelled to enter Sex Offender Treatment Programmes. As a consequence, investigation of the factors which influence an offender's decision to seek voluntary entry into these programmes appears vital. This study focuses on these factors.

The literature review begins with an overview of the effects of sexual abuse on children, prevalence of sexual offending against children, particularly among incarcerated offenders, child sex offenders and recidivism, responses to sexual offending against children including treatment as rehabilitation and factors influencing the decision to seek or decline entry to a Sex Offender Treatment Programme. Prochaska and DiClemente's (1992) Transtheoretical Model of Change and Marshall et al's (1995) analysis of victim empathy in child sex offenders against children are discussed. The review considers such factors as may influence the decision to seek or decline sex offender treatment and describes a pre-therapy intervention aimed at these factors.

Finally an overview of the current study is provided: first, predictors of treatment entry are examined followed by a controlled trial examining the effects of a pretherapy intervention on Stages of Change and empathy factors.

Effects of Sexual Abuse on Victims and Society

Sexual victimisation of children is a serious and widespread problem. In a recent New Zealand study (Anderson, Martin, Mullen, Romans & Herbison, 1993), a random sample (n = 1660) of adult women were asked about their experience of unwanted sexual advances during their childhood. The level of reported sexual abuse involving genital contact was 20% of the sample and a further 13% reported inappropriate touching or non-tactile abuse such as exposure. That is, approximately one in three girls in that study reported experiencing some form of sexual victimisation as a child under the age of 16. The reported incidence of sexual abuse for males is apparently less. Watkins & Bentovim (1992) concluded from their review of the literature a "best guess" that 2 - 5 %of males experience sexual abuse involving physical contact. However, they also point out that there is evidence (Baker & Duncan, 1985 cited by Watkins & Bentovim, 1992) that males are less likely to disclose than females. Given this lack of reporting, the rate for male sexual abuse may actually be comparable with that of females. That possibility notwithstanding, Furby et al (1989) cite studies (Finkelhor, 1984; Kercher, 1980; Russell, 1983) in which the prevalence of reported sexual abuse of children was found to be 3 - 6% for males and 12-28% for females.

The long term sequelae of psychosocial problems, associated with sexual exploitation of children, in the victims and their families has been well documented. (Salter 1988; Briere, 1992; Busby, Glenn, Steggell and Adamson, 1993). Briere and Runtz (1993) reviewed the literature on the long-term effects of sexual abuse and found "strong, albeit inferential, support for the psychological toxicity of childhood sexual victimization" (p 324). Victims can experience serious symptoms of post-traumatic stress, severe anxiety, depression and/or impaired self reference. They can develop behaviours

which are both immediately adaptive but ultimately self-injurious (e.g. substance abuse, eating disorders, self-mutilation). Briere (1992) also noted studies which found a higher incidence of disturbed interpersonal relatedness among sexual abuse victims. Inability to form satisfying relationships is associated with a wide variety of social problems, including breakdown of families, and the continuation of sexually exploitative practices which, in turn, can exacerbate the initially harmful effects of abuse. Victims may also suffer physically either through illness (e.g. AIDS or other sexually transmitted disease) or injury (through forced sexual contact) as a direct result of being sexually abused.

In terms of gender effects, Cureen (1994) found that male victims of sexual abuse frequently develop chronic anger problems which not only affect relationships between themselves and others but can also result in serious assaults and the incarceration of the erstwhile victim of sexual abuse. Other psychosocial problems affecting male victims are sexual identity confusion, male prostitution, alienation from families and difficulty forming adult relationships, whether or not they involve sexual contact. Some of these difficulties are also found in female sexual abuse victims, including prostitution, alienation from families and relationship and sexual difficulties. Victimisation does not stop with the child. Whether the abuse is familial or not, the families of the victims generally cannot avoid the adverse ripple effects of the sexual abuse of one or more of their family members. Emotional and behavioural difficulties experienced by one member of the family can impact on other family members resulting in alienation, emotional disruption, shame as well as the physical consequences that result from acting out or antisocial behaviour.

In the wider community, the effects are often more obvious on a practical level. For instance, Prentky and Burgess (1990) reported that the cost of investigating, arresting, convicting, and imprisoning (for an average of three years) one sexual offender against children has been calculated to be in the vicinity of US$200,000. In addition, the cost to the community of educational

and career opportunities missed by sexual abuse victims, and the cost of abuse-related mental health problems would be in the billions of dollars.

The growing realisation over the last two decades of these problems has led to increased attention focused on how to deter its perpetration. Punishment, rehabilitation, and restorative justice have all been used in New Zealand and elsewhere as responses to the problem. Punishment combined with rehabilitation or specialised psychological treatment has been found to be effective in reducing recidivism among perpetrators of sexual abuse both in New Zealand (McLean & Rush 1990) and overseas (Marshall & Barbaree 1988)

Prevalence of Sexual Offending Against Children

The offence.

There has been a dramatic increase in New Zealand in recorded violent offences in the 1990's and while the rate of increase of all crime is expected to slow down, the incidence of violent crime is predicted to continue rising (Triggs, 1997). The number of convictions for violent offences has more than doubled between 1986 and 1995 (see Table 1.1). Violent sex offences are included in the violent offending category for statistical purposes by the Ministry of Justice, New Zealand. In 1995, the total for all convictions for a sexual offence, regardless of the victim's age and including non-violent sexual offences, was 2326 (see Table 1.1). Of these, there were 1914 convictions for a violent sexual offence (rape, unlawful sexual connection, attempted sexual violation, indecent assault, incest, do indecent act, unlawful sexual intercourse, attempted unlawful sexual intercourse, anal intercourse).

Table: 1.1

Number of Convictions for All Violent Offences and Offences Against the Person (and for the Sub-category of Sexual Offences) in 1986 and 1995

Offence Type	1986	1995	Overall % Change
Violent Offences (Sexual)	7988 (562)	16778 (1914)	110% (240%)
Offences Against the Person (Sexual)	3518 (337)	3534 (412)	0.45% (22%)
Total	11506 (899)	20312 (2326)	76.5% (158.7%)

At least three quarters (75.8%, n = 1761) and probably more (see Table 1.2) of the total number of convictions for a sexual offence, involved victims under the age of sixteen (Spier, 1996). The incidence of all convictions for a sexual offence increased by 258% between 1986 and 1995. Recently, there has been a levelling off. Since 1993, when there were 2309 convictions for a sexual offence, the incidence in many of the offence types (e. g., indecent assault, incest and 'other non-violent sexual offences') has plateaued or declined, while for other offence types, there has been an increase (e. g., rape, +26%). It is probably important to note that it was late in 1993 that the Accident Compensation Commission lump sum payout of $10,000 to victims of sexual abuse was discontinued. This change in legislation may have had an effect on the number of complaints of sexual abuse made to the police. However, it must also be said that laying a complaint with the police was not a precondition for receiving the compensation. Until there look to be some trends based on offence type, the major point as relates to this study remains that the overwhelming majority of sexual offences are against victims under the age of sixteen.

The offenders.

The 1995 Prison Census (the latest available) showed that the number of male inmates convicted of violent offences was 2369 of a total population of 3980 male inmates. The incidence of sexual offences among male sentenced inmates convicted of a violent offence was 39.8% (n = 940). An extrapolation from the Spier's (1996) convictions figures, where just over 75% of the violent sexual offences were against victims under the age of 16, indicates that there were 705 male inmates incarcerated for violent sexual offences against children under 16 years of age. This represents 29.75% of the male sentenced inmates whose major offence (longest sentence or highest court-related seriousness rating) was a violent offence and 17% of the total New Zealand inmate population. These figures do not include those inmates whose major offence was "against persons" but not classified as violent (another 2.6%, n = 109) of the total inmate population. Hence, as this latter category includes offences such as indecent assault, it can be seen that the number of male sentenced inmates, whose major offence is a sexual offence against children, is estimated to be in the vicinity of 20% of the total inmate population. It must be remembered that these figures relate only to the major offence and therefore do not represent the full extent of convictions for sexual offences against children committed by male sentenced inmates. However, it does reflect the extent of the problem and supports the case for ensuring that appropriate interventions are being implemented in an effort to reduce recidivism in this very socially, emotionally, and physically destructive area of offending.

Convictions for sexual offending against children.

When viewed from the perspective of the number of convictions, there was an increase of 158.7% in convictions for sexual offending between 1986 and 1995 (Spier, 1996). This is considerably greater than the increases for the two relevant categories (all violent offences and all other offences against the person) for the same period. The increase for all offences in these two

categories was 76.5%. Whether the incidence of convictions for sexual offences or the number of inmates with violent offences, including sexual offences, is considered there is compelling evidence that the trend is towards an increase in this area. One of the reasons for the increase in convictions may well lie in the

Table 1.2

Number of Convictions for Sex Offences by Age of Victim, 1995

	< 12 years	12-16 Years	>16 Years*	Unknown
Convictions**	951	810	445	117***
Percentage	40.93%	34.87%	19.16%	5.04%

* Under New Zealand law, the age of consent to sex is sixteen years. ** In many incidences the convictions relate to the same offender and victim, that is, there were not 2323 individual victims. *** The precise age category for the 117 victims in the age unknown column was not able to be identified but most were under the age of 17 years N = 104. This brings the total number of victims under the age of 17 to 1865. (Spier 1996).

increased reporting of these crimes by the community (Spier 1996, Triggs 1997). Whatever the reason, the net result is that today there are many more people in prison convicted of sexual offences, particularly those against children. Given the extent of this type of offending in New Zealand communities, there is an obvious need for policy and practices focused on reducing offending in this domain.

Convicted sexual offenders commit a wide range of sexual offences (Abel, Becker, Mittelman, Cunningham-Rathner, and Rouleau 1988; Groth, Longo & McFadin, 1982) and very well may commit many more offences than they are charged with (Marshall & Barbaree, 1988, Marshall, Laws & Barbaree, 1990). Also, a significant number of sexual offences are not reported. For instance, in New Zealand it has been estimated that the percentage of child sexual abuse incidents which are reported is probably quite low (approximately 13%) (Shapcott, 1988).

In this study, the focus is on convicted and incarcerated offenders only. There is believed to be, beyond the realm of the reported statistics, a population of offenders who have either not been caught or against whom a conviction was not able to be brought for legal and judicial reasons. These persons are outside the scope of this study.

Child Sexual Offenders and Recidivism

Furby et al (1989) suggest that recidivism rates can be misleading because of under-reporting of sexual offences, the practice of using mainly official records to gather data about the rates and the artefact created by monitoring *treated* sex offenders thus perhaps leading to greater detection rates than for the less monitored *untreated* offenders. In their review of the literature on sex offender recidivism in North America, these authors drew a number of tentative conclusions about both recidivism and the effectiveness of treating sex offenders. They reported recidivism rates for the full range of sex offenders, with or without treatment, ranging from 0% to 50%. However, (a) inclusion of all types of sex offenders obscures the differential results for sexual offenders whose victims are children and/or successfully completed treatment, (b) treatment methods vary and evolve and Furby et al acknowledge that some may have even been obsolete by the time they reviewed the studies, (c) many studies reviewed were not conducted with sufficient methodological rigour to allow conclusive evidence about sex offender recidivism to be obtained.

In a study of the long term recidivism of child molesters in the United States, Hanson, Steffy & Gauthier (1993) found that 42% of their total sample of offenders released from prison between 1958 and 1974 were re-convicted for sexual crimes, violent crimes or both. A significant proportion (10%) of the total sample were re-convicted between 10 and 31 years after their release. Hanson & Bussiere's (1996) meta-analytic study found that sex offenders who had a low motivation for treatment or who had previously failed treatment for

sexual offences were significantly more likely to reoffend. In another study, Prentky and Burgess (1992) found a recidivism figure of 40% for untreated sex offenders and a lower rate (25%) for treated offenders, five years after discharge from prison. The rates of recidivism are lower for incest offenders, whether treated or untreated. (Marshall, Ward, Jones, Johnston and Barbaree, 1991).

In the New Zealand context, McLean and Rush's (1990) study reported on by Johnston (Personal Communication, 27th October 1995) showed that around 25% of child sexual offenders were reconvicted of a sexual offence within five years of release from an earlier sentence of imprisonment for the same type of offence. Bakker and Riley (1996) recently completed a five year study of recidivism in New Zealand. Their early results showed that there was a marked reduction in reconviction for persons who were convicted of either violent or sex offences and who had undergone psychological treatment. In addition, the frequency of reoffending for persons who had completed psychological treatment was approximately 30% lower than an untreated control group (i. e., 66% versus 36%, respectively). For those treated individuals who did re-offend, the seriousness of subsequent offending was significantly less. At the completion of the study, five years later, the treatment effects had eroded to a 22% difference between the treated and untreated offender groups' recidivism rates (i. e., 80% versus 58%). This reduction was attributed, in part, to the changes in the sample size and the greater numbers of offenders having been released from prison enabling more extensive data gathering about recidivism rates. Finally, Johnston (1996) reported that the reconviction rate for child sex offenders who have successfully completed the cognitive-behavioural Sex Offender Treatment Programme at Kia Marama Unit, Rolleston Prison, Christchurch, New Zealand was 3% at two to three years post release compared with 40% of an untreated comparison group.

Punishment Versus Restorative Justice Versus Rehabilitation: Responses To Sexual Offending Against Children

The ways in which society has reacted to the criminal have evolved through trial and error and, perhaps, under the influence of philosophical attitudes about an individual's importance in the scheme of things. Smith and Berlin (1988) cite LaMar T. Empey's (1967) suggestion that "humanity's historical approach to criminals can be summarized by adding to Glaser's (1964) three R's - Revenge, Restraints and Reformation - the additional R of Reintegration" (p55). Some historical responses to crime described by Smith and Berlin include the pre-Norman English practice of requiring monetary restoration be paid to victims or their kin proportional to the seriousness of the crime and the Roman penchant for feeding criminals to the lions in public spectacles. In the past two centuries, correctional practices in Western culture have been influenced by two major revolutions. Firstly, egalitarianism and humanitarianism meant that punishments were fitted to the crime and not the criminal and that simple incarceration was substituted for various cruelties previously inflicted. Secondly, psychological practices and social factors emphasised rehabilitative practices in the treatment of offenders (Smith & Berlin, 1988). Finally, in even more recent times, restoration to the victim for harm done is gaining importance in Western (including New Zealand) correctional practice. (Consedine, 1995)

Punishment.

Even with some humanitarian trends, punishment is the mainstay of official response to those found guilty of crime, both historically and currently (McGuire & Priestley, 1995). Although New Zealand escaped the ignominy of being a penal settlement like its near neighbour Australia, the practice here is to punish those who break the law. Punishment is often seen as having the dual functions of deterrent to further crime and expression of the community's feelings of anger and hurt towards criminals. However, punishment has been shown to be insufficient, on its own, to deter sex offenders from committing

future crimes (Clark, 1993; Schlank & Shaw ,1996). Stevens (1995) presented evidence which suggests that the longer offenders were in prison, the more likely they were to see crime as part of their future. Meta-analytic evidence (Lipsey, 1992) suggests that, while a small number of offenders are deterred from committing further offences by imprisonment, most offenders are not deterred and some punishment-based programmes have even been associated with a 25% increase in reoffence rates. As a result of such findings, other methods (e. g. rehabilitation and treatment programmes) have been tried, either on their own or in combination with punishment in an effort to reduce the incidence of crime.

Restorative justice.

Restoration (i. e., "making good the harm done") is another response to criminal behaviour which has a long history in Pacific Island, Australian Aboriginal, and Irish traditional justice (Consedine, 1995). In New Zealand, since 1989, restoration has characterised society's response to young offenders under the Children, Young Persons and Their Families Act. Also, since the early 1990's, Aroha Terry and her organisation Kokona Ngakau have been re-establishing an historical restorative response to child abuse within the Maori community. Offenders meet on the marae with the victims and other members of the whanau (family). The process incorporates both sanction and healing (TV3, 1993).

Rehabilitation.

Rehabilitation refers to offenders making changes to their lifestyle and behaviour in order to avoid reoffending. Those targeted for rehabilitation are helped to make these changes in areas such as behaviour, attitudes, morals, values, and lifestyles. Offenders are more frequently being advised or ordered by judges to seek rehabilitation, to attend counselling, to be assessed by a psychologist or to enter group programmes to address aspects of their offending (Judges' Sentencing Notes, 1995 - 1997). While rehabilitation can

be achieved by the individual without help from professionals, this path is generally considered to have more difficulties, including achievement and maintenance of gains (Prochaska & DiClemente, 1992).

Incarceration is used in New Zealand as punishment for serious crime. In the past, it was believed that this would be a sufficient deterrent to further reoffending as well as disincentive to those who may have otherwise offended. However, incarceration, on its own, doesn't appear to work as well as when it is combined with rehabilitative treatment (Bakker & Riley, 1996).

Just over forty years ago, the New Zealand Department of Justice changed its philosophy to consider rehabilitation as another approach to reducing reoffending in this country. In 1955, psychologists, chaplains and a medical service were introduced into prisons. In 1981, the Penal Policy Review Committee recommended community involvement in prison programmes to help change the behaviour of inmates (McKay, 1993). In 1969, a separate division for psychological services was established in the Department of Justice ("Prisons in Change," 1988). Today, it is known as the Department of Corrections, Psychological Service and it is charged with the assessment and treatment of offenders, both when they are in prison and when they are in the community under the supervision of Community Corrections. One group of offenders who regularly come to the attention of the Psychological Service, both in prison and in the community, is that of convicted child sexual offenders or child molesters.

Treatment As Rehabilitation

Treatment of the sex offender has been likened to scaling a snow-covered volcano (Rencken, 1991 cited in Polaschek & Thomas, 1993), potentially discouraging and difficult. Of course, in New Zealand, some of us are accustomed to the challenge of snow- covered volcanoes, and this research was carried out within sight of just such a mountain. Though treatment is potentially difficult, evidence of effective treatment services for

offenders can be found in meta-analyses of large databases (Gendreau, 1996). Lipsey's (1992) meta-analysis of over four hundred treatment studies found that 64% of studies reported a reduction in recidivism attributable to treatment. Reductions in recidivism ranged from 25% to 60%, and the most successful were community-based programmes. Specific treatment programmes have also been developed to assist sexual offenders whose victims are children (Marshall and Barbaree, 1988; Marshall, Johnston, Ward, Jones, & Hudson, 1991; Hudson, Ward and Marshall, 1992; Marshall, 1996). In a review of studies, Marshall et al (1991) reported that child sex offenders can be effectively treated, although not all programs are successful and not all child sex offenders profit from treatment. Programmes based on a cognitive behavioural model and those that use anti-androgens in conjunction with psychological treatments thus far seem to show the most effectiveness (e. g., 3% recidivism at two to three year follow-up, Johnston, 1996).

Regarding psychosocial programmes, and based on both meta-analyses and an extensive literature review, Gendreau (1996) concluded that there are six characteristics of a successful sex offender treatment programme: (a) long and intensive programmes, (b) cognitive-behavioural and targeted at the criminogenic needs of high risk offenders, (c) adherence to the Responsivity principle (i. e., the programme is delivered in a manner that facilitates the learning of new pro-social skills by tailoring the programmes to the learning needs and styles of the offenders), (d) programme contingencies that are delivered in a firm, fair manner with positive to negative reinforcers in the ratio of approximately four to one, (e) sensitive and constructive interpersonal relationship style of therapists towards offenders, and (f) reintegration attempts that include the involvement of the offender in everyday activities and environments outside the programme.

New Zealand Department of Corrections (formerly Justice Department) psychologists (Johnston, 1993; Ward et al 1993; Warwick & Johnston, 1996) have developed a cognitive behavioural Sex Offender Treatment Programme based on the Canadian model and in consultation with W.L Marshall and his

team (e. g. Marshall, 1994). The programme was designed to reduce recidivism amongst men who have sexually offended against children. It is now operating at two special focus prison units in New Zealand: Kia Marama outside Christchurch in the South Island was established in 1989 and Te Piriti outside Auckland in the North Island was opened in 1995. By October 1995, 310 men had completed the Kia Marama programme. The reconviction rate of those treated individuals was just under 3% (i. e. , 10 men). This compares with an overall recidivism base rate of 25% (Johnston, 1995).

A number of community agencies in New Zealand have developed treatment programmes similar to those offered at Kia Marama and Te Piriti (e. g. , SAFE, STOP and the Anglican Social Services' Steps to Safety) to help offenders to address their offending and to change their inappropriate sexual behaviour. Of course, these programmes can only be effective for those who enter them. The psychologists and other workers involved in the task of motivating these offenders to seek treatment can be potentially more effective if they have a better understanding of the factors which influence or are instrumental in the offender's decision to enter treatment. For instance, if an offender's acceptance of responsibility for his offending or his concern for self improvement were shown to be significant factors, then clinicians attempting to encourage offenders to seek treatment could focus their efforts on these issues.

Factors Influencing the Decision to Seek or Decline Entry to a Sex Offender Treatment Programme

One of the tasks of the Department of Corrections psychologists around New Zealand is to make referrals of incarcerated child sex offenders to the Sex Offender Treatment Programme at either Te Piriti or Kia Marama. They are therefore involved in assessing these men and, as importantly, in motivating them to seek this help in changing their inappropriate sexual behaviour so as to reduce both the incidence of this type of offending and the consequent distress to victims and their families. Attendance at the

programme is voluntary. So, in order for motivational strategies to be optimally effective, the psychologists need to have information about the factors which influence the offender's decision to seek or decline therapy. Some of the hypothesized factors are reasonably straight forward (e. g., information about the programme, parole contingencies, support of the offender's family, present prison environment and therapy unit environment) and some involve complex psychological concepts and theories such as empathy, Stages of Change and the Transtheoretical Model of Change. Factors that may influence offenders to delay or avoid helpseeking or treatment and those that may motivate them to enter treatment will now be more closely examined.

Delaying or Avoiding Treatment or Helpseeking.

Many offenders avoid or delay helpseeking. Amato and Bradshaw (1985) found that there were some general clusters of motives that lead people to avoid seeking help for a distressing personal problem. They were (a) fear and stigma, (b) problem avoidance and denial, (c) helper evaluation (i. e., client's view of the therapist), (d) external barriers (e. g., unable to get time off work), and (e) independence (i. e., wanting to solve own problems). In particular, they found that some motive clusters were more likely to be advanced by particular groups of people and that different clusters of concerns were prominent for different stages of the help-seeking process. Problem avoidance and denial have been found to be characteristic motives for avoiding helpseeking in drug addicts. In the current study, it was expected that a number of child sex offenders, whose behaviour has been included, by some theorists, under the addictive behaviours umbrella (Herman, 1990; Barbaree, 1991), would present with problem avoidance and denial of guilt in association with delaying or avoiding treatment to address their offending. Similarly, given the community's abhorrence of this type of offending, fear and stigma were also expected to negatively influence an offender's decision about entering treatment. Fear of telling the group what he had done and of facing it himself and of attracting further stigma, both from within and from others, might lead to avoidance. Those involved in the assessment of child sex offenders will also

recognise individual incidents, including the other clusters of motives proposed by Amato and Bradshaw. For instance, anecdotal examples of external barriers which offenders have mentioned are "the treatment unit is too far away from my family", "no temporary paroles at the treatment centre", "I like it where I am and I don't want to move to another prison". Similar anecdotal examples have also been noted for the clusters including helper evaluation and independence.

Garfield (1994) reported that many clinicians and researchers have found that between 24% and 50% of individuals who were offered psychotherapy either did not turn up to the first interview or did not return for subsequent therapy after the first interview. He cited several studies which investigated the possible factors related to this rejection. Socio-economic status, rated level of motivation, and time on the waiting list were found to be significant factors in the acceptance of therapy. Age and race were less clearly implicated as factors in the rejection of therapy among the studies examined by Garfield. Of particular interest, is a study mentioned by Garfield (Noonan, 1973) which found a significant relationship between the way an individual stated their problem and acceptance of a therapy programme. Those who declined therapy tended to state their problems in a vague and evasive manner. Clinicians who work with child sex offenders may often anecdotally report that the offenders present with little or no motivation to seek treatment for their offending behaviour. This judgement is often based on the observation that the offenders are minimising, rationalising, or being vague about the way in which they discuss their sexual offending behaviours (Barbaree, 1991). Using the Multiphasic Sex Inventory, Barbaree identified indices of denial and minimisation. He found that 66% of child molesters in that study's sample denied and 33% minimised their offending. Responsibility, the presence of harm to the victim, and the extent of intrusiveness of their offences were all minimised by this latter group of offenders. A later study by Marshall (1994) used an interview method employing two independent raters and found that 31% of the sample of child molesters "categorically denied any involvement in the offence for which they had been found guilty, and an

additional 32% minimised their role in the offence, "they attributed responsibility to factors outside themselves, or they claimed to have engaged in only minimally offensive behaviours" (Marshall, 1996, p.173). It comes then as no surprise that when child sex offenders are offered treatment to help them address their offending, they more often than not decline (Laven, 1993; Jury, 1993).

In another study on helpseeking, Deane & Chamberlain (1994) found that treatment fearfulness influenced people's tendency to avoid mental health treatment. Also, fear of therapy is a multidimensional construct and there is a need to determine which treatment fears are most relevant to a number of specific clinical and non-clinical groups. This project explored such factors and their influence on an inmate's decision to enter treatment so that the future efforts of the psychologists and other workers (prison staff) to persuade these offenders to seek to change their behaviour can be potentially more effective.

Laven (1993) investigated the reasons why inmates declined the Sex Offender Treatment Programme at Kia Marama. The most prevalent reason he found was that the inmates did not want to move away from their home area and/or family supports. Kia Marama, the only prison-based Sex Offender Treatment Programme available at the time, is situated in the South Island and is therefore geographically isolated from the main population base (75% of the population live in the North Island). Another major reason found for declining treatment entry was denial of the offence.

The current study sought to investigate more systematically the factors that influenced the decision to enter/decline sex offender therapy. The main purpose of the study was to examine the effects of a motivational intervention, First Step, on the following areas: (a) helping to alter some of the inhibiting factors such as denial, adverse helper evaluation, fear and stigma, lack of accurate information about the process of sexual offending against children and about the Sex Offender Treatment Programme (e. g., the availability of the programmes, the programme effectiveness, whether attendance at the

programme will influence the granting of temporary paroles or early release and the custody and living conditions in the programme unit), (b) lack of victim empathy, (c) lack of knowledge about, or fear of, the assessment and treatment procedures associated with the sex offender treatment programme (e. g., plethysmographic assessment of sexual preference and masturbatory reconditioning), (d) feelings of anger towards the victim, (e) perceived constraints within the beliefs and values of religious or cultural systems which proscribe some of the treatment procedures (e. g., masturbatory reconditioning), (f) lack of desire for self improvement and/or lack of self efficacy, and (g) motivational aspects related to the prison environment (e. g., "I feel settled in the current prison camp", "I prefer not to move to a new camp" or "I do not want to move away from the family who have relocated to be near my current prison").

Culture as A Factor in Seeking Help.

New Zealand is a multi-cultural society where the statutory services (e. g., Health and Corrections) have traditionally been dominated by a Western European world view. In recent years, there has been a growing trend towards recognising the needs of other cultures and the incorporation of the principles of the Treaty of Waitangi, signed between Maori and the British in 1840, into health and correctional practices in New Zealand. World view is particularly central to the way in which health, including mental health issues, are viewed and treated both by individuals and organisations (Durie, 1994). Culture specific responses to life events often require culture specific therapeutic responses to enable healing. For instance, Whakama is a psycho-social and behavioural construct in Maori culture (Sachdev, 1990). Some aspects of the construct are shame, self-abasement, feeling inferior or inadequate, self-doubt, shyness, excessive modesty, and withdrawal. In the context of the current study, a person experiencing whakama may be unwilling to discuss their sexual offending or to consider entering treatment in an environment which they believed would not be sensitive to their cultural needs. Whakama

could be a powerful influence on the progress towards behaviour change and cessation of sexual offending against children.

Another example of how differing world views can impact on mental health issues is also provided by Sachdev (1989) who drew data from nineteen public and private psychiatric hospitals in New Zealand to investigate the epidemiology of psychiatric disorders among Maori. Sachdev reported on a number of studies which showed that urbanization impacts on mental health. Urbanization through internal migration by many Maori people from rural to urban settings has had profound effects on their culture and way of life. Sachdev reported that there is a correlation between the rates of psychiatric admissions and the occurrence of rapid change within the Maori community since colonisation. Moving into urban areas meant moving into a largely European dominated world. Whanau (family) often became dispersed during these moves and the old support and control systems have since been weakened or lost. Legislation, which alienated Maori from their lands, and forbade their healers, the Tohunga, to practice, further exacerbated the effects of urbanisation and cultural upheaval (Durie, 1997). In the confusion thus created, motives for change, the target of change, the means of adaptation available and the influence of extraneous demands have all appeared to contribute to inhibiting helpseeking whether from traditional or contemporary sources.

Similarly, the Pacific Islanders involved in the study have recently moved from their traditional island village cultures to the urban environment of New Zealand's largest city and might be expected to be impacted upon by such large life changes. Samoan and other Pacific Island cultures have a similar concept to whakama known as Ma and it was expected that this may inhibit some offenders from discussing their offending, particularly with a European woman, and from seeking treatment in the Sex Offender Treatment Programme.

It was expected in the current research that there would be some cultural factors which would impact on the decision to attend a Sex Offender Treatment Programme. However, given that the researcher is a European-Australian whose knowledge of the Maori and Pacific Island cultures is limited, no attempt has been made to investigate this factor in depth. Cultural issues were raised by a number of offenders who were involved in the study and were included in analyses of factors predicting the decision to enter the Sex Offender Treatment Programme.

The Sex Offender Treatment Programme at Te Piriti has been designed to incorporate the principles of the Treaty of Waitangi in order to ensure that the treatment is appropriate for all of the participants. Te Piriti's therapy team is multi-cultural with European and Maori staff including a Maori cultural consultant (who is a qualified social worker) and at times a Pacific Island therapist. Kia Marama has engaged the services of cultural consultants to facilitate the presentation of the programme in a culturally sensitive manner. Similarly, cultural consultation was carried out during the process of the current study. Nevertheless, it was expected that there would be some offenders who would quote cultural reasons as factors in their decision to decline treatment.

Attention is now turned to the model of change which underlies the motivational intervention.

Transtheoretical Model of Stages of Change

Sexual offending against children, classified as Pedophilia in the Diagnostic And Statistical Manual of Mental Disorders 4th ed. (DSM-IV, 1994), can be seen as a set of behaviours which has many of the characteristics of addiction or lack of impulse control. As well as the DSM-IV clinical criteria for addiction, a number of other behaviours appear to occur commonly across the addictive behaviours. For instance, child sex offending often includes denial of the problem behaviour, minimisation, rationalisation and consequent

avoidance of treatment aimed at establishing personal control, and reduction of or attempted abstinence from the behaviour (Barbaree, 1991).

The Transtheoretical Model of Change was developed by James Prochaska and Carlo DiClemente (Prochaska & DiClemente 1983; Prochaska 1984) and their team of colleagues at the Cancer Prevention Research Centre, University of Rhode Island. The model has been engaged as an explanation of the change process for many addictive and compulsive behaviours (Hemphill & Howell, 1995; Prochaska et al 1994; Rossi, 1992). In fact, the transtheoretical model can probably be applied to a very wide range of the maladaptive behaviours which are often the focus of clinical intervention.

The present study of the factors that are involved in the decision of child molesters to seek treatment for their problem is, in part, based on the integrative model of change proposed by Prochaska and DiClemente (1983, 1984, 1992). They examined a broad cross-section of the most practised theories of psychotherapy in an attempt to locate common elements across those systems of psychotherapy. From this, and related studies, the three dimensions of their transtheoretical model were identified; Processes of Change, Stages of Change and Levels of Change. These three dimensions have been combined in an integrative transtheoretical model which accommodates the systematic relationships among them. Each dimension contributes to the explanation of the change phenomenon in the following way. The Processes of Change deal with *how* people change, the Stages of Change deal with *when* people change and the Levels of Change deal with *what* changes people make in order to resolve problems. Changes are believed to occur both within and outside the therapy sessions (i. e. the *where* of changes is also a focus of the integrative model). (DiClemente,1986).

The dimension of the transtheoretical model most relevant to the current study is the Stages of Change. Early stage models of change had been advanced by Janis (1968) and Horn (1976) (both cited in Prochaska &

DiClemente, 1992) and Prochaska and DiClemente's many studies have been designed, in part, to make an empirical investigation of the stages and to specify relationships among the stages. "The stages are problem or behaviour specific in that they refer to change status with respect to one specific problem behaviour or problem area. In addition, the stages model assumes a focus on intentional change which involves the individual's participation, rather than imposed change where there is little or no option for alternative behaviours" (Prochaska & DiClemente, 1992, p. 5-6).

Definition of the Stages of Change

Changes in behaviour are viewed as being distinctively sequential over time. DiClemente & Prochaska (1982) discovered that verbal processes (focusing on cognition and affect) were used almost exclusively during the early Stages of Change and that the behavioural processes were used more when the subjects made more active changes and maintained these. Subsequently, they identified five Stages of Change which they called Precontemplation, Contemplation, Determination (later known as Preparation), Action and Maintenance.

Individuals in the *Precontemplation* stage are unaware, underaware, unwilling or discouraged when it comes to changing a particular behaviour. They use few of the change processes and can be rather defensive about the targeted problem behaviour. G.K. Chesterton once said "It isn't that they can't see the solution. It is that they can't see the problem" (Prochaska et al, 1992, p. 1103). They are not considering changing their behaviour either because they are not convinced that negative aspects outweigh positive aspects or because they believe they have the behaviour under control. Precontemplation has been loosely translated in the First Step programme as "I haven't got a problem!"

Those in the *Contemplation* stage are aware that they have a problem and are actively considering change without actually having made a

commitment to change. Prochaska et al (1992) reported that contemplators can become 'stuck' at this stage for prolonged periods because they are not quite ready yet to take action. Contemplation is also characterised by a weighing of the pros and cons of the problem and the solution to the problem. In the First Step programme, the stage is described as "Maybe I have got a problem".

Preparation (Determination) is an intermediate and overlapping stage which combines intention and behavioural criteria. Individuals have unsuccessfully taken action in the past and are intending to take action again in the near future. The criteria necessary for an individual to be considered to be in the Action Stage of Change has not yet been reached.

Action, as its name signals is the stage in which the individual overtly modifies their behaviour, experiences or environment in order to overcome their problems. Action individuals require the skills to carry out the modifications and also to be able to recognise and avoid lapses while new behaviours are being established. Prochaska et al (1992) warn against confusing Action, this most public of stages, with change and overlooking the preparatory activities and the maintenance strategies necessary to ensure change really occurs. To be considered in the Action stage the individual must have altered their behaviour for a period of time (e. g., 1 day to 6 months) and have reached a defined criterion. In the current context, an example would be having no sexual fantasies about children within some defined period.

Maintenance is the stage where individuals consolidate the gains attained during the Action stage and work to prevent relapse. This stage is dynamic and extends from 6 months to life so long as the individual remains free of the undesirable behaviour (e. g., sexual offending against children). This stage remains dynamic to the extent that the environment contains cues that can trigger the problem behaviour, or the new behaviour is one which occurs infrequently and is therefore more likely to extinguish.

Progress through the Stages of Change is not linear and relapse is the norm in most behaviour change attempts (DiClemente et al, 1992). This is a worrying thought in the context of sexual offending against children where relapse necessitates the creation of new victims and the associated trauma to them and their families. Marlatt and Gordon (1985) developed the Relapse Prevention model which guides clinical efforts towards maintenance in many programmes including the Sex Offender Treatment Programmes.

Prochaska et al (1992) presented a spiral pattern to illustrate how most people actually move through the Stages of Change. Regression to an earlier stage is the norm although this does not necessarily imply that there is a return to Precontemplation. The majority of relapsers (e. g., 85% of smokers) appear to recycle back to Contemplation or Preparation stages. (Prochaska & DiClemente, 1984)

Prochaska & DiClemente (1984) reported on research done in the 1970's which indicated that large numbers of individuals stopped smoking tobacco on their own without seeking professional help and that formalised programmes had often failed with a majority of smokers. They claimed attempts to explain this phenomenon had been limited by retrospective methodologies and inadequate models of change. In their own analysis, they found that these individuals consistently used a systematic set of overt and covert activities to modify thinking, behaviour, and affect relevant to particular problems. These activities were called Processes of Change. In therapeutic settings, the therapist's behaviours, as well as the client's, are thought to be reflective of the various Processes of Change (e. g., when a therapist provides information and encourages the client to personalise this information, they are engaging in the Consciousness Raising Process of Change). These Processes can be applied by therapists, clients, or individuals attempting to modify their problems without therapy (Prochaska et al, 1988). There was a significant correlation between Processes of Change and Stages of Change, which are specific constellations of attitudes, intentions and behaviours that are relevant to an individual's status in the Process of Change. The findings of

this and related studies (Prochaska, Velicer, DiClemente & Fava, 1988) have clinical relevance as they give clear guidance for the design of interventions based on the Stage of Change with which the individual client presents for therapy. In particular, individuals who present in the Precontemplation stage, will be employing very few Processes of Change and may well be actively or passively resisting change through outright denial of the existence of the problem.

McConnaughy, Prochaska, & Velicer (1983), using a clinical sample (adult outpatients presenting for therapy at a community facility, private therapist, military counselling centre or university campus counselling centre) developed a measure of the Stages of Change. Later McConnaughy, DiClemente, Prochaska, and Velicer (1989) carried out a cross-validation study with a new clinical sample (adult outpatients coming to the Texas Research Institute for Mental Sciences). During the development of the scale, which became known as the University of Rhode Island Change Assessment (URICA), McConnaughy et al found that the construct embodied in Determination (later known as Preparation) overlapped those of Contemplation and Action to such an extent that a reduction in the number of Stages the URICA scale measured was indicated. Hence, Determination was no longer measured as a separate stage. This scale was used in the current study to evaluate outcomes of treatment and the relationship between the Stages of Change and the decision to enter a Sex Offender Treatment Programme. McConnaughy et al proposed that considering the Stages of Change as a cluster-based profile was more beneficial to clinical application. Details of the profiles identified are presented in Chapter 3 (Method section).

Client compliance is a practical problem that has been identified with treatment programmes (Garfield 1994). It is generally believed that psychological treatment programmes require the active participation on the part of the offender. Prochaska et al (1992) argue that complementarity between the Stage of Change of the offender and the treatment programme being presented is necessary for entry to, and compliance with, a therapy

programme. Others have examined the effect that particular characteristics of offenders have on their involvement with therapy. In her examination of attributions in sex offenders, McKay (1993) states "A view held by a number of professionals is that nonadherent behaviour results from an 'attitude' problem on the part of the client." (p. 9). This 'attitude' problem can be interpreted as indicative of the Stage of Change wherein the offender is located and the Processes of Change which he is (or is not) using. McKay investigated the role of attributions in child sex offending and found that this group of offenders viewed the causes of their behaviour as internal, stable and uncontrollable. This attributional style does not readily predispose them to enter treatment. Foon (1986) noted that attributions contributed to clients' expectations of the outcome of their therapy. He found that clients' favourable expectations for therapy were increased when the clients' locus of causality and locus of control matched those of the therapist. To encourage greater alignment between offenders' and therapists' locus of causality and locus of control, McKay suggested the development of various programmes designed to identify offenders' attributions and retrain them in preparation for entry to treatment programmes aimed at reducing recidivism in this area of offending. Matching offender and therapist attitude and attribution appears to be consistent with Prochaska, DiClemente and Norcross's (1992) argument that the programme must match the Stage and Process of Change present within the client at the time of their entry to the programme.

The Sex Offender Treatment Programme was designed to provide therapy at the Action stage. Those offenders who have not entered this stage will be unlikely to be ready or willing to be referred to the treatment programme. For instance, denial and minimisation are clear indications of an offender's not having reached the Action stage. Acceptance into the programme requires that an offender acknowledges at least some of his offending behaviours. Individuals who are in the early Stages of Change may benefit from a pretreatment intervention which encourages them to progress through to the later Stages of Change. A brief intervention, First Step, was

designed to facilitate this progress through the Stages of Change and towards entry to the main Sex Offender Treatment Programme.

Victim Empathy in Sexual Offenders Against Children

The Stage of Change an offender is at is, in part, a function of his success in utilising a specific Process of Change (i. e., "Environmental Re-evaluation"). In the present context, this refers to his understanding of the effects of his sexual behaviour on his child victim(s) (i. e., victim empathy). Discussion about the role empathy plays in influencing the choices individuals make about their behaviour towards others has been engaged in for hundreds, if not thousands, of years (Hume, 1777 cited by Eisenberg and Fabes, 1990). Being able to take the perspective of the other and becoming emotionally aroused by that experience underlies the empathic process. In common parlance, it may be confused with sympathy. However, empathy is essentially being able to feel what the other person feels whereas sympathy involves the other-oriented desire for the other person to feel better.

Early theorists' explorations of the empathy construct have identified its cognitive and affective dimensions and the way in which it appears to influence behaviour between individuals by mediating the development of non-egocentric, other-oriented thought and behaviour. (Smith, 1759; Spencer, 1870; Piaget, 1932; Mead ,1934; Hoffman, 1977 cited in Davis, 1983; Hogan 1969; Mehrabian & Epstein, 1972). Miller & Eisenberg (1988) found that empathy does increase prosocial behaviours and reduce aggression and externalizing antisocial behaviour. Victim empathy modules are prevalent in almost all (94%) sex offender treatment programmes (Marshall, 1996). Empathy for victims is thought to play an important role in preventing recidivism for child molesters. Finkelhor (1984) constructed the Four Preconditions Model of Child Sexual offending. The four components of this model are motivation to sexually abuse, overcoming internal inhibitors to sexual offending, overcoming external inhibitors to sexual offending, and overcoming the resistance of the child. Increased victim empathy could

potentially reduce the incidence of sexual offending by operating at the first two steps of the model (e. g., a potential offender's appreciation of the child's negative experiences of abuse may inhibit his intention to have sexual contact with the child). It may also be a factor influencing a child molester's decision to seek treatment to address his offending and reduce the chance of recidivism. Hence, in the current study, it was hypothesised that offenders with greater levels of empathy would be more likely to seek a referral to the Sex Offender Treatment Programme.

Marshall, Hudson, Jones, and Fernandez (1995) reported on a number of studies of empathy in sex offenders (Langevin et al, 1988; Seto, 1992; Marshall et al, 1993, all cited in Marshall et al, 1995) which used the Interpersonal Reactivity Index (IRI, Davis, 1983), and which seemed to show that there were no differences in empathy between child molesters and nonoffenders or between various types of sex offenders. In another study, Marshall & Maric (1994) using other well known measures of general empathy, Hogan's (1969) Empathy Scale and Mehrabian & Epstein's (1972) Questionnaire Measure of Emotional Empathy, found clear deficits in generalised empathy among incarcerated child molesters. However, in those studies which did show differences between groups, (Rice et al, 1990; Seto,1992), Marshall et al found that the sex offenders' scores were within the range of the scores of the normative sample (i. e., within plus or minus one standard deviation of the mean). In 1993, Marshall, Jones, Hudson & McDonald found in using the IRI that a group of outpatient child molesters showed deficits in empathy which they described as "not so low as to suggest real problems with empathy" (p. 108). Marshall et al's (1995) main criticism of this group of studies was that they used generalised measures of empathy that have reflected the assumption that empathy is a trait that will be consistently revealed across persons, situations, and time. They also argue that measures that are specifically tailored to the population being measured (e. g., child sex offenders) are needed.

Marshall et al (1995) presented their more specific model of empathy as a staged process involving *emotion recognition* - accurate recognition of the emotional state of another person; *perspective-taking* - the ability to put oneself in the observed person's place and see the world as they do; *emotion replication* - the vicarious emotional response that replicates the emotional experience of the target person; and *response decision* - the observer's decision to act or not on the basis of their feelings. Marshall and his colleagues in New Zealand and Canada embarked on a series of projects to investigate sex offenders' empathy as defined by their model. They found that child molesters displayed significantly less skill at recognising the emotions displayed by both adults and children compared to normal controls (Hudson et al, 1993). Marshall et al, (1995) also suggested that sex offenders might be more likely to be specifically deficient in empathy toward their own actual victims or perhaps toward the more general class of victims of sexual abuse. Consequently, they developed a victim empathy measure designed specifically for child molesters. This measure requires respondents to indicate (a) what thoughts, feelings or behaviours, they think a child who has either been disfigured in a motor accident or sexually abused would have and (b) what thoughts and feelings they (the respondents) would have when thinking about this child. Three scenarios were presented - a non-specific child victim of sexual abuse, a motor accident victim and the offender's own victim. Marshall et al (1995) reported that while child molesters could accurately identify the emotions of an accident victim, they were less able when the victim was a non-specific victim of sexual abuse. Their deficit was even greater when they were asked to identify the emotions experienced by their own victim. In addition, significant differences were found in person (victim)-specific empathy between child molesters and nonoffenders. Another investigation (Marshall et al, 1994) found that child molesters had deficits in emotion replication of emotions that matched the distress felt by their own victims. As these deficits were not apparent with the other two classes of victims, Marshall et al concluded that deficits in empathy at the perspective-taking and the emotion replication stages are highly person-specific.

It was hypothesised that victim specific empathy would be an important influence on treatment entry, particularly if the offender was denying his part in the offending.

First Step: A Pretherapy Programme to Influence the Decision to Seek Treatment for Sexual Offending Against Children

Sexual offenders are often described as being "in denial", accepting little or no responsibility for their offending and as not wanting to change (Barbaree, 1991; Nugent & Kroner, 1996). For instance, Jury (1993) found that 47.1% (n = 25) of a sample of child sex offenders in Waikeria prison either totally denied the offence or denied personal responsibility for an offence they admitted committing (e. g., "it was the child's fault").

Lack of motivation to enter a treatment programme can be viewed as a combination of client, therapist and therapy process variables. For instance, Johnston (1993) discussed various client variables: simply not understanding what is expected of him in therapy, having low expectations of success or an unrealistic self image incongruent with the other's view of him as an offender, may equate motivation to change with simple "willpower" to abstain and therefore have had past failures at controlling his offending behaviour, may not view his behaviour as morally wrong or may be clinically depressed or psychiatrically disturbed at the time he is offered a referral to the treatment programme. Therapist variables include confrontational versus supportive approaches, myths about the role of therapists and therapy process variables such as directly addressing the lack of motivation with the client, imposed versus mutually agreed goals of therapy, long delay between referral and treatment, match between client's and therapist's formulations for therapy, perceived rewards for therapy, modelling and support of the therapy group, failure to build a good therapeutic relationship, therapist creativity in encouraging the client, and therapist's reaction to non-compliance with programme tasks (Johnston, 1993). This study is concerned with evaluating the provision of a "pre-therapy" intervention, First Step. The intervention was

designed to address client motivation directly by employing sound empirically-demonstrated therapy practice to increase the offenders' motivation to enter a Sex Offender Treatment Programme as defined by a progression through the Stages of Change and a greater appreciation of victim empathy.

Miller & Rollnick (1991) and Kear-Colwell (1996) argue for a Motivational Interviewing approach to individuals who are in the early stages of change. Brown and Miller (1993) demonstrated that Motivational Interviewing techniques in assessment were followed by greater participation in the treatment programme and significant changes in addictive behaviours at follow-up. In the absence of motivation to change, treatment must first focus on motivating the offender to engage in a programme. Proponents of motivation-to-treatment programmes with offenders argue that this process must always involve negotiation, allowing the locus of control to remain with the individual to ensure any changes will be longer lasting. Following the development of an interactive relationship, the therapist can attempt to motivate the offender to want to change for himself (e. g., to avoid the costs of offending). The offender is then helped to identify the triggers that gave rise to sequences of lapse behaviours that could lead to offending. He first gains an understanding of the nature of the triggers and his vulnerability to them and then is more in a position to move on to treatment to assist him develop relapse prevention strategies. In line with motivational issues, Kear-Colwell suggested that up to 75% of treatment time should be spent in the Precontemplation and Contemplation Stages of Change. Change through action, he argues, can then follow more swiftly once the offender has admitted his role and wants to make changes. Follow-up by O'Donohue and LeTourneau (1993) of a brief group treatment for the modification of denial found that the majority of offenders in the study continued to admit their responsibility for the offending during subsequent sex-offender therapy and that there was an above average compliance with that therapy.

The First Step programme was designed to motivate and, in a related way, to educate convicted child sex offenders. Components of First Step

educational content included the Finkelhor (1984, 1986) model which proposes the necessary presence of four preconditions before sexual offending will occur. These are: (a) Precondition One - Motivation to Sexually Abuse, including sexual arousal to children, emotional congruence with children and a blockage to alternative sources of sexual and emotional gratification, (b) Precondition Two - Overcoming Internal Inhibitors, including normal prohibitions such as moral and cultural beliefs about the inappropriateness of this type of offending, (c) Precondition Three - Overcoming External Inhibitors, for instance, isolating the child from their carers and, (d) Precondition Four - Overcoming The Resistance of the Child to the sexual advances by favour or force. Other models which guided the content of the First Step programme were: (a) Marlatt & Gordon's (1985) Relapse Prevention model which emphasizes the acquisition of self-regulatory skills to avoid lapsing into the addictive behaviour (b) Warwick & Johnston's (1996) Offence Chain which combines concepts from the Finkelhor and Relapse Prevention models in a description of the problems, planning, relapse and reaction phases in the offending cycle and (c) Jenkin's (1990) invitation to responsibility approach. Besides the educational basis of First Step, there was also a motivational approach - helping child sex offenders understand their offending, while assisting them to move through the Stages of Change towards seeking therapy to address their offending. It was hypothesised that exposure to a brief motivational and educational programme would have a positive influence on the offenders' Stages of Change and victim empathy.

CHAPTER 2

OBJECT OF THE STUDY

The object of the present study was (a) to identify the factors which influenced the convicted child sex offender's decision to enter a sex offender treatment programme and (b) to investigate the effect of a brief motivational and educational programme Stages of Change and empathy.

Hypotheses

1. Factors that Influence the Decision to Seek or Decline a Sex Offender Treatment Programme:
   a) That offenders take into account a number of different factors when deciding to seek treatment for child sexual offending behaviour.
   b) These factors include (a) family, (e. g., the family's opinion on whether treatment is necessary or not) (b) victim(s) (e. g., feelings of remorse for hurting the victim or conversely feelings of anger towards the victim who has made the complaint that led to the conviction) (c) information from other inmates and prison staff either for or against the programme (d) motivationally oriented information from psychologists (e. g., about the availability of the programmes, the programme effectiveness, and the custody and living conditions in the programme unit) (e) paroles (i. e., belief that attendance at the programme will influence the granting of temporary paroles or early release) (f) religious or cultural reasons (i. e., constraints within the beliefs and values of these systems which proscribe some of the treatment procedures (e. g., concerns about masturbatory reconditioning), (g) self improvement, (h) shame, (i) assessment and/or treatment procedures in the Sex Offender Treatment Programme (e. g.,

plethysmographic assessment of sexual preference and masturbatory reconditioning), (j) aspects of the prison environment (e. g., settled in the current prison camp, prefer not to move to a new camp or want to move closer to the family).

c) That denial of guilt and the degree of acceptance of responsibility for the behaviour for which they are convicted are predictors of offender treatment entry or refusal.

2. <u>Stages of Change and Victim Empathy as Predictors of Sex Offender Treatment Programme</u>

a) That the Stage of Change profile and victim empathy scores will predict willingness to enter the Sex Offender Treatment Programmes.

b) In terms of the Stages of Change, that Contemplators would be more likely to seek a referral to the Sex Offender Treatment Programmes than Precontemplators.

c) That increased victim empathy would be associated with increased willingness to seek a referral to the Sex Offender Treatment Programmes

3. <u>First Step - Motivational and Educational Group Programme</u>,

a) That the presentation of a motivational and educational group programme, First Step, would alter the Stage of Change profile of participants, in particular that their Stage of Change profile would move from a less to a more advanced stage (e. g., the Precontemplation, "I have not got a problem", stage to a more active Contemplation or Participation-based stage).

b) That, the First Step programme would also result in increased motivation to enter a more comprehensive Sex Offender Treatment Programme as indicated by Stages of Change cluster analysis.

c) That there is a waning of motivation to enter treatment and an entrenchment of offence enabling attitudes with increased time. In this study, it was assumed that a wait-list control condition (i. e., time) would not result in positive change in Stage of Change,

empathy or in increased willingness to enter an Sex Offender Treatment Programme compared to the First Step condition which would result in such positive changes.

CHAPTER 3

METHOD AND STATISTICAL DESIGN

Description of Sample

The subjects were 104 male incarcerated offenders convicted of sexual offences against children under the age of sixteen years. They were resident in one of three minimum security prisons, Tongariro/Rangipo, Ohura and Waikeria, New Zealand. All of the subjects were referred by the prison Case Management Committee to Psychological Service for assessment when they arrived in the prison. From the total of 104 participants, 39 attended the First Step programme (see below for description). The other 65 were involved in a related study (Knowles, 1997) at Waikeria Prison where there was no First Step programme available to them. They were included to provide additional information on select issues related to helpseeking (see procedure). All of the data used for this study are original.

Participation was voluntary and access to the First Step programme was not contingent on participation in the study. There were no custodial consequences (e. g., temporary paroles or early release) contingent on participation in the study.

The age range of participants was 20 to 72 years (M = 45 years, SD = 13 years). The ethnic composition of the sample was 69% European, 27% Maori, 2% Pacific Islander and 2% Other (i. e., two men who were Maori/European chose to be identified as New Zealanders). Their sentence range was from under a year to Preventive Detention (i. e., indeterminate length) and the offences had occurred from less than one year ago to more than ten years ago (see Chapter 4 for descriptive statistics).

Measures

Assessment was by a multi-trait, multi-method model using both semi-structured interviews, and self-report methods (University of Rhode Island Change Assessment (URICA) and Person-Specific Empathy Scale (PSES)). Interviewers also had access to the subjects' prison files from which some demographic and conviction information was gathered.

Semi-Structured Interview

A semi-structured interview, administered to First Step participants at pretreatment, was used to assess whether each subject had decided to seek treatment at a Sex Offender Treatment Programme. It also sampled the factors that influenced this decision to enter or decline the programme and gathered demographic information. The semi-structured format was chosen to facilitate a more rigourous data collection procedure by ensuring that all subjects were asked the same questions with the same briefing while allowing the flexibility to build rapport and to explore further the subjects' responses during the interview (Hoinville & Jowell, 1978; Hezler, 1983; Fowler, 1993). Though some specific factors were hypothesized, it was anticipated that the factors that would influence the offenders' decision to attend treatment would be varied. It was necessary to capture as much of this information as possible in order for the conclusions to be well founded and for subsequent interventions to be effective. Marshall (1994, cited in Marshall, 1996) found evidence that structured interviews are a valuable source of information with the population of sexual offenders against children. Offenders may reveal more in interviews than in self-report measures, some of which may be readily transparent. Contradictions and inconsistencies in the information supplied by these offenders are more likely to be revealed when both types of assessment are used together. The interview process allows for exploration and clarification of the offenders' views and any contradictions or inconsistencies which may then be noticed by the interviewer.

From a cross-cultural perspective, Bond (1983) suggested that semi-structured interviews, using open-ended questions, are more culturally appropriate as there is less chance of imposing the constructs, valid in one culture, onto another culture where they may not be equally valid. As the subjects are drawn from a culturally diverse population, a sampling of the beliefs and cognitions in relation to the construct being explored was sought through a semi-structured interview containing open-ended questions.

In addition to open-ended questions, the semi-structured interview also included a checklist of the factors hypothesized as having an influence on the subject's decision to enter treatment. This checklist was composed using information gathered in the process of a pilot study (see procedure). It followed the less structured part of the interview.

The semi-structured interview began by gathering demographic variables including prison, age, ethnicity, sentence length, sentence elapsed, time since offence occurred, offence details, prior treatment details, case management, programme knowledge, decision to attend Sex Offender Treatment Programme, and contact with a psychologist. The interview then focused on the factors that influenced the offender's decision to enter a Sex Offender Treatment Programme. A limited assessment was also made of alcohol and drug use (a full assessment of addiction to substances to DSM-IV criteria, was not included in the structured interview so information about the level of addiction is not diagnostic and is limited to age of use initiation, frequency, and quantity of use). Finally, there was a question about the offenders' acceptance of responsibility for the offences for which they had been convicted (see Appendix C for full text). The checklist portion of the interview included the items listed in Table 3.1 (see also for reliability estimates).

Table 3.1

Checklist of Items Included in the Semi-Structured Interview.

Wife/Partner	Children (Not victim)
Victim (Complainant)	Father
Mother	Other relatives
Friends outside the prison	Inmates - this prison
Inmates - other prisons	Unit Manager
Case Officer	Prison officers
Counsellor (Specify)	Social Worker
Chaplain	Psychologist
Not guilty	Home Leave
Early Release	"I like the prison I'm in now"
Don't like moving prisons	"I want to move closer to family"
Assessment procedures (specify)	Treatment procedures (specify)
Religious beliefs	Cultural beliefs
"I want to help myself"	"I want to avoid coming back to prison"
"I feel bad about what I have done"	"I feel victimised by the Justice system"
Conditions at Te Piriti (*Kia Marama*)	Presentation by Te Piriti (*Kia Marama*)

Alpha reliability was α = .64 and a Spearman-Brown split half reliability of .56. Interrater reliability not applicable as only one psychologist administered the interview.

University of Rhode Island Change Assessment (URICA)

Stage of Change profile.

In evaluating the First Step programme, the primary dependent variable was Stage of Change profile as measured by the URICA scale (previously called Continuous Stage of Change measure) (McConnaughy, Prochaska & Velicier, 1983; McConnaughy, DiClemente et al, 1989; Prochaska, DiClemente and Norcross, 1992). The URICA is designed to be adapted for particular problem behaviours (e. g., alcohol abuse, cigarette smoking, sexual abuse of children). The scale was adapted to the problem behaviour which is the focus of this investigation (i. e., sexual molestation of children under the age of 16 and the Sex Offender Treatment Programmes at Te Piriti and Kia Marama). The 32 item measure has four subscales, Precontemplation, Contemplation, Action and Maintenance. There are 8 items in each subscale. Each item was rated on a five-point Likert scale from 5 = Strongly Agree to 1 = Strongly Disagree and the four subscales were then calculated. The raw scores for each subscale were then converted to T-scores according to norms for subjects seeking psychotherapy and a profile was produced for each subject across the four subscales. High scores on the Precontemplation subscale indicated that the respondent did not believe he had a problem with sexual offending against children. A high score on the Contemplative, Action and Maintenance subscales indicated that the respondent recognised a need for or was making changes to his behaviour. The pattern of scores across the four subscales was the primary variable of interest. Raw score cutoffs (T-score = 50) for the URICA Scale are - Precontemplation (16-18), Contemplation (34-35), Action (32-33) and Maintenance (27-29).

With principal component factor analysis, McConnaughy et al (1983,1989) found four distinct components among the 32 items of the URICA scale. The four Stages of Change, Precontemplation, Contemplation, Action and Maintenance, which are measured by the URICA, are represented by high loadings on the four distinct components. In the later study (1989), all of the

items in the Precontemplation, Contemplation and Maintenance subscales loaded on their respective components. Seven of the eight Action items had their highest loadings on the original factor (Action). One of the items (Item 20. "I have started working on my problems but I would like help") in the Action subscale loaded predominantly (.63) on the Contemplation stage component and to a lesser extent on the Action stage component (.31). McConnaughy et al reported that in their two studies, 58% and 45% of the total variance, respectively, is accounted for by the four components. Internal consistency varied slightly between the studies. The alphas for the later study (McConnaughy, 1989) were lower and were as follows: Precontemplation .79, Contemplation .84, Action .84, Maintenance .82. In the present study, alpha reliabilities were calculated as follows: Precontemplation .87, Contemplation .80, Action .74, Maintenance .58.

Cluster analysis of URICA subscales.

McConnaughy et al (1983, 1989) using a hierarchical agglomerative clustering procedure classified the heterogeneous pool of subjects into a small number of homogeneous subject profiles or clusters. During the 1983 study they identified eighteen distinct clusters. The majority (90%, n = 140) of their subjects were involved in seven major and two minor clusters as described in Table 3.2. The remaining nine clusters consisted of only one to three subjects and were therefore considered uninterpretable. In a replication study (1989) they found similar clusters emerging. In this study, an eight cluster solution was the most clearly interpretable. They proposed that these clusters be used as clinical norms. The clusters as described by McConnaughy et al (1983, 1989) (see Table 3.2) are: 1983 sample - Major clusters - *Uninvolved* - respondents demonstrate a lack of action, they are not ignoring, nor are they thinking about their problems, *Immotive* - respondents are not contemplating change, nor are they engaged in changing; rather, they are maintaining the status quo, *Pre-Participation* - respondents somewhat involved in thinking about, acting on, and maintaining changes and tend not to ignore the existence of the problem, *Decision-making* - respondents are still

contemplating their problems and yet they have begun to take some action, *Non-Contemplative Action* - respondents are acting rather than thinking about changing, and they are not maintaining any changes they may have made previously, *Participation* - respondents are not ignoring the presence of a problem; rather, they are engaged in thinking about the problem, taking some action on changing it, and maintaining changes already made, *Maintenance* - respondents are maintaining previous improvements. Minor clusters - *Reluctance* - respondents seem to be reluctant to take action on a problem, although there is a sense that they might be thinking about it, *Non-Reflective Action* - respondents are characterised as taking action while not acknowledging that a problem exists. The 1989 sample produced many similar clusters to the earlier sample - *Uninvolved, Immotive*, *Decision-making, Participation* and *Maintenance* were all similar to the earlier study profiles. The new clusters were *Precontemplation* - similar to the earlier Reluctance profile but with higher Action score; indicating a reluctance to change, *Discouraged* - similar to the Non-Contemplative Action and Uninvolved profiles; however, the Maintenance subscale is significantly lower; respondents are not thinking about changing in new ways nor are they working to maintain any changes they may have made previously, *Contemplation* - respondents are thinking about changing but have not begun to take action on the problem. The relative Precontemplation, Contemplation, Action and Maintenance subscale profiles for each cluster are set out in Table 3.2 as they were described by McConnaughy et al (1983, 1989).

Cross-cultural applicability of URICA.

Although most of the developmental work on the URICA was carried out on populations which were predominantly European-American (Rossi, personal communication 29 February 1996), the measure was also found to have discriminative validity using a large group (n = 2875) of Mexican-American smokers (Gottlieb et al, 1990). The scales discriminated among groups of smokers with different intentions toward smoking cessation. Hence the URICA has been found to be a useful instrument across some cultures.

Table 3.2

Stages of Change Clusters Identified and Described by McConnaughy et al (1983 and 1989).

	Cluster	PC	CO	AC	MA
Major clusters (1983)					
1	Decision-Making	Below	Average	Average	Below
2	Maintenance	Average	Average	Average	Above
3	Participation	Below-	Above	Above	Above
4.	Pre-participation	Below	Just Above	Just Above	Just Above
5	Non-Contemplative Action	Average	Below	Average	Below
6	Immotive	Average	Below	Below	Average
7	Uninvolved	Average	Average	Below	Below
Minor Clusters (1983)					
8	Reluctance	Close Average	Close Average	Well Below	Below
9	Non-Reflective Action	Well Above	Below	Average	Average
Clusters (1989)					
1	Decision-making	Below	Above	Above	Below
2	Participation	Below-	Above	Above	Above
3	Maintenance	Above	Above	Above	Above
4	Immotive	Above	Below	Below	Average
5	Precontemplation	Well Above	Well Below	Well Below	Well Below
6	Uninvolved	Average	Average	Average	Average
7	Discouraged	Average	Average	Average	Well Below
8	Contemplation	Below	Above	Well Below	Average

Stages of Change: PC = Precontemplation, CO = Contemplation, AC = Action, MA = Maintenance

Readability assessment of URICA.

A readability assessment of the URICA scale yielded a Gunning Fog Index of Grade 6.7 and a Flesch Readability Ease Index of 83.7 and Flesh-Kincaid Grade 4.1 indicating that the scale, as a whole, has an acceptable readability level for the target population. However, the presence of double negatives in some of the questions caused some subjects to have difficulty in comprehending the meaning. However, assistance was provided in these instances.

Person Specific Empathy Scale

The Person Specific Empathy Scale (PSES) has 150 items in six subscales (A to E) and was developed by Marshall, Hudson, Jones and Fernandez (1995). They found that sex offenders are significantly different from the general population in their experience of empathy in the context of specific persons. These persons are either their actual victims or the particular class to which their victim belongs (for example, children, girl children, boy children, women). The subjects were presented with three different scenarios involving children. The subjects were asked to identify from a checklist the type and intensity of various emotions, thoughts or behaviours which may be characteristic of the three different children in the scenarios. They were also required to similarly identify their own reactions to each of these children's experiences. The children are depicted as a non-specific victim of child sexual abuse (scales A and C summed for Sexual Abuse Victim scale), a car accident victim who is disfigured (scales B and D summed for Accident Victim scale), and the offender's own child victim, (scales E and F summed for offender's Own Victim scale) (Fernandez, personal communication 6 April 1996). The subjects respond to the checklist of feelings, thoughts and behaviours on an eleven point Likert scale from 0 = "not at all" through "to some degree" to 10 = "very much". Reliability data for the original study was not available; however, in the current sample, the measure was found to have adequate reliability
(Cronbach's alpha = .96, Guttman's split half reliability = .79 and Spearman-Brown = .88).

First Step Programme

First Step is a manualized educational and motivational programme. It is targeted at increasing child sex offenders motivation to enter a Sex Offender Treatment Programme at either Te Piriti or Kia Marama. Participation in the Sex Offender Treatment Programme is voluntary and quite a large proportion of convicted child sex offenders either deny their offending or decline treatment or both (Jury ,1993; Laven, 1993). Hence, the First Step programme focused on motivation as an intermediate pre-treatment target and employed techniques to increase this motivation.

The theoretical base of the First Step programme lies in Prochaska and DiClemente's (1992) transtheoretical model of the interrelationship of the Stages and Processes of Change. The Processes of Change which Prochaska, DiClemente and Norcross (1992) list as particularly relevant in the early stages of change are defined by them as follows (p 1108). *Consciousness Raising* - "increasing information about self and problem: observations, confrontations, interpretations, bibliotherapy", *Dramatic Relief* - "experiencing and expressing feelings about one's problems and solutions: psychodrama, grieving losses, role playing", *Environmental Re-evaluation* – "assessing how one's problem affects physical environment: empathy training, documentaries", and *Helping Relationships* - " being open and trusting about problems with someone who cares: therapeutic alliance, social support, self-help groups". These processes have been incorporated into the modules of the First Step programme to facilitate offenders' progress through from the Precontemplation to the Contemplation and Action Stages of Change.

The content of the programme includes (a) an invitation to question their own cognitions about their conviction, (b) the process of sexual offending against children as embodied in the Finkelhor Model (Finkelhor, 1984 & 1986) and in the offence Chain (Warwick & Johnston, 1996), (c) an invitation to take responsibility for their actions (Jenkins, 1990), (d) information about the programme including a documentary of the Sex Offender Treatment

Programme in operation at Kia Marama, (e) a Maori approach to this offending (Marae Justice), (f) victim empathy, (g) an introduction to the Relapse Prevention Model (Marlatt & Gordon, 1985) and (h) the change process spiral as envisaged by Prochaska, DiClemente and Norcross (1992).

The manualized programme was presented in 8 to 10 hours in two sessions one week apart. The intention was to introduce ideas and concepts, to the offenders, that they may have not encountered previously and/or to give them the opportunity to consider them in general and in relation to themselves and their own offending. The manual is available from the author (Norrie, 1995).

Procedure

For treatment, the design was a two by two factorial, repeated measures design with two conditions, wait-list control and treatment. The subjects were administered the URICA and Empathy scales pre and post wait-list and pre and post treatment. All subjects in the two conditions received treatment. The wait list period was four to six weeks after the initial assessment. The 'treatment only' group received treatment following the initial assessment without an intervening waitlist period. The semi-structured interview was used to determine predictors of sex offender treatment entry and, consequently, was administered during the initial assessment session, either pretreatment (Treatment only group) or prewaitlist (Wait and treatment group).

During the period of the study, all inmates received into either Pine or Birch Units, Tongariro/Rangipo Prison or into Ohura Prison, who had been convicted of a sexual offence against children under the age of 16, were referred by the respective prison Case Management committees to Psychological Service for assessment for therapy to address their offending. All those referred were offered the opportunity to attend First Step and were asked to take part in the study. Seven offenders declined First Step and a

further five attended First Step but declined to take part in the study and to complete the associated scales. Declining the First Step was mostly accompanied with denial of the offences. It was considered unethical to question offenders who declined to take part in the research for their reasons. Additionally, no reasons were volunteered by this group.

The two groups of subjects, waitlist and treatment, were composed in the following manner. All the subjects in the pilot study, which was conducted with 15 offenders from Ohura Prison, took part in the treatment condition. All of the remaining subjects, who also received treatment (n = 24,) were also included in a pre-treatment waitlist condition. They were resident at either Ohura or Tongariro/Rangipo prisons. Hence the assignment of subjects to treatment or waitlist was controlled by the time at which the referral to the First Step programme was made by the Case Management committees during the data collection period. The remaining 65 subjects were from Waikeria prison and had taken part in another study (Knowles, 1997) and have been included in the analysis of the relationship between Stages of Change and decision to enter the Sex Offender Treatment Programmes.

Each participant was interviewed individually by the researcher. He was advised of the purposes of the study (see Appendix A) and told that participation would neither count for, nor against, early release or temporary paroles (weekend leave). If they volunteered, they were then asked to sign a consent form (see Appendix B). The semi-structured interview was then completed, followed by the measures. The waitlist and treatment groups completed the URICA and Empathy scales, while the Waikeria group completed the URICA scale.

Treatment consisted of the presentation of the First Step programme to groups of between 5 and 8 inmates. The programme was presented by the researcher, a graduate psychology student (who was also an experienced teacher and counsellor), according to the manual. It was presented over two days. All of the Tongariro/Rangipo subjects had a one week break between the two sessions of the programme and all of the Ohura subjects attended the

programme on two consecutive days. This was done for economic reasons as Ohura Prison is in a remote location and it was more cost effective for the researcher to stay overnight and present the programme in a block form.

Treatment Manual

The 35 page manual (Norrie, 1995) describes the goals and strategies that were used for each treatment module. However, a flexible and clinically sensitive application requires some adjustments (e.g. Dobson & Shaw,1988). Each offender was given a handbook which summarised the main topics covered in the First Step programme.

Wait-list Control

Offenders assigned to the wait-list control condition were given the same measures as those in the treatment condition at the beginning, and at the end, of the 4 week wait period. All wait-list control subjects received the treatment at the end of the waiting period.

Treatment Integrity

The treatment manipulation check involved attendance by an independent observer (a clinical psychologist who is a member of the academic staff of the Department of Psychology, Massey University, N. Z.) at two consecutive sessions of the programme at Tongariro/Rangipo prison. A treatment integrity checklist was used.

CHAPTER 4

RESULTS

Preliminary Analyses

Age

The age range of the offenders in the whole sample (n = 104) was 20 to 72 years. The modal age group for both samples was age range 31-40 years (n = 29; FS, n = 14) followed closely by the age range 41-50 years (n = 27; FS, n = 10). There was 68.3 % of the whole sample and 71.8% of the First Step group aged 50 or younger. The mean age for the First Step group was M = 44.87 years (SD = 13.03) years. Specific age data for the Waikeria sample was not available, hence specific age data (mean and SD) is not available for the whole sample beyond defining the modal interval.

The difference in the age distribution between the 1995 census population of male sex offenders against children (CSO) (Bakker et al 1997) and the whole research samples was not significant χ^2 (5, N = 104) = 9.1177, $p > .05$; however, the difference between the 1995 CSO population and the First Step group was significant χ^2 (5, N = 39) = 14.9634, $p < .02$. For most age groups, there was a difference in numbers in the First Step sample compared to the 1995 Census. Only the 41-50 year age group was approximately equal (see Table 4.1).

Sentence Length

The range of sentence length was six months to Preventive Detention (i.e., indeterminate length). The sentence mode for the whole sample was the category "greater than 6 years" (> 6). The sample who attended the First Step

programme (n = 39), all of whom were minimum security inmates at Tongariro/Rangipo or Ohura prisons, had shorter sentences on the whole (Modal sentence range 2 - 4 years, n = 14, followed closely by sentence range 4 - 6 years, n = 12) than the Waikeria prison group (Mode is "greater than 6 years" n = 30). The differences in sentence lengths between the whole (First Step plus Waikeria) sample and the First Step sample was significant, χ^2 (5, $\underline{N}$ = 104) = 16.42158, $\underline{p}$ = .006. Almost half (46.2%, N = 30) of the Waikeria prison group had a sentence in excess of 6 years and a further 7.7% had a sentence of preventive detention, whereas, only 20.5% of the First Step group had such long sentences. This probably reflects the fact that Waikeria prison has medium as well as minimum security inmates. Medium security inmates are more likely to have longer sentences which reflect a more serious nature of offence.

Time Since Offence

The offence had occurred within the last 5 years for 68% of the men, between 6 and 10 years ago for 10% and over 10 years ago for 22% of the offenders (see Table 4.2)

Sentence Elapsed

Seventy-seven percent of participants had completed between 4 and 24 months of their sentence, another 21 % had completed more than 24 months of their sentence. The remaining 2% had completed under four months (see Table 4.2)

Table 4.1

Comparison of Age of Whole Research Sample (n = 104) and the First Step Sample (n = 39) with the 1995 Census of Male Sex Offenders Against Children (CSO) Sentenced Inmates, New Zealand (n = 604).

Age	1995 Male CSO (%)	Whole Sample (%)	First Step (%)
≤20 years	1.32	3.8	2.6
21-30	16.36	10.6	7.7
31-40	25.95	27.9	35.9
41-50	27.11	26.0	25.6
51-60	19.34	17.3	12.8
>60	9.92	14.4	15.4

Ethnicity

Participants in this study identified their ethnic background as follows: 72 (69.2%) Europeans, 28 (26.8%) Maori, 2 (2%) Pacific Islanders, 1 (1%) European/Maori, and 1 (1%) New Zealander. There was a difference between the ratio of ethnic groups in the 1995 New Zealand prison population of male sex offenders against children (CSO) (Bakker 1997) and the ratio in both the whole sample of child sex offenders in the study, χ^2 (3, N = 104) = 11.929069, $p < .01$, and the First Step sample, χ^2 (3, N = 39) = 9.8859, $p < .05$. The 1995 prison Census showed proportionately fewer incarcerated European CSO's than were found in either the whole sample or the First Step sample. The proportion of Maori in the Census population and the whole sample was quite similar with a smaller proportion represented in the First Step sample. There was a much larger proportion of Pacific Islanders in the Census population than in either of the study's samples and finally there were fairly similar numbers of CSO's in the "other" category. It should be noted that, for the

Table 4.2

Distribution of Research Sample : Age, Sentence Length, Sentence Elapsed, Time Since Offence Occurred. Whole sample (All) n = 104, First Step (FS) sample (n = 39).

Age	All	FS	Sentence Length	All	FS
<20 years	4	1	<1 Year	2	2
21-30	11	3	1-2	8	3
31-40	29	14	2-4	23	14
41-50	27	10	4-6	28	12
51-60	18	5	>6	38	8
>60	15	6	PD*	5	0

Sentence Elapsed	All	FS	Time Since offence Occurred	All	FS
<1 month	2	1	<1 yea	11	4
1-4	14	9	1-5	60	27
4-12	30	12	6-10	10	4
12-24	36	7	>10	23	4
>24	22	10			

*PD = Preventive Detention (i. e., indeterminate length of sentence)

Census data, this latter category included ethnic groups such as Asian. This was not the case for the study samples where the other category was made up of 2 men with mixed European/Maori descent who did not wish to identify with either group specifically.

Table 4.3

Comparison of Ethnicity of Whole Research Sample (n = 104) and the First Step Sample (n = 39) with the 1995 Census of Male Sex Offenders Against Children (CSO) Sentenced Inmates, New Zealand (n = 605)

Ethnicity	1995 Male CSO (%)	Whole Sample (%)	First Step (%)
European	56.90	69.2	69.23
Maori	27.41	26.8	20.51
Pacific Islanders	12.48	2.0	5.13
Other*	3.21	2.0	5.13

* Other includes 3.5% from the category "European and Maori" (Census of prison Inmates 1995)

Alcohol and Drug Use

Of the offenders who took part in the First Step programme (n = 39), 84.6% had used alcohol and 66.5% started drinking between the ages of 14 and 20. Forty-six percent drank more than six drinks per session and 23.1% drank daily with a further 25.6% drinking at least weekly. Drug use was considerably less widespread in the sample with 25.6% reporting that they had previously used drugs. These drug users reported initiating use between the ages of 10 and 25 years, with the majority (70% of drug users) reporting that they had been using drugs very heavily (i.e.,10 joints or 70mg THC per week, Flintoft et al 1992). A full assessment of addiction to substances (using DSM-IV criteria) was not included in the structured interview, so information about the level of addiction is not diagnostic and is limited to

frequency and quantity.

Decision to Seek Treatment at a Sex Offender Treatment Programme

At the initial assessment, offenders were asked if they had decided to enter a Sex Offender Treatment Programme to address their offending. Their responses constituted the Decision variable. Even if they said that they wanted to go (i.e., decided to go), it was not assumed that they had actually been referred to the programme at the time of the interview. The majority of the whole sample (64.4%, n = 67) had decided against going to the Sex Offender Treatment Programmes. When the non-treatment Waikeria prison participants were removed from the sample, there was still a majority (56.4%, n = 22) deciding against a referral to treatment at the Sex Offender Treatment Programmes (see Table 4.4).

Table 4.4

Frequency of Decision to Seek or Decline Treatment at the Sex Offender Treatment Programme Prior to First Step

Decision	Frequency	Percent	Cum percent
No	22	56.4	56.4
Yes	14	35.9	92.3
Not eligible*	3	7.7	100.0
Total	39	100	100

* Not eligible because of insufficient time to the end of their sentence

Five participants reported having sought treatment prior to coming to prison and none of these had completed that programme. These men reported that the reason for non-completion was imprisonment before the programme ended. The "SAFE" community programme is 2 years long and the offenders

sought treatment only after being charged, so it is not surprising that none of them completed prior to imprisonment.

Relationship Between Decision to Enter A Sex Offender Treatment Programme and Alcohol and Drug Use.

No significant relationships were found between substance use and the decision to seek treatment or to follow through on a referral to the Sex Offender Treatment Programme (all p's > .1).

Factors Influencing the Decision to Seek or Decline Entry to a Sex Offender Treatment Programme

One of the hypotheses of the project was that there would be a number of factors that would influence the offenders' decisions to seek referral to a Sex Offender Treatment Programme. Chi square analysis showed that three factors were significantly related to the decision to seek/decline treatment (see Table 4.5), although all of the factors listed were advanced by at least one inmate as instrumental in their decision. The significant factors were (a) the desire for self improvement χ^2 (1, N = 36) = 10.0800, p = .001, (b) degree (some, none) of acceptance of responsibility for actions for which convicted, χ^2(1, N = 36) =5.91811, p = .01 (c) denying guilt χ^2(1, N = 36) = 4.86234, p = .03. There Was a trend for one other factor, treatment procedures at the Sex Offender Treatment Programme (e. g., masturbatory reconditioning), χ^2(1, N = 36) = 2.520, p = .1 to have an influence on the treatment entry decision. Both acceptance of responsibility χ^2 (1, N = 36) = 13.27609 p =.0002, (r = .61, p = .00009) and failure to deny guilt χ^2 (1, N = 36) = 10.1525 p =.001 (r = -.53, p = .0008) were significantly related to the desire for self improvement and all predicted the decision to enter an Sex Offender Treatment Programme. Offenders who accepted responsibility, did not deny guilt and sought self improvement were more likely to decide to seek entry to the Sex Offender Treatment Programme. In addition, the trend indicated that those offenders who actively considered the Sex Offender Treatment Programme were more

likely to decide to seek treatment. Those who did not take aspects of the treatment into consideration were more likely to decide against treatment.

Table 4.5

Factors that Influenced Offenders' Decision to Seek or Decline the Sex Offender Treatment Programme(n = 36*).

Factor	χ^2
Self Improvement	χ^2 (1, N = 36) = 10.0800, p = .001
Accepting responsibility for offending	χ^2(1, N = 36) =5.91811, p = .01
Deny Guilt	χ^2(1, N = 36) = 4.86234, p = .03
SOTP** Treatment procedures	χ^2(1, N = 36) = 2.520, p = .1

*3 subjects excluded as not eligible for the Sex Offender Treatment Programme, ** SOTP = Sex Offender Treatment Programme

Acceptance of responsibility by the offenders for their offending.

The majority (53.8%, n = 21) of offenders who attended the First Step programme accepted responsibility for all of the actions for which they had been convicted. A further 17.9% (n = 7) said that they were responsible for some of the actions, and 28.2% (n = 11) denied responsibility for any of the actions for which they had been convicted.

Decision to enter a sex offender treatment programme and acceptance of responsibility

Almost all (n = 10, 91%) of the deniers decided not to enter therapy while, of those who accepted some or all responsibility for their convictions, 13 (52%) wanted to go to the Sex Offender Treatment Programme and 12 (48%) decided not to go. This difference, between offenders who accepted responsibility and those who denied responsibility, was significant, χ^2 (1, N = 36) = 5.918, $p = .01$ indicating that acceptance of responsibility is more likely to be related to a decision to enter therapy (see Table 4.5).

Alcohol and drug use and acceptance of responsibility.

A significant relationship was shown between reported drug use and acceptance of responsibility, χ^2 (2, N = 38) = 7.05714, $p < .03$ (see Table 4.6). All of the offenders who reported using drugs accepted at least some responsibility for the offences, with most drug users (90%) also accepting responsibility for all of their offences. All of the offenders who denied responsibility (n = 10) also reported not using drugs. It was, therefore, more likely that those who were willing to report that they used drugs were also willing to take responsibility for their sexual offences against children. However, in the absence of independent information about drug use, no conclusions about the relationship between denying drug use and either accepting or denying responsibility for the sexual offences against children can be made. It is quite likely that there were many men in the sample who actually did not ever use drugs, particularly those in the older age groups.

The correlation between alcohol use and accepting responsibility for the offences was not significant. χ^2 (2 N = 38) = 1.49368 $p > .1$. In addition, alcohol and drug use did not predict the decision to enter sex offender treatment (all p's > .1)

Table: 4.6

Drug Use and Acceptance of Responsibility for Some or All of the Offences.

Use Drugs	Responsibility		
	All	Some	None
No	12	6	10
Yes	9	1	0

n = 38, information about drug use was not available for 1 man in the First Step sample.

Assessment by Psychologist

Usually all child sex offenders are interviewed by a psychologist as soon as possible after sentencing and before being transferred to Tongariro/Rangipo or Ohura prisons which were not "receiving prisons". However, an unexpectedly large proportion (44%) of the sample reported having not been interviewed by a psychologist prior to assessment for the First Step programme.

Stages of Change as a Predictor of Decision to Enter Sex Offender Treatment Programme

The URICA scale responses from the Waikeria offenders have been combined with those of the offenders who attended the First Step programme and used in the study of the relationship between the Stage of Change profile and the decision to go into treatment at Te Piriti or Kia Marama.

Stage of Change, in particular the Precontemplation and Contemplation stages, was found to be a predictor of the Decision to enter a Sex Offender Treatment Programme. If an offender had a Precontemplation T-score of 45 or more (i. e., average or above), then there was a 66.3% chance that he would decline treatment at a Sex Offender Treatment Programme. If he had a Contemplation T-score of 45 or more then there was a 56.8% chance that he would seek treatment. Both of these rates are higher than the whole sample base rates for either declining (62.5%) or seeking (34.6%) treatment (see Table 4.7). This adds further support to the argument for the Precontemplation and Contemplation subscales as predictors of the decision to seek Sex Offender Treatment Programme entry. Hence, increasing the Contemplation and/or decreasing the Precontemplation scores appears to increase the likelihood of a decision to enter the Sex Offender Treatment Programme.

Chi square analysis of the whole sample and the First Step sample, after the non-eligible subjects were removed, found, in the whole sample that there were significant relationships between the decision to enter treatment and the Contemplation (χ^2 (15 $\underline{N}$ = 95) = 29.17163, $\underline{p}$ = .02) and Maintenance (χ^2 (9 $\underline{N}$ = 95) = 18.17789, $\underline{p}$ = .03) subscales. There was also a trend for the Precontemplation (χ^2 (11 $\underline{N}$ = 95) = 16.49592, $\underline{p}$ = .1) subscale to predict the decision to enter the Sex Offender Treatment Programme. For the First Step sample there were no significant relationships between URICA subscales and the decision to enter or decline the Sex Offender Treatment Programme. (see Table 4.7).

Stages of Change and acceptance of responsibility.

There was a significant relationship between being in the Action Stage of Change (i. e., T score = ≥ 45) and accepting at least some responsibility for the offending χ^2 (13, N = 33) = 24.88, p = .023 (r = .01). No other Stages of Change significantly predicted acceptance of responsibility.

Table 4.7

Stage of Change as a Predictor of the Decision to Seek or Decline the Sex Offender Treatment Programme.

Decision	T Score (Mean = 50, SD = 10)				
	Total N(%)	PC ≥ 45(%)	CO ≥ 45(%)	AC ≥ 45(%)	MA ≥ 45(%)
NO	65(62.5%)	53(66.3%)	15(40.5%)	22(45.8%)	24(50%)
YES	36(34.6%)	24(30%)	21(56.8%)	24(50%)	22(45.8%)
Not Eligible	3(2.9%)	3(3.8%)	1(2.7%)-	2(4.2%)	2(4.2%)
Total	104(100%)	80(100%)	37(100%)	48(100%)	48(100%)

Empathy as a Predictor of Decision to Enter Sex Offender Treatment Programme

Analyses assessed the influence of victim empathy on the decision to enter a Sex Offender Treatment Programme. No significant relationships were found between either total empathy or any of the empathy subscales, and the decision to seek treatment or acceptance of responsibility.

Table 4.8

Relationship Between Stages of Change and Decision to Seek Entry to the Sex Offender Treatment Programme

	Whole Sample (n = 95)
PC	χ^2 (11 N = 95) = 16.49592, p = .1
CO	χ^2 (15 N = 95) = 29.17163 , p = .02
AC	ns
MA	χ^2 (9 N = 95) = 18.17789, p = .03
	First Step Sample (n = 30)
	all relationships non-significant

PC = Precontemplation, CO = Contemplation, AC = Action, MA = Maintenance

Stages of Change cluster and acceptance of responsibility.

At pre-First Step, a significant majority of the offenders were taking at least some responsibility for their offending but the majority were also saying that it was not a problem (i. e., in the Precontemplation cluster), χ^2 (4 N = 24) = 16.0421 p = .002 (see Table 4.9).

Table 4.9

Stage of Change Cluster by Degree of Acceptance of Responsibility

	Accept Responsibility for offending		
	All	Some	None
Pre-First Step Cluster (χ^2 (4 N = 24) = 16.0421 p = .002)			
Participation	0	2	1
Precontemplation	15	1	3
Uninterested	0	2	0

Predictors of Decision to Enter Sex Offender Treatment Programme

Using the First Step sample, an hierarchical multiple regression was performed using decision to seek/decline entry to a Sex Offender Treatment Programme as the dependent variable, with self improvement, acceptance of responsibility, Sex Offender Treatment Programme treatment procedures, and deny guilt as the independent variables (i. e., those factors found, in previous sections, on their own, to be predictors).

Table 4.10 displays the results of the hierarchical multiple regression. Overall the regression was significantly different from zero, F(4, 31 = 4.33887, p = .007. Altogether 36% (adjusted 27.6 %) of the variability in decision to seek/decline entry to a Sex Offender Treatment Programme was accounted for by the four variables included in the equation. Desire for self improvement was overwhelmingly the major factor accounting for 31.4% of the variance on its own. It was followed by treatment procedures in the Sex Offender Treatment Programme (2.9%), degree of acceptance of responsibility (1.5%) and denial of guilt (< 0.1%). None of the demographic variables were found to

be predictors, on their own, and hence, their exclusion from the regression analysis for the First Step sample.

All four dependent variables are, on their own, predictors of the decision to seek/decline entry to a Sex Offender Treatment Programme. In combination, only desire for self improvement was a unique predictor of decision to seek/decline entry to a Sex Offender Treatment Programme. However, it is also the case that each variable, contributed uniquely to the total variance.

An hierarchical multiple regression was also performed using decision to seek/decline entry to a Sex Offender Treatment Programme as the dependent variable and demographic variables (age group of offenders) and those Stages of Change previously shown, at initial assessment, to be predictors of decision, as independent variables. When the whole sample (i. e., including the Waikeria offenders) was analysed there were no unique predictors of decision to seek/decline entry to a Sex Offender Treatment Programme. There was a trend for Contemplation to predict decision to seek/decline entry to a Sex Offender Treatment Programme. Overall the regression was significantly different from zero, $\underline{F}(4, 90) = 3.96894$, $p = .005$. Altogether 15% (adjusted 11%) of the variability in decision to seek/decline entry to a Sex Offender Treatment Programme was accounted for by the three Stages of Change, Precontemplation (1.8%), Contemplation (9%) and Maintenance (0.7%), and the demographic variable, age group (3.4%), all of which were included in the equation (see Table 4.10).

Table 4.10

Hierarchical Multiple Regression of Predictors of the Decision to Seek/Decline Entry to a Sex Offender Treatment Programme: First Step and Whole Samples

Variables	B	Beta	Sig T	R Square (Adjusted)	Change
First Step Sample (n = 30)					
Self Improvement	.433326	.404880	.0415	.314 (.294)	.314
Responsibility	.099852	.093297	.8321	.329 (.288)	.015
Deny Guilt	-.119568	-.108629	.7939	.329 (.267)	.000
SOTP Treatment	.179139	.180555	.2438	.358 (.276)	.029
Overall R Squared = .358					
Overall Adjusted R Squared = .276					
Whole Sample** (n = 92)					
Age Group	-.002017	-.005539	.9603	.034 (.023)	.034
Precontemplation	-.000567	-.015330	.8971	.052 (.032)	.018
Contemplation	.005395	.276280	.1017	.143 (.114)	.091
Maintenance	.004999	.125638	.3906	.150 (.112)	.007
Overall R Squared = .15					
Overall Adjusted R Squared = .11					

* Responsibility = Acceptance of responsibility. ** Since only a limited number of variables were assessed with the whole group (including Waikeria) it was not possible to pursue regression that combined these demographic factors with the three factors (self-improvement, denying guilt and accepting responsibility) in an earlier regression.

Treatment Outcome - First Step Programme

The effects of treatment were analysed by means of a 2 (treatment vs. wait-list; between groups) X 2 (assessment periods; within groups) mixed-factorial ANOVA. The means and standard deviations of the measures are presented in Tables 4.11 to 4.19 and changes over time for the two groups are presented in Figures 4.1 to 4.5.

In considering the effects of the First Step treatment programme (i. e., the independent variable) the primary dependent variables were Stages of Change (both individual subscale means and cluster analysis of the subscales) and Victim Specific Empathy.

Stages of Change

The Stages of Change profile was measured by the URICA scale. Analyses of interaction effects revealed a significant Condition by Time interaction, $F(1,40) = 6.71$, $p = .01$, for the Contemplation subscale indicating that after the offenders had attended the First Step programme, they were more actively considering change following this programme, whereas those on the wait list were less likely to be doing so. On all other Stages of Change the Condition by Time interactions were non-significant (all p's > . 1, see Table 4.11).

No significant time or condition effects were found, however two trends were found. There was a difference between the Waitlist and Treatment groups for contemplation scores as the trend $F(l,40) = 2.64$, $p =.1$ shows[1].

Footnote 1: When the data from the Waikeria group was added and the difference between the Non-First Step (Waikeria + Waitlist) and the Treatment (First Step) groups were examined there was no significant difference (p = .07). That is, the significant difference ($t(50) = 3.52$, $p = .001$) between the Waitlist (Mean = 41.38) and Treatment, (Mean = 23.95) groups at pre test appears to be an artefact of the sample size. Given differences between pre waitlist and pre treatment scores, a secondary analysis of covariance (ANCOVA) using pre treatment scores was non-significant ($p > .1$). However, use of ANCOVA in treatment outcome analyses has been recommended against (Rosenthal, 1987). That said, given this finding, regression to the mean as underlying the significant ANOVA interaction cannot be discounted.

There was a trend over time for the Action scores to increase for the whole sample $F(1,40) = 2.27$, $p = .1$. None of the other main effects, time or condition, were significant (All p's > .1, see Table 4.11).

Table 4.11

Pre and Post Mean T-scores on the URICA Scale Across the Wait (n = 18) and Treatment (n = 24) Conditions.

		Precontemplation	Contemplation	Action	Maintenance
Wait	Pre	51.94	41.38_1	44.72	43.06
	Post	57.77	33.61	46.39	43.30
Treatment	Pre	60.00	23.95_1	37.08	41.25
	Post	60.41	31.88	42.92	45.20

Effects	**Precontemplation**	**Contemplation**	**Action**	**Maintenance**
Condition	$F(1,40) = 1.41$, $p > .1$	$F(1,40) = 2.64$, $p = .1$**	$F(1,40) = 1.40$, $p > .1$	$F(1,40) = 0.00$, $p > .1$
Time	$F(1,40) = 1.55$, $p > .1$	$F(1,40) = 0.00$, $p > .1$	$F(1,40) = 2.27$, $p = .1$**	$F(1,40) = 1.11$, $p > .1$
Condition by Time	$F(1,40) = 1.17$, $p > .1$	$F(1,40) = 6.71$, $p = .01$*	$F(1,40) = 0.7$, $p > .1$	$F(1,40) = .84$, $p > .1$

** p = .1, * p = .01

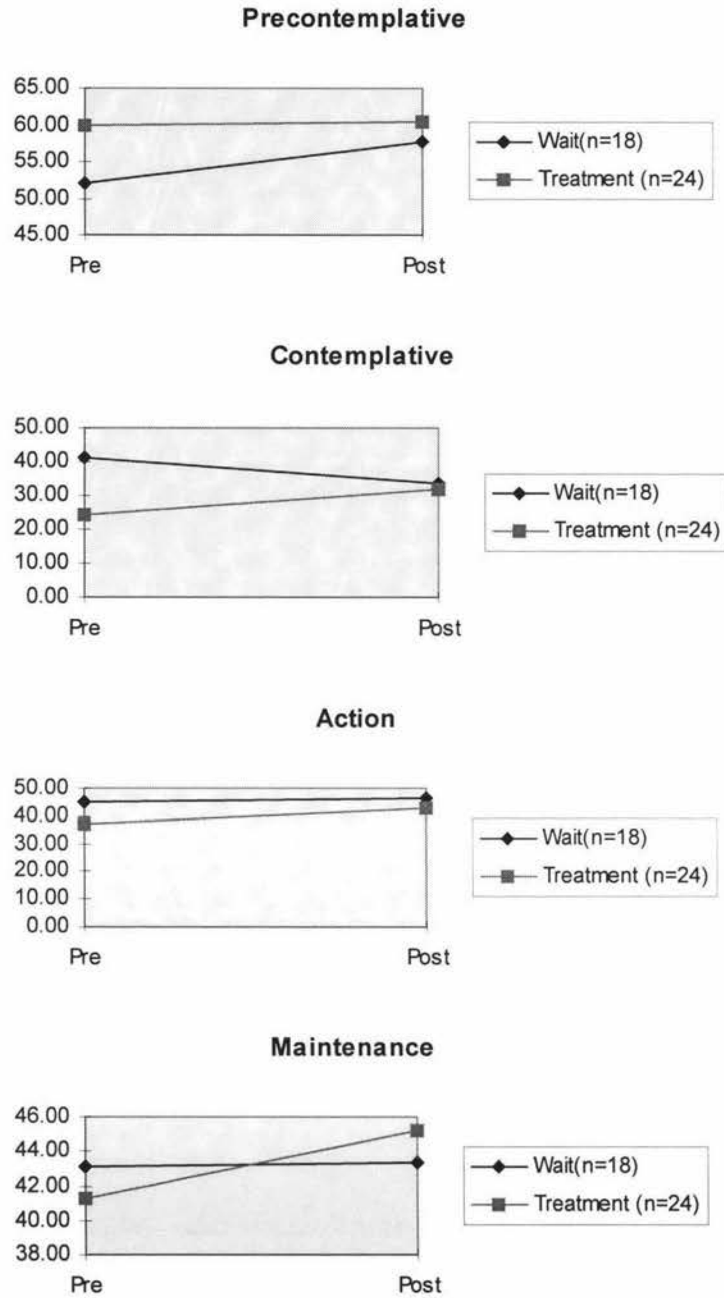

Figure 4.1. Pre and Post Mean T-scores on the URICA Scale Across the Wait (n = 18) and Treatment (n = 24) Conditions

Consistent with the finding of one significant ANOVA interaction, a post-hoc t-test analysis of the change scores for the URICA subscales resulted in one significant finding - the Contemplation scale ($t(40) = 2.59$, $p = .01$). That is, this analysis indicated that the treatment group progressed and the waitlist group regressed. In comparing pre-post scores for each condition, the regression in Contemplation scores over the wait period was not significant ($p > .1$) and the progression in Contemplation scores after First Step was significant ($t(23) = -2.19$, $p < .04$). Non-significant changes were found for the Precontemplation, Action and Maintenance scales (see Table 4.12).

Table 4.12

Change Scores for URICA Scale[1]

Change Scores	PC	CO	AC	MA
Wait	5.83	-7.78	1.67	0.278
Treatment	0.42	7.92	5.83	3.96
t-tests	$t(40) = -1.08$, $p > .1$	$t(40) = 2.59$, $p = .01$*	$t(40) = 0.84$, $p > .1$	$t(40) = 0.91$, $p > .1$

1. Increases in Precontemplation indicate deterioration, increases in other scales indicate improvement.
PC = Precontemplation, CO = Contemplation, AC = Action, MA = Maintenance

While all of the results for the Contemplation scale represent a positive finding in favour of First Step, and as noted - Footnote 1, regression to the mean can not be ruled out; however, the fact is that the treated subjects got significantly better after attending First Step as reflected on this scale.

Following First Step the Precontemplation subscale mean remained steady at T-score = 60. The significant increase in Contemplation and nonsignificant increases in Action and Maintenance signal some growing openness by the offenders to acceptance that their sexual offending is a

problem which they need to take action to change. The lack of movement on the Precontemplation scale suggests that the offenders, as a group, were failing to acknowledge that they had a problem and were still in need of further intervention. More specific cluster analyses examined individual changes more closely and are now presented.

Hierarchical Cluster Analysis of Stages of Change

Hierarchical cluster analysis was used to identify the most common Stages of Change profiles exhibited by the offenders in the sample. Changes in these clusters, following presentation of the First Step intervention, were analysed. McConnaughy et al (1983, 1989) used an eight cluster solution; however, preliminary analysis indicated that this was unsuitable as the small size of the First Step sample (n = 39) made obtaining meaningful clusters difficult. Following McConnaughy et al's identified clusters derived from initial statistical clustering (see Methods), a variety of initial solutions were derived. These were examined before three cluster solutions were chosen for both pre and post conditions with the exception of a two cluster solution revealed at post wait-list. A four cluster solution was discarded because it produced clusters which were very similar (i. e., two versions of a Precontemplation cluster[2] as defined in Table 3.2). Consequently, it did not provide any more useful information than a more parsimonious three cluster solution. In each table, the order of presentation of clusters reflects an increasingly advanced Stages of Change profile.

Footnote:2. At both pre and post waitlist, an additional Precontemplation cluster was initially identified. This profile containing one subject at pre-waitlist and two subjects (11%) at post-waitlist was in a more extreme Precontemplation range (e. g., Precontemplation Mean T score = 80 and Contemplation Mean T score = 5). Since both profiles reflected Precontemplation clusters, their data was combined to produce one overall Precontemplation cluster profile that resulted in the three and two cluster solutions at pre and post waitlist respectively.

Waitlist condition.

The pre waitlist clusters were as follows in Table 4.12 and Figure 4.2.

Table 4.13

Mean Pretest scores for Stages of Change Cluster Profiles from the First Step Wait-List Group (n = 18).

Cluster	PC	CO	AC	MA
1 Immotive (n = 2)	50	45	28	55
2* Precomtemplation (n = 9)	60	30	41	35
3 Participation (n = 7)	42	55	55	50

* Cluster 2 includes a subject who fell into Cluster 4 which is an extreme Precontemplation profile

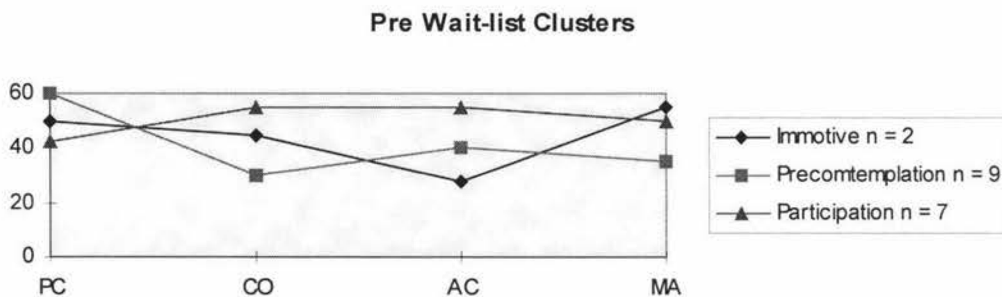

Figure 4.2. Pretest Mean T-score Cluster Profiles for the First Step Wait-list Group (n = 18).

Movement among clusters across wait-list period.

At pre waitlist, the subjects in the waitlist group (n = 18) fell into one of three clusters in the three cluster solution - an Immotive cluster, a Precontemplation cluster and a Participation cluster (McConnaughy et al, 1989) (see Table 4.13 and Figure 4.2). At post waitlist, there were two

clusters: a Precontemplation cluster and a Participation cluster. Tables 4.13 and 4.14 show that from pre to post waitlist 50%, (n = 9) of the subjects remained in the Precontemplation cluster while a further 39% (n = 7) moved into the Precontemplation cluster at post waitlist. Both of the Immotive subjects progressed to the Precontemplation cluster, and 5 Participation subjects regressed to this cluster. Only two of the original prewait-listed Participation subjects maintained in this cluster at post waitlist.

Table 4.14

Mean Post Test T-scores for Stages of Change Cluster Profiles from the First Step Wait-list group (n = 18).

Cluster	PC	CO	AC	MA
2* Precontemplation (n = 16)	60	30	44	42
3 Participation (n = 2)	38	60	65	55

* Cluster 2 includes two subjects who fell into Cluster 1 which was an extreme Precontemplation profile.

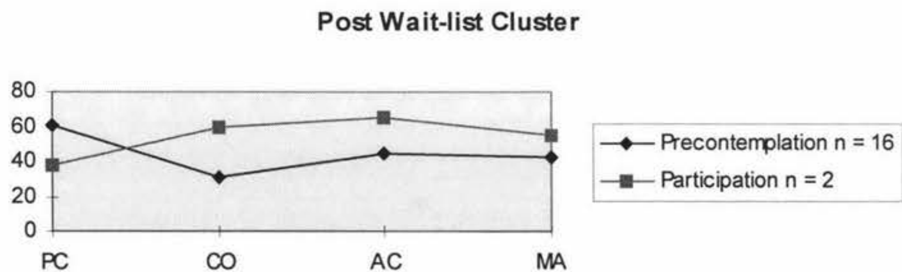

Figure 4.3. Post-test Mean T-score Cluster profiles for the First Step Wait-list group (n = 18).

The changes in the number of subjects, in all of the clusters, from pre to post waitlist period was not significant (χ^2(2, N = 18) = 3.535 p = .17).

However, a post hoc analysis of the URICA subscale changes, from pre to post waitlist, for the five Participation cluster subjects who regressed to Precontemplation found significant regression on the Contemplation $F(1,4)=17.52$, $p = .01$, and Action, $F(1,4)= .56$, $p = .05$ subscales and a significant regressive trend on the Maintenance, $F(1,4) = 4.57$, $p = .09$, subscale. The movement on the Precontemplation scale was not significant, $p > .1$. See Table 4.15.

Table 4.15

Mean T-scores for Pre Waitlist Participation Subjects Who Regressed to Precontemplation at Post Waitlist (n = 5).

	PC	CO	AC	MA	Cluster type
Pre	43	53	55	51	Participation
Post	50	36	44	47	Precontemplation

PC, $F(1,4) = 2.04$, $p =.2$; **CO**, $F(1,4) = 17.52$, $p = .01$; **AC**, $F(1,4) = 7.56$, $p = .05$; **MA**, $F(1,4) = 4.57$, $p = .09$

Overall changes post waitlist.

Overall, the trend for waitlist subjects was to maintain their Precontemplation ("I have not got a problem") stance or to regress from Participation to Precontemplation. A couple of participants progressed but only slightly and, like most others, ended up in Precontemplation at post waitlist. For this sample, time in prison, on its own, did not help and even hindered the acceptance by some offenders that they have a problem and that they may need to take steps to avoid reoffending. See Table 4.16 for a summary of movement between clusters.

Table 4.16

Frequency of Subjects in the Clusters at Pre and Post Waitlist.

Clusters at:	POST		
PRE	Precontemplation	Participation	Row Total
Immotive	2		2
Precontemplation	9		9
Participation	5	2	7
Column Total	16	2	18

Movement of subjects between the clusters is not significant (χ^2 (2, N = 18) = 3.535 p= .17).

First Step treatment condition.

The pre First Step clusters were Uninterested, Precontemplation and Participation (see Table 4.17 and Figure 4.4).

Table 4.17

Mean Pretest T Scores for Stages of Change Cluster Profiles from the First Step Treatment Group (n = 24).

Cluster	**PC**	**CO**	**AC**	**MA**
1 Uninterested (n = 2)	40	-05	08	30
2 Precontemplation (n = 19)	65	21	36	41
3 Participation (n = 3)	42	60	63	52

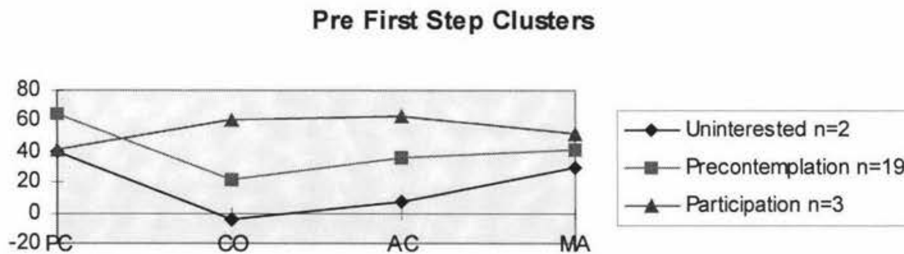

Figure 4.4. Pre test T- score Cluster Profiles for the First Step treatment group (n = 24).

Movement of offenders among clusters after First Step.

The effects of the First Step programme are reflected in the changes both in the number of subjects making up the post treatment profiles and in the movement of specific subjects between pre and post treatment profiles, (see Tables 4.17 and 4.18 and Figures 4.4 and 4.5). At pretreatment, there were three subjects showing a Participation profile (i.e., Contemplation, Action and Maintenance T scores above 50). At post treatment, there were eight subjects with this profile. The five new Participation cluster subjects progressed from the Precontemplation to the Participation cluster at post treatment. Post hoc analysis of the change in each mean subscale score for these five subjects found that there was an important trend for three of the subscales: Precontemplation, $F(1,4) = 6.45$, $p = .064$, Contemplation, $F(1,4) = 6.95$, $p = .06$ and Maintenance, $F(1,4) = 5.71$, $p = .07$. This trend was supportive of the hypothesis that the First Step programme would be associated with a reduction in Precontemplation and an increase in the Contemplation scores. An (adaptive) increase in the Maintenance score was also found.

Of the other participants in the Precontemplation cluster at pre First Step, eleven progressed into the Non-Reflective Action (McConnaughy et al 1983) cluster at post treatment and three remained in the Precontemplation cluster. Post hoc analysis of the change in each mean subscale score for these eleven subjects found that there was an important trend for two of the subscales: Contemplation, $F(1,10) = 2.67$, $p = .1$ and Action, $F(1,10) = 3.40$, $p < .1$. The two pre-First Step "Uninterested"[3] subjects progressed into the Precontemplation cluster at post treatment (all subscale changes were non-significant except for the trend in the Maintenance subscale, $F(1,1) = 42.25$, $p = .1$).

The Precontemplation cluster decreased in size from n = 19 at pre treatment to n = 5 at post treatment. There is a significant difference, reflecting improvement, in the mean T-scores for the subscales in the Precontemplation cluster from pre treatment to post treatment for three of the subscales: Precontemplation, $t(22) = -3.51$, $p = .002$, Contemplation, $t(22) = 3.27$, $p = .003$, Action $t(22) = 3.57$, $p = .002$, Maintenance, $t(22) = .05$, $p > .1$. The majority (16 out of 19) of the pre First Step Precontemplation cluster subjects progressed, as a result of the treatment, to the Participation or Non-Reflective Action clusters.

Overall changes at post First Step.

The changes in frequency of subjects moving across the profiles was significant, $\chi^2(4, N = 24) = 14.71579$ $p = .005$ (see also Table 4.19). Overall the trend for the First Step treatment group was that most of the subjects (i. e., n = 18 or 75%) progressed forward in their Stages of Change.

Footnote: 3. The Cluster analysis identified two subjects, see Table 4.16 Cluster 3- "Uninterested", whose responses did not match any of the McConnaughy et al's sample clusters. Their mean T scores were in the range 40 to -5 (McConnaughy et al 1989) at pre-First Step treatment suggesting a minimal response set perhaps caused by failure to engage in the process.

Table 4.18

Mean Post-test T Scores for Stages of Change Cluster Profiles for the First Step Treatment Group (n = 24).

Cluster	PC	CO	AC	MA
1 Participation (n = 8)	36	58	58	53
2 Non-Reflective Action (n = 11)	64	32	48	42
3 Precontemplation (n = 5)	86	-7	10	40

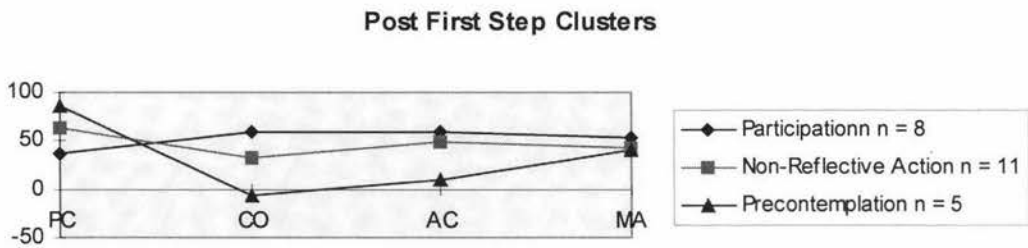

Figure 4.5. Posttest T- score Cluster Profiles for the First Step Treatment Group

Table 4.19

Frequency of Subjects in the Clusters at Pre and Post First Step Treatment Programme.

Clusters at:	POST			
	Precontemplation	Non-Reflective Action	Participation	Row Total
PRE				
Uninterested	2	0	0	2
Precontemplation	3	11	5	19
Participation	0	0	3	3
Column Total	5	11	8	24

Movement of subjects between the clusters was significant χ^2 (4, N = 24) = 14.71579 $p = .005$

Victim Empathy

Victim empathy, as measured by the total score on the Person Specific Empathy Scale, showed a significant Condition by Time interaction, $F(1,20) = 5.06$, $p < .05$ (see Table 4.19). These changes were in the predicted directions (i. e., a reduction in empathy over the wait period and an increase after First Step treatment). There was a significant Condition by Time interaction on the Sexual Abuse Victim subscale, $F(1,32) = 4.28$, $p < .05$. The changes reflected in the Sexual Abuse Victim subscale occurred mostly in the waitlist group where offenders became less empathic while they waited for treatment. The treatment group members maintained their empathy at almost the same level after the First Step as they had before the intervention.

Table 4.20

Pre and Post Scores on the Person Specific Empathy Scale Across the Waitlist and First Step Treatment Conditions

		Total Score	**Sexual Abuse Victim**	**Accident Victim**	**Offender's Own Victim**
Wait	Pre	993.43	349.06	292.87	305.30
	Post	930.43	307.41	292.37	279.2
Treatment	Pre	891.00	316.06	305.30	328.95
	Post	923.75	317.59	279.2	330.95

Effects	**Total Score**	**Sexual Abuse Victim**	**Accident Victim**	**Offender's Own Victim**
Condition	$F(1, 20) = 0.29$, $p > .1$	$F(1, 32) = 0.14$, $p > .1$	$F(1, 24) = 0.0$, $p > .1$	$F(1, 35) = 1.21$, $p > .1$
Time	$F(1, 20) = 0.51$, $p > .1$	$F(1,32) = 3.69$, $p < .1$	$F(1, 24) = 1.84$, $p > .1$	$F(1, 35) = 0.4$, $p > .1$
Condition by Time	$F(1, 20) = 5.06$, $p <. 04$*	$F(1,32) = 4.28$, $p < .05$*	$F(1, 24) = 1.7$, $p > .1$	$F(1, 35) = 0.81$, $p > .1$

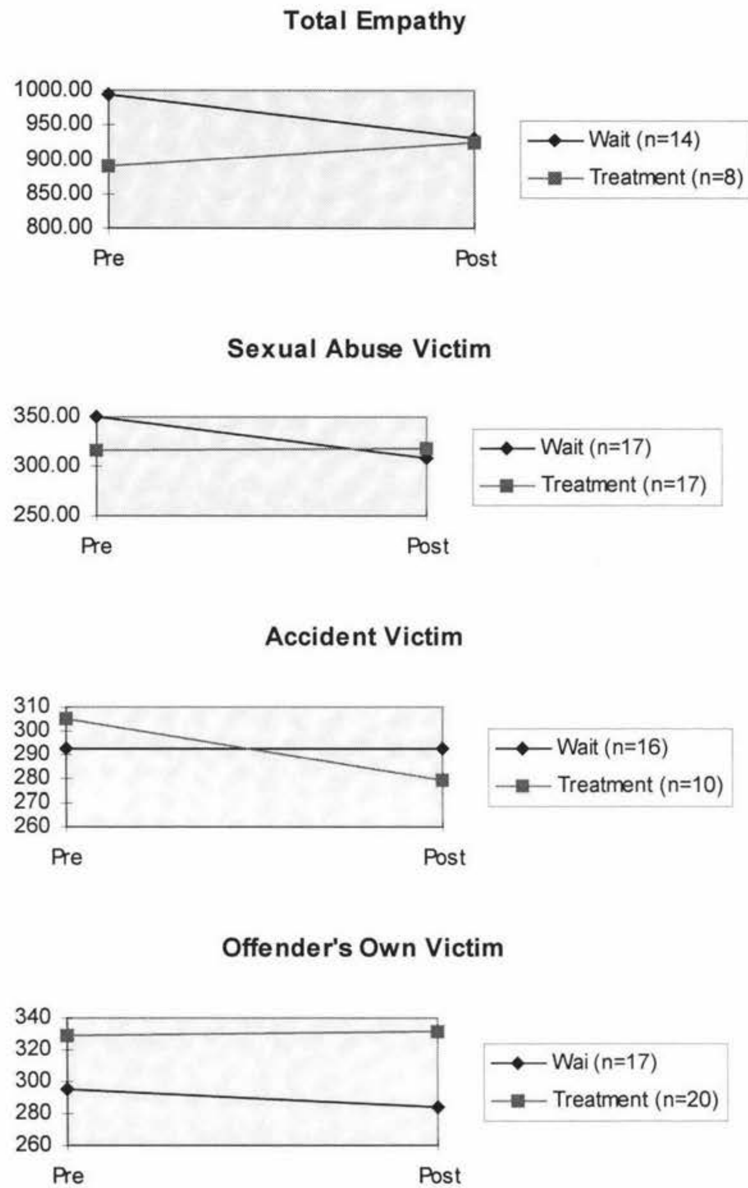

Figure 4.6. Pre and Post Scores on the Person Specific Empathy Scale Across the Wait and Treatment Conditions

Consistent with the ANOVA findings, a post hoc t-test analysis of the change scores for the Person Specific Empathy Scale found significant differences on

the Total Empathy ($t(20) = -2.25$, $p < .04$) and the Sexual Abuse Victim ($t(32) = -2.07$, $p < .05$) scales. The Accident Victim and Offender's Own Victim scales returned non-significant results (p's > .1, see Table 4.21. A post hoc t-test comparing pre to post treatment scores for the Total Empathy and Sexual Abuse Victim scales revealed that there was no significant change in these two scales across the First Step treatment condition (p's > .1). However, there was a significant decline in Total Victim Empathy ($t(13) = -2.21$, $p < .05$) and in Sexual Abuse Victim Empathy ($t(16) = -3.49$, $p = .003$) over the waitlist period. Child sex offenders' Total Victim Empathy scores significantly decreased while in prison without treatment. (They also gave support to the steadying effect on victim empathy in offenders observed pre to post First Step intervention).

Table 4.21

Change Scores for Person Specific Empathy Scale

Change Scores	**Total Score**	**Sexual Abuse Victim**	**Accident Victim**	**offender's Own Victim**
Wait	-63.00	-41.65	- 0.50	-11.35
Treatment	32.75	1.53	-26.10	2.00
t-tests	$t(20) = -2.25$, $p < .04$*	$t(32) = -2.07$, $p < .05$*	$t(24) = 1.30$, $p > .1$	$t(35) = -0.99$, $p > .1$

Treatment Integrity

The First Step treatment programme was delivered in accordance with the manual. There were no instances where other forms of therapeutic intervention were used in place of the treatment manual. The treatment manual was implemented in a flexible manner that maintained programmatic strategies while permitting an appropriate response to each groups' needs. Accordingly, the independent variable (treatment) was deemed to have

integrity. As part of this process, an independent fidelity assessment of the presentation of the First Step programme was carried out and confirmed by a clinical psychologist from Massey University's academic staff at Tongariro/Rangipo Prison (using a checklist type rating), following observation of two separate consecutive sessions.

CHAPTER 5

DISCUSSION

General Outline of Findings

The results of this study provide important data for enhancing our understanding of the factors that influence the incarcerated child sex offender's decision to seek entry to a Sex Offender Treatment Programme. There was evidence that the motivational/educational intervention, First Step, had an influence on the way that the offenders thought about their offending behaviour. In particular, this was supported by their movement through the Stages of Change, as illustrated by changes in the numbers of offenders in each identified Stages of Change cluster. Prochaska, DiClemente and Norcross (1992) argued that entry to and compliance with change programmes, which are usually Action oriented, is more likely when the individual's Stage of Change is congruent with the focus of the programme. This is supported by the finding that there was a significant relationship between the offender's Stages of Change and his decision to enter the Sex Offender Treatment Programme. The support for First Step further buttresses Barbaree (1991) and O'Donohue and LeTourneau (1993) proposals for the necessity, particularly in cases where the problem is denied, for a pre-treatment intervention designed to encourage a frame of mind that is more amenable to treatment entry and compliance.

Linked with the issue of denial and Stages of Change are the factors which were found to be significantly related to an offender's initial decision to enter treatment. For instance, the desire for self improvement and a willingness to accept responsibility were positively related to the decision to enter treatment, and denying guilt was negatively linked with the decision. If an offender did not have the opportunity to obtain detailed information about the Sex Offender Treatment Programme from a Department of Corrections psychologist prior to the assessment carried out in this study, he was more

likely to decline the programme. Also having information about the treatment procedures in the Sex Offender Treatment Programme is not an apparent disincentive to seeking treatment for the majority of those offenders who took this information into consideration when making their decision about entry to the programme. On the contrary, trends indicated that it predicted the decision to seek treatment. Only 44% of the First Step sample reported having been interviewed by a Department of Corrections psychologist prior to taking part in this study. This appeared to indicate a need to review the case management process to ensure that all child sex offenders have an opportunity to discuss the Sex Offender Treatment Programme with a departmental psychologist, preferably early enough on in their sentence to allow them to be eligible to be referred to the programme if they decide to seek entry.

Victim empathy was another factor which had been hypothesized to have an influence on the decision to enter treatment; however, this hypothesis was not supported in the present study.

Stages of Change and First Step

An hierarchical agglomerative analysis produced a number of clusters related to the Stages of Change. Offender membership in these clusters varied as a function of both the waitlist and treatment conditions.

After attending the First Step programme, the majority of child sex offenders (75%) progressed and became more engaged in the process of changing their behaviour. Specifically, the offenders in the Participation group are, according to McConnaughy et al's (1989) guidelines, reporting more active involvement in seeking changes. They are not ignoring the presence of a problem, rather, they are engaged in thinking about the problem, taking some action on changing it, and maintaining changes already made. The large and significant increase in the number of child sex offenders in the sample reporting a positive change in their Stages of Change profile following First Step, showed that a pre-treatment intervention has an important role to play.

The First Step programme appeared to stimulate these offenders to consider their position vis-à-vis their offending and to begin to do something about altering their behaviour in this area.

Precontemplation profiles featured at pre First Step and pre waitlist. These offenders were a priori not acknowledging that they had a problem with sexual offending against children and not considering making any changes. In addition, almost all of the offenders in the waitlist condition regressed to or remained in the Precontemplation position. That is, these offenders were failing to recognise that they had a problem with sexual offending against children. While being in this cluster which is characterised by 'not recognising that he has a problem with sexual offending against children' is usually not a positive sign, in the case of two of the offenders it appeared to be an improvement. These offenders had been in the "Uninterested" cluster at pre First Step and moved to the Precontemplation cluster at post First Step. This movement was interpreted as their having become more engaged, or less disengaged, in the change process as a result of their attendance at First Step. A more encouraging result was the progression of eleven offenders from the Precontemplation to the Non-Reflective Action group after the programme and suggests that, while they were avoiding thinking about their offending behaviour as problematic, they were starting to do something about changing their behaviour. The change these eleven made begs to be followed up with more specific therapy as these offenders may need to acknowledge their behaviour is problematic before any confidence could be placed in their having made lasting changes which would reduce the risk of their reoffending. Finally, the five offenders who progressed into the Participation cluster after First Step and the additional three who maintained themselves in this cluster showed evidence of being actively engaged in thinking about their problem with sexual offending against children and in taking some action on changing their sexual behaviour and maintaining changes they had already made. It would be important to facilitate their entry to the Sex Offender Treatment Programme and/or to provide them with group or individual therapy in order to maintain this positive direction and avoid the potential regression. The First Step

programme has been shown to have some beneficial effect on assisting those child sex offenders in the current study to advance in their Stage of Change profile. It is expected that enhancement of the programme and further individual therapy could build on this initial progress as many offenders who attend First Step do not immediately proceed to full scale treatment (the Department of Corrections Psychological Service policy is for treatment to be placed towards the end of an individual's sentence).

The presence in the Precontemplation profile of the majority (n = 16) of the waitlist subjects at post waitlist confirms another hypothesis of the study: that being in prison without intervention tends to be associated with a waning of motivation to enter treatment and an entrenchment of offence enabling attitudes. In particular, this is confirmed by the large proportion (66%) of the waitlist subjects who had been in the more active Participation cluster and who regressed to the Precontemplation -"I have not got a problem" - cluster during the waitlist period.

The significant movement of offenders, in both the treatment and the waitlist conditions, can be interpreted as supporting the need for a programme like the First Step intervention. Three quarters (n = 18) of the 24 subjects who completed the First Step programme made bona fide cluster based and progressive changes. This is important as these offenders are notoriously hard to change, particularly if they are in denial (Nugent & Kroner, 1996).

While supporting the effectiveness of a motivational and educational intervention, these results suggest also that there is scope for improvement of the First Step programme in order to increase the progress made by the participants through the stages of change. In particular, the lack of a significant Condition by Time interaction for the Precontemplation subscale was unexpected and indicates a need for further investigation into the Processes of Changes expected to be active in this Stage of Change and the way this is operationalised in the First Step programme. The nature of the treatment programme was such that it was not expected to significantly alter the Action

and Maintenance subscale scores and this was borne out. Finally, significant group-based improvement was noted on the Contemplation scale as a function of treatment and further supports the idea this pretherapy intervention is meeting the objective of promoting increased willingness in many offenders to consider entering therapy for sexual offending against children.

Empathy and First Step

Davis (1983) argued that empathy has both cognitive and affective dimensions and that it appears to influence behaviour between individuals by mediating the development of non-egocentric, other-oriented thought and behaviour. Therefore, a motivational and/or educational programme which places emphasis on victim empathy could be expected to have a greater impact on an offenders acceptance of responsibility for his behaviour and for making prosocial changes in his behaviour. The short victim empathy module included in the First Step programme did not have a significant impact on the victim specific empathy of the child sex offenders who attended the programme, but did have a beneficial impact as relates to overall empathy scores. In particular, the results again supported the hypothesis that offenders may become more entrenched in 'offending-enabling' attitudes in the absence of interventions. This is illustrated by the significant reduction in the total Empathy score and in Sexual Abuse Victim Empathy score over the waitlist period.

Most of the significance of the Condition by Time interaction for the whole Empathy scale and for the Sexual Abuse Victim subscale can be accounted for by a significant decrease in the means of both scales over the wait period. This significant reduction in empathy over the wait period is of great interest as it adds specific information about the general regression in Stages of Change which was observed in those offenders in the waitlist group. There was a regression over the waitlist period towards Precontemplation and a failure to recognise the need for treatment and behaviour change. Prochaska et al (1992) describe the path of change as spiral with individuals

progressing and regressing successively in their efforts to address their problems. A pattern of regression on a dependent variable, such as empathy, or Stage of Change during the wait period and either maintaining the status quo or progression in these variables following an intervention, bolsters the arguments supporting the intervention (e. g., First Step). As indicated in the Results, in terms of regression to the mean playing a role, future research is needed to clarify this issue. However, findings here suggest that time alone is no ally in the change process. (See also Knowles, 1997).

While empathy levels were maintained by those who attended First Step, the failure of the First Step programme to have any significant effect on victim specific empathy can probably be attributed to the manner in which this topic was approached. The one and a half hour empathy module was obviously not enough to make a significant difference. Nevertheless, victim empathy has been successfully included in other motivational programmes, (e. g., O'Donohue & LeTourneau, 1993). In addition, the slight, though not significant, increase in victim empathy after treatment gives rise to speculation that not only may treatment halt the downward trend in victim empathy as indicated in the present study but, more speculatively, that it may be instrumental in reversing this trend. Based on current results, a revision of the First Step programme is going to include an enhanced victim empathy component.

The victim empathy module was included largely because of the widespread inclusion of this issue in sex offender treatment programmes (Marshall 1996)and to sensitize these potential participants. However, at least in its current form, no significant predictive relationships were found between empathy and other variables investigated (e. g., Stages of Change profiles and Decision to enter a treatment programme). The questions about the role that empathy and victim empathy have at the pre-treatment stage of decision-making require more thorough investigation before any other definitive statements can be made.

Factors that Influence the Decision to Seek or Decline a Sex Offender Treatment Programme

The desire for self improvement was found to be the most important factor influencing the First Step offenders' decision to seek treatment. Hierarchical multiple regression showed that 31.4% of the variance in the decision to seek treatment was explained by the offenders' wanting to make positive changes in their lifestyles and behaviour. A further 4.4% of the variance in the decision to seek therapy was accounted for by two other factors degree of acceptance of responsibility by offenders for their offending and the treatment procedures in the Sex Offender Treatment Programme. All three of these factors clearly have implications for therapists engaged in the motivation of offenders to accept that they have a problem with sex offending and to seek help to alter this behaviour. That the 'desire for self improvement' was significantly related to 'acceptance of responsibility' and the failure to 'deny guilt' provides a link back to the Stages of Change model as well. Precontemplation is a stage where individuals are not recognising they have a problem and therefore not seeking self improvement. The First Step programme incorporated strategies from the Motivational Interviewing techniques developed by Miller & Rollnick (1991) to encourage individuals to acknowledge their problem behaviour and to consider appropriate action to change it. Many of the offenders who attended the First Step programme showed a movement from the Precontemplation profile to Participation and Non-Reflective Action profiles wherein they were beginning to show increased interest in their own self improvement.

In the current study, the large percentage (56.4%) of offenders declining Sex Offender Treatment Programme entry served to emphasise the argument that incarceration without relevant intervention leads to a maintenance or regression in attitude. Without programmes designed to stimulate and maintain motivation for treatment to address their sexual offending against children, offenders appear to become less inclined to seek treatment. This bolsters the findings of research carried out at Waikeria prison

by Jury (1993) and Knowles (1997). Jury found 47% (n = 24) of a sample of child sex offenders declined treatment for their sexual offending. Knowles (1997) has shown that motivation to attend a Sex Offender Treatment Programme is relatively higher at the beginning of an offender's sentence than later on in his sentence. The Waikeria prison samples (Jury, Knowles) included offenders received directly from the courts into the prison (e. g., they were in the early part of their sentence, still adjusting to their sentenced state and therefore more likely to be feeling remorse and willingness to enter treatment). Most of the offenders in Tongariro/Rangipo and Ohura , which do not receive inmates directly from the courts, have had an opportunity to adjust to their incarceration while previously in another prison (e. g., Waikeria). There was a greater percentage of offenders declining treatment in the Ohura and Tongariro/Rangipo sample than declined treatment in the Waikeria sample, and it is suggested that this was due, in part, to the fact that the former had become adjusted to prison life and that more of them had become less willing in the absence of motivational interventions to seek entry to a Sex Offender Treatment Programme. However, elapsed sentence time was not found to be a significant predictor of decision to seek/decline treatment in the current study and it seems that the issue requires further investigation before a definitive statement can be made.

The finding that 'denying guilt' and the 'degree of acceptance of responsibility for the offending' had a significant impact on the offender's decision to seek treatment is not likely to be surprising to therapists who work with these offenders. An interesting finding was that the majority of offenders who accepted some or all responsibility (n = 16), prior to the First Step programme, were in the Precontemplation cluster. They were saying that they had committed the offences but that it was not a problem to them. While there was clearly a positive change of profile for many of these offenders, it is not so clear whether they had altered some specific stances vis-à-vis their offending (e. g., taking fully responsibility). Future research should clarify this issue.

Clinicians who work with child sex offenders will be familiar with the offenders' expressed reluctance to undergo physical assessment using the plethysmograph and their anxiety about treatment procedures such as masturbatory reconditioning. It was thought that these two factors would be important to the decision process when an offender was considering seeking therapy from the Sex Offender Treatment Programme. The number of offenders who named assessment procedures as featuring in the decision-making process was not significant. By contrast, the number of offenders who considered treatment procedures when deciding about therapy was an important issue. Hierarchical multiple regression found that information about treatment procedures accounted for 2.6% of the variance in the decision to seek/decline Sex Offender Treatment. Of those who decided to seek entry, the majority (56.3%) had considered the treatment procedures and of those who had decided to decline treatment the majority (70%) had not considered treatment procedures while making their decision. This may have been an artefact of the information the offenders had about these procedures prior to the structured interview. More than half ($n = 22$) of the offenders had talked to a Department of Corrections psychologist, who would have outlined the assessment protocol as part of gaining the informed consent of any offender who was referred to a Sex Offender Treatment Programme, prior to this study. As those offenders, who had been interviewed by a psychologist, were subsequently evenly split in their decision to seek or decline treatment, there was no apparent overall effect of this consultation. However, of those offenders who had been interviewed by a Department of Corrections psychologist, trends indicated that there was less likelihood that they would consider the assessment procedures (e. g., plethysmographic assessment) in a negative light when making their decision to seek or decline therapy. The clinical relevance of these findings is that providing offenders with information about the assessment and treatment procedures allows them to make a more informed choice about the Sex Offender Treatment Programme without apparently prejudicing them against the programme and with the increased likelihood that they will go to the programme when they know more about it.

As there were no significant relationships found in the current study between alcohol and drug use and the decision to enter therapy, assessment and treatment of these issues could be considered independently of any intervention to encourage offenders to seek treatment for the sexual offending against children. Hanson and Bussiere's (1996) meta-analysis found that a history of substance abuse was unrelated to sexual offender recidivism, further supporting the suggestion that these two issues, substance abuse and sexual offending, be treated as comorbid conditions rather than having any necessary causal relationship.

A factor which may interfere with the effect of the First Step programme on treatment entry decision is the accessibility of the Sex Offender Treatment Programme. Each group in the programme is usually oversubscribed and offenders are usually required to attend the Sex Offender Treatment Programme in the latter stages of their sentence. This can mean that they have a long time to wait between attending the First Step programme and the period when they would be most likely to be timetabled into the programme. Many of the offenders said they would go to the Sex Offender Treatment Programme if they could go reasonably promptly and not have to wait, sometimes years, until the last year of their sentence to be admitted into the programme. This, along with results from the regression, confirms Knowles (1997) findings that many offenders would prefer to enter therapy to address their offending early in their sentences.

When the whole sample (including the Waikeria offenders) was included in the multiple regression analysis the influence of some demographic variables became apparent. Already discussed was the issue of time in prison. In addition, the age of the offenders accounted for 3.4% of the variance in decision to seek/decline entry to a Sex Offender Treatment Programme. Offenders in the sample were more likely to seek treatment if they were aged between 21 and 30 years. Also, the older an offender was (beyond 30 years) at the time of being offered entry to the Sex Offender Treatment Programme the more likely he was to decline. Here again, elapsed

time worked against motivation. While ethnicity explained an insignificant (trend only) 3.5% of the variance in decision to seek treatment the finding that the proportion of each ethnic group who sought treatment was approximately the same (Europeans - 39%, Maori 32%) is encouraging as there has been some question about the attractiveness and suitability of the Sex Offender Treatment Programme to non-European offenders. The issue of ethnicity will now be further explored.

Ethnicity

The ethnic distribution of the sex offenders against children in the sample studied (see Table 4.3) did not match the distribution, of this same offender group, in the 1995 Prison Census (Bakker et al 1997). The reasons for this are not clear; however, the small size of the sample might have played a role. The 1995 Prison Census found a 60:40 European to non-European distribution; however, the ratio for the sample in the current study more closely matched West and Templer's (1994) findings. In a population of sex offenders against children, they found that that there was an approximate ratio of 70:30 White (European) to Black child molesters.

Exploration of ethnicity in relation to the other variables in the study was not encompassed by the main hypotheses. However, to ignore such an important variable altogether was also considered inappropriate as there is a growing awareness of the importance that ethnicity, and more specifically cultural background, has as an influence on *why, how, when, where* and *with whom* help is sought for personal problems. This issue was addressed in terms of assessing whether cultural reasons predict the decision to enter a Sex Offender Treatment Programme. In this study, cultural issues were not a significant factor influencing this decision.

Limitations, Methodological and Design Issues

Perhaps the most important design issue affecting the findings of the study relates to data gathering about the decision to seek treatment after attending the First Step programme. Another short, structured interview could have been included at this post intervention stage allowing for formal data gathering about any changes in the offenders intentions in relation to eventual entry into the Sex Offender Treatment Programme. This interview could also have served to establish whether the offenders' concerns, about such factors as treatment procedures, had been allayed by the First Step programme and to what extent they had altered their acceptance of responsibility for the offences for which they had been convicted. A follow-up that deals with these issues is being considered and may be pursued in preparation for manuscript submission to a peer reviewed outlet, but is outside the scope of the time frame for this thesis.

A second area where the design could have been strengthened also concerned the gathering of post First Step data. Some of the offenders indicated that, after their release, they would be seeking help, to avoid reoffending, from counsellors or community programmes such as SAFE or Steps to Safety which specifically target sexual offenders against children. Another offender spent several months after attending the First Step programme considering whether to go to the Sex Offender Treatment Programme. He consulted with a prison psychologist, (the researcher) and attended the "Te Piriti Roadshow" (a presentation by Sex Offender Treatment Programme staff about the programme) before finally accepting a referral to the Sex Offender Treatment Programme at Te Piriti. In this way, a follow-up of offenders who are still in prison is thought to provide more conclusive and ecologically valid information about the longer term effectiveness of the First Step intervention. It may well be that the decision to seek a referral to the Sex Offender Treatment Programme is influenced by a number of factors over time. A valuable source of information (actual referral to the Sex Offender Treatment Programme over time) about the effectiveness of the First Step

programme in influencing offenders to seek treatment is yet to be tapped (but may be pursued during manuscript preparation).

Conclusion

Motivation of offenders to enter therapy to address their offending remains a significant portion of the Department of Corrections psychologist's therapeutic tasks. Entry into a programme is quite clearly tantamount to the provision of therapy to offenders to help them to address their sexual offending against children. There is a growing interest in the dynamics and processes which are antecedent to entry to therapy. This study has added to the knowledge in this area by showing that a pre-treatment intervention can make a difference in influencing offenders' attitudes and by identifying some of the factors which influence an offenders decision to seek treatment for his offending. However, the study has given rise to some questions which can only be answered by further investigation. For instance, the First Step programme could be reviewed and enhanced to include: (a) a more in-depth approach to victim empathy, perhaps over two or more modules, (b) more personal engagement of the offenders by requiring some disclosure of the offences for which they were convicted, (c) more activities such as "decisional balance" exercises (Miller & Rollnick, 1991), and (d) weekly modules of one and a half to two hours over five to seven weeks rather than the blocked format of the current programme. It would be expected that these changes would encourage more engagement of the offenders and allow more time for the ideas and issues explored to be processed by the participants between modules.

Some methodological directions for future studies include (a) the collection of data about the decision of the offenders at both pre and post treatment and/or waitlist, (b) follow-up (currently being considered) to study longer-term effects of the intervention, of further incarceration without continuing intervention, and to ascertain whether offenders had entered treatment either after First Step, while incarcerated, or after their release, (c)

data collected about those who declined the First Step programme - denial status and reasons for declining the programme (though not currently possible given informed consent procedures) and eventual full scale treatment status (currently being considered).

It may well be that information based on the Stages of Change profiles obtained from the URICA measure could prove useful to Case Management committees charged with the task of identifying inmates' readiness to address their offending. Further norming of this measure on New Zealand specific populations and extension to other offender groups necessary before this measure could be used in such a widespread manner.

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APPENDIX A

MASSEY UNIVERSITY

Factors Related To Sexual Offender Programme

Information Sheet

RESEARCHERS: JOAN NORRIE C/- P. O. BOX 225, TAUPO
PHONE 07 378 0857:
DR. KEVIN RONAN, DEPARTMENT OF PSYCHOLOGY,
MASSEY UNIVERSITY, PALMERSTON NORTH

This research is being undertaken as part of Joan Norrie's study for a Master of Arts in Psychology. We would like to know what factors relate to your decision to join one of the two Sex Offender Treatment Programmes provided by the Department of Corrections. The programmes are Te Piriti and Kia Marama.

Your participation in the research project is entirely **voluntary**. You may attend the First Step programme without being part of the research project.

If you decide to take part in the research project we will ask you to meet with our researcher to complete some tests. Then if you have volunteered to attend the First Step programme, you will now complete it. After this programme we will ask you to complete another test. This will not be as long as the first one and will require approximately one hour.

Testing information is strictly confidential and will only be used for purposes of the study. A report will be written at the end of the study summarising the findings, but only group information will be reported and no individual will be identifiable in any reports. A summary of the findings will be available from the investigators at the conclusion of the study around December 1996.

If you would like information, there is a place for your address on the consent form attached.

Participation is entirely **voluntary**. You also have the right to ask any further questions about the study that occur to you now, during, or following your participation.

If you decide to participate, we would appreciate it if you could try to answer all the questions but you have the right to refuse to answer any particular questions and the right to withdraw from the study at any time.

One final reminder: All information about individuals is strictly confidential. Individual information obtained during this study will not be supplied to the Department of Corrections. Only group information without individual identifiers will be included in the report. Decisions regarding temporary paroles (home leaves) or early release will not be affected whether you decide to participate or not. Thank you for considering this.

APPENDIX B

Factors Related To Sexual Offender Programme

CONSENT FORM

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researchers on the understanding that it is completely confidential.

I wish to participate in this study under the conditions set out on the Information Sheet.

Signed:

Name:

Date:

Address (if require summary of findings):

APPENDIX C

Semi-Structured Interview

Date....................Number................

Factors that influence the decision to enter or not a sex offender treatment programme

Firstly, please I would like to ask you a few questions about yourself.

a) Placement in prison Ohura Pine Birch

b) What is your Age

c) Ethnicity

i) European

ii) Maori

iii) Pacific Islander, (Specify).............

iv) Other (Specify)

d) How long is your prison sentence

e) How much of your sentence have you completed to date?

f) How many years is it since the offence that you are currently sentenced on occurred

About your offences and other treatment. Is this your...

g) First offence?

h) First sexual offence?

i) What previous sexual offences have you been convicted of?

j) Have you had previous treatment for a sexual offence?

k) Which programmes did you attend? STOP, SAFE, Te Piriti/Kia Marama

l) Did you complete it? If NO then Why?

I am going to ask you some questions about Case Management and some of the programmes you may have heard of or be deciding whether to attend.

(I) Have you been to Case Management?
Yes/No

If Yes - then was it in (a) This Unit
(b) Other unit specify

If No - then how long have you been in this unit

(2) Which of these programmes have you heard about.

First Step
Pine Programme
Te Piriti
Kia Marama

(3) Which of these programmes have you said you would like to attend.

First Step
Pine Programme
Te Piriti
Kia Marama

(4) Have you talked with a Psychologist about a referral to Te Piriti (*Kia Marama*)? Yes/No

If Yes - then was it in (a) This Unit
(b) Other unit specify

If No would you like to talk to a psychologist about Te Piriti (*Kia Marama*)

I would like to ask you some questions about what things have helped you to decide to attend (*not attend*) the Te Piriti (*Kia Marama*) programme. Usually when people make a decision they think about the pros and cons of the action they intend to take. Sometimes they talk to other people or hear things before they make the decision. Some of these people will give information and reasons for taking an action like going to a treatment programme and some will give information and reasons for not taking the action and not going to the treatment programme. I am interested in hearing about all the things, situations, conditions, information and people which have been part of your decision to attend (*not attend)* Te Piriti (*Kia Marama*).

(5) Tell me about the things and people and thoughts that influenced your decision to go (*not go*) to the treatment programme at Te Piriti (*Kia Marama*).

(Use minimal encouragers to draw out as much information as possible. Encourage the person to be specific about people, situations and conditions which have influenced his decision)
Record answers on separate page.

(6) Is there anything else about how you made your decision to go (*not go*) to the programme.

You have mentioned the things and people who influenced your decision. I have a list of some of the things and people I have thought of that may have been part of a person's decision to attend (not attend) the programme. As I read them down please tell me if they have been part of your thoughts and decision about the programme.

(7) Which ones in this list have been part of your information gathering and decision to attend (*not attend*) the Te Piriti (*Kia Marama*) programme. You will probably have mentioned some of them already. We will tack these as well.

Wife/Partner	Children (Not victim)
Victim (Complainant)	Father
Mother	Other relatives
Friends outside the prison	Inmates- this prison
Inmates - other prisons	Unit Manager
Case officer	Prison officers
Counsellor (Specify)	Social Worker
Chaplain	Psychologist
Not guilty	Home Leave
Early Release	I like the prison I'm in now
Don't like moving prisons	Want to move closer to family
Assessment procedures (specify)	Treatment procedures (specify)
Religious beliefs	Cultural beliefs
Want to help myself	Want to avoid coming back to prison
Feel bad about what I have done	Feel victimised by the Justice system
Conditions at Te Piriti (*Kia Marama*)	Presentation by Te Piriti (*Kia Marama*)

Tell me more about (*items ticked in list not already discussed*)

Now I'm going to ask you about your use of alcohol and drugs.

(8) Before coming to prison did you use...

(a) alcohol (b) other drugs

(9) When did you start using ....
alcohol *named* drugs?

(10) Did you use alcohol (drug)
daily, weekly, monthly or less

(11) How much did you use on each occasion?
(a) alcohol specific quantities
e.g. number of drinks
(b) drugs - specific quantities

Now I'm going to ask you about your offences

(12) This is a list of your convictions (show computer printout or warrants) Please tell me if it is correct. Have you done all of these things?

If (a) **All**...next question
If (b) **Some** then Which ones are not correct. Tell me more about the ones
that
are not correct? How are they not correct?
If (c) **None** then Tell me more about these convictions which are not correct? How are they not correct?

Are there any questions that you would like to ask?

APPENDIX D

University of Rhode Island Change (URICA)

McConnaughy E.A., Prochaska, J. O. & Velicer W. F (1983, 1989)

Number.......... **Date..............**

Each statement describes how a person might feel when considering or starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case make your choice in terms of how you feel right now not what you felt in the past or would like to feel. For all the statements that refer to your "problem" answer in terms of sexual abuse of children under 16 years of age

There are FIVE possible responses to each of the items in the questionnaire:

1-strongly agree,
2-agree,
3-undecided,
4-disagree,
5-strongly disagree

Circle the number that best describes how much you agree or disagree

1. As far as I'm concerned I don't have any problems that need changing. 1 2 3 4 5

2. I think that I might be ready for some self-improvement. 1 2 3 4 5

3. I am doing something about the problems that have been bothering me. 1 2 3 4 5

4. It might be worth while to work on my problem. 1 2 3 4 5

5. I'm not the problem one. It does not make sense for me to have treatment. 1 2 3 4 5

6. It worries me that I might slip back on a problem that I have already changed, so I am ready to work on my problem. 1 2 3 4 5

7. I am finally doing some work on my problem. 1 2 3 4 5

8. I've been thinking that I might want to change something about myself. 1 2 3 4 5

9. I have been successful in working on my problem but I'm not sure that I can keep up he effort on my own. 1 2 3 4 5

10. At times my problem is difficult, but I'm working on it. 1 2 3 4 5

11. Working on my problem is pretty much a waste of time for me because the problem doesn't have to do with me. 1 2 3 4 5

12. I'm hoping that treatment will help me to better understand myself. 1 2 3 4 5

13. I guess I have faults, but there is nothing that I need to change. 1 2 3 4 5

14. I am really working hard to change. 1 2 3 4 5

15. I have a problem and I really think I should work on it. 1 2 3 4 5

16. I'm not following through with what I had already changed as well as I had hoped, and I want treatment to prevent a relapse of the problem. 1 2 3 4 5

17. Even though I'm not always successful in changing, I am at least working on my problem. 1 2 3 4 5

18. I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it. 1 2 3 4 5

19. I wish I had more ideas on how to solve my problem. 1 2 3 4 5

20. I have started working on my problems but I would like help. 1 2 3 4 5

21. Maybe treatment will be able to help me. 1 2 3 4 5

22. I need a boost right now to help me maintain the changes I've already made. 1 2 3 4 5

23. I may be part of the problem, but I don't really think I am. 1 2 3 4 5

24. I hope someone at a treatment programme will have some good advice . 1 2 3 4 5
25. Anyone can talk about changing: I'm actually doing something about it. 1 2 3 4 5

26. All this talk about psychology is boring. Why can't people just forget about their problems? 1 2 3 4 5

27. I'm working to prevent myself from having a relapse. 1 2 3 4 5

28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved. 1 2 3 4 5

29. I have worries but so does the next guy. Why spend time thinking about them? 1 2 3 4 5

30. I am actively working on my problem. 1 2 3 4 5

31. I would rather cope with my faults than try to change them. 1 2 3 4 5

32. After all I had done to change my problem, every now and again it comes back to haunt me. 1 2 3 4 5

APPENDIX E

Person Specific Empathy Scale

Marshall, W.L., Hudson, S.M., Jones, R. and Fernandez, Y.M. (1995)

General Instructions

In answering the following questions, there are not right or wrong answers. I am only interested in how you really feel bout these things. In asking other people these questions, I have got a lot of very different answers, so it si clear that different people think quite differently about these issues. I simply want you to be honest about **your** feelings and beliefs.

There are six parts to the questionnaire, and you will be asked how you feel about a child in each instance. Please be sure to answer every question in each of the six parts.

How to fill out the questonnaire

After reading a brief passage, you will have to indicate either: how the **child** in the passage feels, or how **you** feel about the child. You should circle the number on the scale that most accurately reflects your opinion.

For example, if you were asked if a child was made happy by the experience in the passage, and you thought he or she was to a certain degree, then you would circle the number 5 as follows: ** Draw circles on original**

	not at much		to some degree						very	all
Happy	0	1	2	3	4	5	6	7	8	9	10

If you thought the child was made very unhappy by the experience, then you would circle the number 0 as follows:

	not at much		to some degree						very	all
Happy	0	1	2	3	4	5	6	7	8	9	10

If you thought the child was made very happy by the experience, then you would circle the number 10 as follows:

	not at much		to some degree						very	all
Happy	0	1	2	3	4	5	6	7	8	9	10

If you thought the child was made a little unhappy, or occasionally unhappy, then you might circle the number between 0 and 5. If you thought the child was made reasonably happy but not necessarily very unhappy, you might circle somewhere between 5 and 10. Please try to use all of the scale when answering, rather than just marking 0 or 5 or 10, each time. If you have any questions about how to do this, please ask and I will helpyou. If you have no further questions, please go ahead and answer each and every question.

Part A

In this section, I want you to think about a child (girl or boy) who has had sex with an adult male. These sexual acts occurred several times over several months, but have now stopped. Now, I want you to circle the number that best indicated the degree to which you think this child would be experiencing the following, emotions, thoughts or behaviours.

	not at all		to some degree							very much
1. Guilty	0	1	2	3	4	5	6	7	8	9	10
2. Sad	0	1	2	3	4	5	6	7	8	9	10
3. Angry	0	1	2	3	4	5	6	7	8	9	10
4. Self-confident	0	1	2	3	4	5	6	7	8	9	10*
5. Nightmares	0	1	2	3	4	5	6	7	8	9	10
6. Fearful of close relationships	0	1	2	3	4	5	6	7	8	9	10
7. Suicidal thoughts	0	1	2	3	4	5	6	7	8	9	10
8. Problems with school work	0	1	2	3	4	5	6	7	8	9	10
9. Fearful of being hurt	0	1	2	3	4	5	6	7	8	9	10
10. Successful at school	0	1	2	3	4	5	6	7	8	9	10*
11. Repulsed by sex	0	1	2	3	4	5	6	7	8	9	10
12. Well-adjusted attitude to sex	0	1	2	3	4	5	6	7	8	9	10*
13. Sleep disturbances	0	1	2	3	4	5	6	7	8	9	10
14. Feelings of loneliness	0	1	2	3	4	5	6	7	8	9	10

	not at all			to some degree							very much
15. Withdrawn from others	0	1	2	3	4	5	6	7	8	9	10
16 Tense	0	1	2	3	4	5	6	7	8	9	10
17. Relaxed	0	1	2	3	4	5	6	7	8	9	10*
18. Has psychiatric problems	0	1	2	3	4	5	6	7	8	9	10
19. Has low energy	0	1	2	3	4	5	6	7	8	9	10
20. Shows tendency to blame themselves for all problems	0	1	2	3	4	5	6	7	8	9	10
21. Feelings of helplessness	0	1	2	3	4	5	6	7	8	9	10
22. Argues with others	0	1	2	3	4	5	6	7	8	9	10
23. Fearful of being alone	0	1	2	3	4	5	6	7	8	9	10
24. A tendency to cling to their mother	0	1	2	3	4	5	6	7	8	9	10
25. Proud of self	0	1	2	3	4	5	6	7	8	9	10*
26. Is in pain	0	1	2	3	4	5	6	7	8	9	10
27. Upset	0	1	2	3	4	5	6	7	8	9	10
28. Feels sinful	0	1	2	3	4	5	6	7	8	9	10
29. Feels dirty	0	1	2	3	4	5	6	7	8	9	10
30. Ashamed	0	1	2	3	4	5	6	7	8	9	10

Part B

Now I want you to think about a child who was disfigured in a car accident and had to spend a month in hospital. The child is now out of hospital and will live with a permanent disability.

Please circle the number that best indicates the degree to which you think this child would be experiencing the following emotions, thoughts, or behaviours.

	not at all			to some degree						very much	
1. Guilty	0	1	2	3	4	5	6	7	8	9	10
2. Sad	0	1	2	3	4	5	6	7	8	9	10
3. Angry	0	1	2	3	4	5	6	7	8	9	10
4. Self-confident	0	1	2	3	4	5	6	7	8	9	10*
5. Nightmares	0	1	2	3	4	5	6	7	8	9	10
6. Fearful of close relationships	0	1	2	3	4	5	6	7	8	9	10
7. Suicidal thoughts	0	1	2	3	4	5	6	7	8	9	10
8. Problems with school work	0	1	2	3	4	5	6	7	8	9	10
9. Fearful of being hurt	0	1	2	3	4	5	6	7	8	9	10
10. Successful at school	0	1	2	3	4	5	6	7	8	9	10*
11.Repulsed by sex	0	1	2	3	4	5	6	7	8	9	10
12. Well-adjusted attitude to sex	0	1	2	3	4	5	6	7	8	9	10*
13. Sleep disturbances	0	1	2	3	4	5	6	7	8	9	10
14. Feelings of loneliness	0	1	2	3	4	5	6	7	8	9	10

	not at all		to some degree								very much
15. Withdrawn from others	0	1	2	3	4	5	6	7	8	9	10
16 Tense	0	1	2	3	4	5	6	7	8	9	10
17. Relaxed	0	1	2	3	4	5	6	7	8	9	10*
18. Has psychiatric problems	0	1	2	3	4	5	6	7	8	9	10
19. Has low energy	0	1	2	3	4	5	6	7	8	9	10
20. Shows tendency to blame themselves for all problems	0	1	2	3	4	5	6	7	8	9	10
21. Feelings of helplessness	0	1	2	3	4	5	6	7	8	9	10
22. Argues with others	0	1	2	3	4	5	6	7	8	9	10
23. Fearful of being alone	0	1	2	3	4	5	6	7	8	9	10
24. A tendency to cling to their mother	0	1	2	3	4	5	6	7	8	9	10
25. Proud of self	0	1	2	3	4	5	6	7	8	9	10*
26. Is in pain	0	1	2	3	4	5	6	7	8	9	10
27. Upset	0	1	2	3	4	5	6	7	8	9	10
28. Feels sinful	0	1	2	3	4	5	6	7	8	9	10
29. Feels dirty	0	1	2	3	4	5	6	7	8	9	10
30. Ashamed	0	1	2	3	4	5	6	7	8	9	10

Part C

In this section I want you to think about a child who had sex with an adult male several times over several months. This sexual involvement has now stopped.

I want you to use the same scale as before, but this time indicate how you feel about what this child experienced. Remember there are not right or wrong answers. Just be honest about your feelings. Please circle the number that best indicates how you feel about this child's experience.

	not at all			to some degree						very much	
1.Guilty	0	1	2	3	4	5	6	7	8	9	10
2. Sad	0	1	2	3	4	5	6	7	8	9	10
3. Angry	0	1	2	3	4	5	6	7	8	9	10
4. Sexual	0	1	2	3	4	5	6	7	8	9	10*
5. Pain	0	1	2	3	4	5	6	7	8	9	10
6. Affection	0	1	2	3	4	5	6	7	8	9	10
7. Upset	0	1	2	3	4	5	6	7	8	9	10
8. Proud	0	1	2	3	4	5	6	7	8	9	10*
9. Devastated	0	1	2	3	4	5	6	7	8	9	10
10. Helpless	0	1	2	3	4	5	6	7	8	9	10
11. Responsible	0	1	2	3	4	5	6	7	8	9	10
12. Sick	0	1	2	3	4	5	6	7	8	9	10
13. Good	0	1	2	3	4	5	6	7	8	9	10*
14.Frustrated	0	1	2	3	4	5	6	7	8	9	10
15. Hopeful	0	1	2	3	4	5	6	7	8	9	10*
16. Trusting	0	1	2	3	4	5	6	7	8	9	10*
17. Ashamed	0	1	2	3	4	5	6	7	8	9	10
18. Disgusted	0	1	2	3	4	5	6	7	8	9	10
19. Curious	0	1	2	3	4	5	6	7	8	9	10*
20. Shocked	0	1	2	3	4	5	6	7	8	9	10

Part D

Now I want you to think about a child who was disfigured in a car accident and had to spend a month in hospital. The child is now out of hospital and will live with a permanent disability.

Please circle the number that best indicates how you feel about this child's experience.

	not at all		to some degree							very much
1.Guilty	0	1	2	3	4	5	6	7	8	9	10
2. Sad	0	1	2	3	4	5	6	7	8	9	10
3. Angry	0	1	2	3	4	5	6	7	8	9	10
4. Sexual	0	1	2	3	4	5	6	7	8	9	10*
5. Pain	0	1	2	3	4	5	6	7	8	9	10
6. Affection	0	1	2	3	4	5	6	7	8	9	10
7. Upset	0	1	2	3	4	5	6	7	8	9	10
8. Proud	0	1	2	3	4	5	6	7	8	9	10*
9. Devastated	0	1	2	3	4	5	6	7	8	9	10
10. Helpless	0	1	2	3	4	5	6	7	8	9	10
11. Responsible	0	1	2	3	4	5	6	7	8	9	10
12. Sick	0	1	2	3	4	5	6	7	8	9	10
13. Good	0	1	2	3	4	5	6	7	8	9	10*
14.Frustrated	0	1	2	3	4	5	6	7	8	9	10
15. Hopeful	0	1	2	3	4	5	6	7	8	9	10*
16. Trusting	0	1	2	3	4	5	6	7	8	9	10*
17. Ashamed	0	1	2	3	4	5	6	7	8	9	10
18. Disgusted	0	1	2	3	4	5	6	7	8	9	10
19. Curious	0	1	2	3	4	5	6	7	8	9	10*
20. Shocked	0	1	2	3	4	5	6	7	8	9	10

Part E

Now I want you to think about your own victim or victims, and the experiences they had with you.

Using the same scale as before, circle the number that best indicates the degree that your victim(s) would be experiencing the following emotions, thoughts or behaviours.

	not at all			to some degree							very much
1. Guilty	0	1	2	3	4	5	6	7	8	9	10
2. Sad	0	1	2	3	4	5	6	7	8	9	10
3. Angry	0	1	2	3	4	5	6	7	8	9	10
4. Self-confident	0	1	2	3	4	5	6	7	8	9	10*
5. Nightmares	0	1	2	3	4	5	6	7	8	9	10
6. Fearful of close relationships	0	1	2	3	4	5	6	7	8	9	10
7. Suicidal thoughts	0	1	2	3	4	5	6	7	8	9	10
8. Problems with school work	0	1	2	3	4	5	6	7	8	9	10
9. Fearful of being hurt	0	1	2	3	4	5	6	7	8	9	10
10. Successful at school	0	1	2	3	4	5	6	7	8	9	10*
11.Repulsed by sex	0	1	2	3	4	5	6	7	8	9	10
12. Well-adjusted attitude to sex	0	1	2	3	4	5	6	7	8	9	10*
13. Sleep disturbances	0	1	2	3	4	5	6	7	8	9	10
14. Feelings of loneliness	0	1	2	3	4	5	6	7	8	9	10

	not at all		to some degree							very much
15. Withdrawn from others	0	1	2	3	4	5	6	7	8	9	10
16 Tense	0	1	2	3	4	5	6	7	8	9	10
17. Relaxed	0	1	2	3	4	5	6	7	8	9	10*
18. Has psychiatric problems	0	1	2	3	4	5	6	7	8	9	10
19. Has low energy	0	1	2	3	4	5	6	7	8	9	10
20. Shows tendency to blame themselves for all problems	0	1	2	3	4	5	6	7	8	9	10
21. Feelings of helplessness	0	1	2	3	4	5	6	7	8	9	10
22. Argues with others	0	1	2	3	4	5	6	7	8	9	10
23. Fearful of being alone	0	1	2	3	4	5	6	7	8	9	10
24. A tendency to cling to their mother	0	1	2	3	4	5	6	7	8	9	10
25. Proud of self	0	1	2	3	4	5	6	7	8	9	10*
26. Is in pain	0	1	2	3	4	5	6	7	8	9	10
27. Upset	0	1	2	3	4	5	6	7	8	9	10
28. Feels sinful	0	1	2	3	4	5	6	7	8	9	10
29. Feels dirty	0	1	2	3	4	5	6	7	8	9	10
30. Ashamed	0	1	2	3	4	5	6	7	8	9	10

Part F

Again I want you to think about your own victim or victims, and the experiences they had with you. Please circle the number that best describes how you feel about the encounters you had with your victim(s).

	not at all			to some degree							very much
1.Guilty	0	1	2	3	4	5	6	7	8	9	10
2. Sad	0	1	2	3	4	5	6	7	8	9	10
3. Angry	0	1	2	3	4	5	6	7	8	9	10
4. Sexual	0	1	2	3	4	5	6	7	8	9	10*
5. Pain	0	1	2	3	4	5	6	7	8	9	10
6. Affection	0	1	2	3	4	5	6	7	8	9	10
7. Upset	0	1	2	3	4	5	6	7	8	9	10
8. Proud	0	1	2	3	4	5	6	7	8	9	10*
9. Devastated	0	1	2	3	4	5	6	7	8	9	10
10. Helpless	0	1	2	3	4	5	6	7	8	9	10
11. Responsible	0	1	2	3	4	5	6	7	8	9	10
12. Sick	0	1	2	3	4	5	6	7	8	9	10
13. Good	0	1	2	3	4	5	6	7	8	9	10*
14.Frustrated	0	1	2	3	4	5	6	7	8	9	10
15. Hopeful	0	1	2	3	4	5	6	7	8	9	10*
16. Trusting	0	1	2	3	4	5	6	7	8	9	10*
17. Ashamed	0	1	2	3	4	5	6	7	8	9	10
18. Disgusted	0	1	2	3	4	5	6	7	8	9	10
19. Curious	0	1	2	3	4	5	6	7	8	9	10*
20. Shocked	0	1	2	3	4	5	6	7	8	9	10