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The Relationship Between Collateral Therapy and the Adult Pedophile's Ability to Advance Through Levels of Treatment

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THE RELATIONSHIP BETWEEN COLLATERAL THERAPY AND THE ADULT PEDOPHILE'S ABILITY TO ADVANCE THROUGH LEVELS OF TREATMENT

by

Julie G. Bennion

A thesis submitted in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

in

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(Marriage and Family Therapy)

Approved:

UTAH STATE UNIVERSITY
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ABSTRACT

The Relationship Between Collateral Therapy and the Adult Pedophile's Ability to Advance Through Levels of Treatment

by

Julie G. Bennion, Master of Science
Utah State University, 1998

Major Professor: Dr. D. Kim Openshaw
Department: Family and Human Development

The purpose of this study was to examine the relationship between collateral therapy and the adult male pedophile's ability to advance through levels of treatment. Data from a convenience sample of 27 adult male pedophiles attending therapy at Intermountain Specialized Abuse Treatment Centers were collected for this study. Data were collected from participants' files on 22 independent variables, including the primary independent variable, collateral sessions. The dependent variable was the time it took participants to advance through levels of treatment.

A comparison of measures of central tendency for participants who had and those who had not participated in collateral therapy indicated a moderate difference in the
number of days it took to complete a level when the sample was divided into collateral versus non-collateral participants. Though not statistically significant, results of a correlational analysis revealed an inverse relationship between collateral sessions and time. Results of t-tests run to examine the difference in group means between those who had collateral therapy and those who did not indicated no significant difference in group means. However, a difference approaching significance was found in the advancement from Level II to Level III. Those who participated in collateral therapy appear to have finished Level II sooner than those who had no collateral therapy.
I would like to thank Dr. D. Kim Openshaw, my major professor, for his help and encouragement during the long process of completing this project. His vision and determination contributed greatly to the development and realization of my ideas. I would also like to thank my committee members, Drs. Brent Miller and Carolyn Barcus, who offered much needed direction and assistance throughout the conceptualization and development of this study. Special thanks goes to Roxane Pfister, who was always available to help with the important process of data analysis.

I am very grateful for the cooperation and assistance of clinical directors, therapists, and clients at Intermountain Specialized Abuse Treatment Centers of Utah. Not only did they willingly provide access to the data that I became so interested in examining, but the agency and the people there also provided a crucial part of my training as a Marriage and Family Therapist. My hope is that the results of this project will be helpful in the process of program evaluation at their agency.

Most of all, I would like to thank my family, who have supported me throughout my entire academic career. From them I gained my deeper love of knowledge and confidence in
myself and my abilities. Especially, I wish to thank my husband, Randy, without whose patience and support this project never would have been possible.

Julie G. Bennion
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CHAPTER 1
INTRODUCTION

One of our country's most damaging trends is the dramatic increase of sexual abuse. Sexual crimes present a dangerous threat to all members of society, regardless of age, race, or gender. Recent research indicates that the incidence of abuse, particularly against children, is increasing at an even faster rate than is reported by state protection agencies (Children's Defense Fund, 1997). Over the last few years there has been a significant rise in the number of sexual offenders who are incarcerated (Anderson, Gibeau, & D'Amora, 1995). This social problem is not new, however. National child abuse reporting laws and the public's increased awareness have been instrumental in the rise of reported cases of sexual abuse (Children's Defense Fund, 1997; Trepper & Barrett, 1986a). As a result, the news media emphasize sexual offenses as a critical treatment issue in our society today. Clientele at outpatient treatment centers for sex offenders are growing, and now more than ever, clinicians in various mental health fields are being asked to treat sex offenders in their private practices (MacHovec, 1994; Maletzky, 1991; Prendergast, 1991; Trepper & Barrett, 1989). There are a number of questions that need to be addressed as clinicians gain the
training and experience necessary to provide adequate treatment for sex offenders.

One area in which treatment for sex offenders has recently evolved is in the inclusion of the offender's significant others in treatment. This practice of treating the larger system (of which the individual client is a part) is referred to as "systemic" psychotherapy or family therapy. The theory and practice of systemic therapy has influenced all areas of the helping professions from social work, to psychology, to nursing. Based on systems theory, this way of thinking of the individual as part of a complex group of larger systems and social contexts has been instrumental in shaping modern day theory, research, and practice. The influence of systems theory on the practice of psychotherapy in our society continues to expand and has transformed the way we look at many important treatment issues in the field, including the treatment of sex offenders (Trepper & Barrett, 1986b, 1989).

Court-ordered treatment for sex offenders in the state of Utah has recently expanded to include a minimum of one collateral therapy session per month. A collateral session is a session with the client's therapist that includes members of the client's family or social network. This innovation is particularly noted at the Intermountain
Specialized Abuse Treatment Centers (hereinafter referred to as ISAT). Court-ordered sex offenders attending weekly individual and group therapy sessions at ISAT are now more involved in systemic kinds of therapy during their treatment (i.e., marital and family therapy, interagency cooperation, etc.).

Sex offenders in treatment at ISAT are involved in a variety of therapeutic services ranging from weekly appointments to intensive treatment. Individual as well as group therapy encourages the development of responsibility for the crime, assertiveness and empathy training, psychoeducation, and so forth. The offender treatment program includes four levels, with the initial level designated as Level 1.

Adjunctive to the emphasis on individual and group therapy is involvement with a support network, which may include family members, spouses, or other significant individuals in the life of the client (e.g., friends, clergy, other professionals). Therapists of the offenders utilize these collateral resources to facilitate treatment, inviting one or more significant others to participate in collateral sessions. The purpose of the collateral session is to assess the client's social skills and support network and to provide any needed interventions to enhance the
supportive abilities of those systems. ISAT has adopted an agencywide policy recommending the inclusion of collateral sessions into the therapeutic regimen. Thus, the use of collateral sessions is one objective way of identifying a systemic approach to treatment.

As an offender progresses through treatment at ISAT and assignments are completed, level reviews are scheduled with the clinical director. During this review, the client’s progress is evaluated and a determination is made regarding advancement to the next level. Offenders are expected to complete each of the four levels within a specified time frame, which varies from level to level. The overriding purpose of this study is to examine whether the implementation of collateral therapy sessions at ISAT influences the progress of a client from level to level in his sex offender treatment program.

The first section of the literature review includes a brief description of the basic tenets of systems theory and how it has influenced the practice of psychotherapy, specifically its recent inclusion into the theories surrounding the treatment of sex offenders. The second section outlines the basic treatments for sex offenders and details how systems theory has influenced their treatment protocols. It also describes the specific treatment program
where this study took place.

The third section of the literature review covers the ins and outs of evaluating treatment, reviews sex offender treatment outcome studies (including those programs that have included systemic treatment components), and discusses the reasons why current outcome studies fall short.

This study involved the analysis of basic sex offender treatment components (e.g., individual sessions, collateral sessions) in order to determine the relationship between systemic parts of the treatment (i.e., collateral sessions) and progress through treatment (i.e., completing treatment phases in the specified amount of time). The study did not attempt to measure process or outcome, only the relationship between different components of treatment and the offender's ability to move through treatment in a timely manner.
Systems Theory

General systems theory originated in the fields of mathematics, physics, and engineering in the late 1940s and early 1950s (Guttman, 1991). Its basic philosophy includes the belief that naturally occurring phenomena organize themselves into "systems," or self-governing subunits of greater systems. A system is defined as "a unified whole that consists of interrelated parts, such that the whole can be identified as being different from the sum of its parts, and any change in one part affects the rest of the system" (Guttman, 1991, p. 41). Von Bertalanffy, who wrote General Systems Theory in 1968, is recognized as the father of the systems theory movement (Skynner, 1981). The idea that "the whole is greater than the sum of its parts," has been responsible for significantly influencing many aspects of our society today. For example, contemporary views about group dynamics in business, education, and the health fields are based on this principle.
Family Therapy

The influence of systems theory spans the mental health field, but it has been particularly influential in the development of what is now referred to as family therapy. Systems theory departs from the notion of linear causality and speaks in terms of circular communication patterns and feedback loops (Watzlawick, Beavin, & Jackson, 1967). Family therapy is one of the mental health professions where systems-oriented therapy is practiced. Coyne and Liddle (1992) defined the important aspects of systemic family therapy as the interactions and relationships between people:

From this perspective, interactions, relationships, and context are primary; individuals and the mental life and behavior attributed to them are social constructions and dependent on context for their identity. Systems therapy is an application of this conceptual framework, a way of viewing clinical problems, not a specific set of techniques. (Coyne & Liddle, 1992, p. 44)

Family therapy is now used in many different treatment settings and is not restricted to just immediate family members attending therapy sessions together. Extended family, partners, close friends, and so forth are also
recognized as significant parts of the client's social systems, where successful interventions can be made (Breunlin, Schwartz, & Kune-Karrer, 1992; Burbatti, Castoldi, Maggi, & Novick, 1993). The basic premise of family systems theory states that it is the context of human relationships that matters, and that all the properties of these relationships can be divided into two groups: structure and process. Boundaries and subsystems make up most of what is considered structure, while circularity is the main process that takes place in family communication (Nichols & Schwartz, 1991).

Outcome research in family therapy has been the major research focus in the field over the last 20 years. With the careful use of objective variables, early outcome studies report impressive results, documenting convincing evidence that family therapy techniques surpass traditional approaches when working with difficult populations (Nichols & Schwartz, 1991).

Systemic Therapy

Beyond the family system. Over the past few years, many proponents of family therapy have begun to expand their views about what systemic therapy should include, recognizing the tremendous influence of larger systems
outside the immediate family (Breunlin et al., 1992; Burbatti et al., 1993; Luepnitz, 1988). Urging each other to become more systemic, many family therapists have begun to apply their knowledge of systems theory to more than just the family system. Burbatti et al. (1993) have detailed their personal extension of family therapy to systemic therapy in their book, *Systemic Psychotherapy with Families, Couples, and Individuals*. Like family therapy, systemic therapy focuses on the here and now, regarding relationships as the primary point of focus. The goal of systemic therapy is to restructure the system, whether that system is a couple system, a social network system, or an individual system (Burbatti et al., 1993).

A more systemic approach to therapy leaves the therapy system open for others (not just family) in the client's larger systems to join. These may include spouses, ex-spouses, partners, friends, clergy, co-workers, or other professionals (clinical, legal, or other). White, Essex, and O'Reilly (1993) have outlined how the systemic perspective can help empower the family and connect it with its larger social systems, including professional systems. They have also discussed how systemic therapy works when child protection becomes an issue and other professionals are involved in the therapeutic setting.
Working systemically with individuals. The theories behind the practice of individual therapy have also experienced some systemic maturation, as clinicians maintain that it is possible to work systemically with individuals. Brown-Standridge has argued that "operating from an ecosystemic epistemology does not preclude family therapy from focusing on the individual responsibility of each family member" (1987, p. 206). Jenkins and Asen (1992) emphasized that the shift from a psychodynamic approach to a more interactional way of doing therapy should not be misconstrued as an excuse to disregard the individual. Instead, individual therapy should be regarded as one of many interventions available. "Systemic therapy is thus not a question of how many people are seen, but refers to the theoretical framework which informs what the therapist does" (Jenkins & Asen, 1992, p. 1).

Jenkins and Asen (1992) have offered a framework for systemic practice with individuals. Its main premise is that the relationship the therapist and client engage in must be an open therapy system—a system in which significant others are able to join at any time. Furthermore, therapy is often conducted as if others were there (e.g., Gestalt therapy), encouraging the client to consider the interactional context of various issues. This
technique can be contrasted with the exclusive relationship that takes place in more psychodynamic approaches where the client's reactions are only considered in relation to the therapist.

**Systemic therapy in varied treatment settings.** Today, systemic therapy is used in a variety of treatment settings. Its precepts are applied in multiple clinical settings with groups, individuals, and families. A vast number of referrals to therapy clinics are originating in the offices of other professionals and paraprofessionals, such as caseworkers, school personnel, medical and legal professionals, and the clergy.

Interactions with the field of medicine are increasing as practitioners of both the medical health and the mental health fields recognize the magnitude of the mind-body connection. A prime example of this is Nova University's offering of a graduate degree entitled "family systems health care clinical specialist." The program trains family therapists to work in primary care settings in the community. Their job is to provide care for family systems and to create an exchange of ideas between the fields of systemic therapy and biomedicine. The goal of this kind of systemic treatment is to preserve the growth and enrichment gained in therapy throughout the entire lifespan (Munchnik,
Treatment for juvenile and adult offenders blends the clinical disciplines with the legal professions. Clearly, as these very different parts of our society work together for the good of individuals and families, systems theory makes intuitive sense. As Nichols and Schwartz so aptly put it, "It makes sense that if you don't deal with a person's context then it will be difficult for them to achieve or maintain change" (1991, p. 168).

Systemic Treatment for Sex Offenders

One of the areas where systemic therapy is being practiced today is in the treatment of sex offenders (Fish & Faynick, 1989; Trepper, 1986; Trepper & Barrett, 1989). Many outpatient community-based treatment programs that treat court-ordered clients for sexual abuse issues are incorporating systemic principles into their treatment programs.

Overview of Treatment Modalities for Sex Offenders

Most outpatient treatment programs for adult sex offenders in the U.S. are based heavily on the behavioral approach (Abel, Mittleman, Becker, Rathner, & Rouleau, 1988;
MacHovec, 1994; Maletzky, 1991; Marshall, Laws, & Barbaree, 1989). The efficacy of behavioral techniques when working with this population has been demonstrated in a number of comparative studies (for a review see Maletzky, 1991; Pallone, 1990). Other elements of treatment that are most often combined with behavioral therapy are a combination of cognitive and group therapy (Maletzky, 1991). Marshall, Laws, and Barbaree (1989) cited the limited knowledge about the etiology of deviant sexual behavior as one of the primary reasons why mainly behavioral approaches have been applied in the past. "In these early programs, the offensive behavior was understood to be entirely sexual in motivation, and no other factors were thought to encourage or facilitate the expression of this sexual desire" (p. 363). As a result, many programs simply aimed their treatment goals at reducing deviant arousal.

Today, it is recognized that there are many elements to the cycle of sexual offense. Treatment modalities include everything from aversive conditioning techniques, to drug therapy, to psychoeducation (Maletzky, 1991; Pallone, 1990; Prendergast, 1991). However, none of these are as widely used as the cognitive-behavioral approach (MacHovec, 1994; Maletzky, 1991). Cognitive-behavioral intervention is the most popular form of treatment today, and though no two
programs are alike, most of them have the following areas of concern in common: "(1) Sexual behaviors and interests, (2) Broad range of social difficulties, and (3) Cognitive distortions about the offensive behavior" (Marshall et al., 1989, p. 364). A cognitive-behavioral approach focuses on teaching the offender how to gain control over deviant cycles of sexual offending by including psychoeducation and objective goal-setting (among other strategies) in the treatment package (Becker, Kaplan, & Kavoussi, 1988).

Most cognitive-behavioral treatment programs for sex offenders include group therapy in the treatment regimen. Because of the manipulative characteristics associated with sex offenders, it is most beneficial if the client is working with more than one therapist during treatment and utilizing the confrontive atmosphere of a group of his peers. As Prendergast has stressed, "The seductive and manipulative personality of the offender should be one of the most important of all therapeutic considerations" (1991, p. 98). Group therapy provides peer feedback necessary to aid in the process of change. It is not just a supplement to individual therapy, but may be the most powerful catalyst of change in the offender's treatment (Prendergast, 1991).
Of all of the different treatment modalities and techniques used to rehabilitate sex offenders, there is very little mention of systemic types of therapy. Marshall et al., editors of Handbook of Sexual Assault: Issues, Theory, and Treatment of the Offender (1989), have devoted entire chapters to hormonal treatment, the teaching of social skills, and the modification of cognitive distortions. However, treatment that includes family or significant others in actual therapy sessions is never mentioned. McFall (1989) discussed the widely accepted procedure of enhancing the offender's social skills, but then he reminded the reader, "There is little or no empirical support for the widespread belief that social-skills training is an effective treatment for sex offenders" (p. 326). Apparently, different forms of treatment are sometimes adopted largely on intuitive appeal rather than treatment efficacy (McFall, 1989). It would seem to make intuitive sense (especially in the case of incest) that an offender's family and social systems could benefit from therapeutic interventions. Yet, inviting significant others to participate in the offender's therapy seemed largely unheard of in this review of the literature.
Prendergast (1991) came close to initiating what could have been a move toward a more systemic treatment for offenders when he wrote that "treatment not only for the psyche of the offender, but also for his body, mind and social being as well [is needed]" (p. 175). This idea, which he labeled his "holistic approach," includes individual and group therapy, sex education, social skills training, anger management, relapse prevention, vocational re-education, substance abuse treatment, and aftercare. Although this program appears at first glance to be rather comprehensive, it is clear that little effort is made to understand or intervene in the client's most influential context--the marriage, family, or social support system.

It becomes clear in the writings of Maletzky (1991) that the influence of systemic family therapy on the treatment of sex offenders has been modest to date. For example, in a chapter entitled "Adjunctive Techniques," Maletzky's mention of the impact of sexual abuse on families was very brief (p. 143). Then, after a short paragraph addressing the importance of understanding the impact of sexual abuse on the family, he referred the reader to more detailed reviews of marriage and family therapy techniques in the literature instead of offering any information in his chapter.
Prendergast discussed the severely impaired interpersonal relationships that are characteristic of offenders. An inability to relate to anyone on an intimate level, even a spouse, is often seen in an offender's long list of relational difficulties. The fear of becoming too vulnerable makes the offender distance himself from others, relating only on the surface (1991). However, this knowledge does not seem to have much influence on the chosen treatment modalities.

Cook and Howells, editors of *Adult Sexual Interest in Children* (1981), made no mention of intervening in the offender's couple or family subsystems. Lakey (1994) outlined the characteristics of the adolescent sex offender and discussed the treatments of choice with this younger population. Many of the treatment choices are the same as in working with adults, such as skills training, group therapy, sex education, and so forth. However, even in this author's discussion about the treatment of adolescents, a group most likely to still be very connected to their families of origin, systemic or family therapy was not brought up. Yet nearly all of the authors in this literature review admitted that the offender's personal relationships are seriously marred.
Applying the Efficacy of Systemic Therapy
to the Treatment of Sex Offenders

Many different treatment modalities and techniques are used to rehabilitate sex offenders. However, most of the literature contains little or no mention of systemic types of therapy. Perhaps it is because many times a sex offender is ostracized from his family and social network and seems rather alone. And it may be simply because therapists who work with this population are not adequately trained in systemic treatment. Whatever the reason, it seems evident that one of the greatest challenges for the proponents of systemic therapy is to figure out how to integrate its principles into the various helping professions. As Carpenter and Treacher have pointed out, the principles and practices of systemic family therapy are "not just an esoteric activity practiced with a small group of 'suitable' and willing 'clients', but a valuable approach to the problems of the whole range of users encountered by workers in the health and social services" (1993, p. 2).

Involving significant others in treatment. Maletzky (1991) addressed the most obvious reason why sex offenders' families should be involved in his chapter on adjunctive techniques in treating offenders:

In the experience of most clinicians, it is a rare
family that is not fractured by the occurrence of sexual abuse. At the very least, information should be obtained through significant others about the offender and the effect he has had on the household. The therapist can be of service to the courts and to the offender and his family by trying to understand and communicate the impact sexual abuse has had on all family members. (p. 154)

Although its influence on the treatment of sex offenders is small, systemic theory has been very influential in the domain of the sexual abuse victim. As a result, some systemic treatment programs for victims may include the perpetrator if that person is a significant other. Finkelhor (1986) pointed out that systems theory has assisted professionals in recognizing sexual abuse in two important ways. First, the approach recognizes that children exhibiting disturbed behavior may be acting out symptoms of their abuse at the hands of a parent or significant other. Secondly, the approach puts its emphasis on the workings of the system and therefore has the ability to focus both on the perpetrator and on the victim in hypothesizing about boundaries, coalitions, and deviant cycles. As a result, it provides a different perspective on sexual abuse than does traditional psychoanalytic theory.
Systemic treatment that helps offenders relate in healthier ways to the people around them makes a lot of sense considering some of the more common characteristics found among this population. For example, Pithers, Beal, Armstrong, and Petty (1989) found that among their sample of pedophiles, 38% were depressed, and more than 50% were observed by their therapists to exhibit cognitive distortions, low self-esteem, emotional inhibition or over-control, and a deficit in social skills. These same patterns are evident in a number of studies involving pedophiles (Cook & Howells, 1981; Stermac, Segal, & Gillis, 1989). It seems evident that directly involving an offender's significant others and considering the context in which these problems develop would undoubtedly benefit treatment.

The incest family. In cases of incest, systemic treatment is able to provide services to both the victim and the perpetrator as well as the family system in which the abuse occurred (Trepper & Barrett, 1989). Research now focuses more on the interaction and context of the family in which the incest took place and less on individual psychopathology (Larson & Maddock, 1986). Systemic variables (e.g., context, boundaries, etc.) help clinicians understand the incest process in terms of family
interaction. Structural factors often examined include intrapsychic, interpersonal, and intergenerational boundaries. The family/society boundaries are also important. Functional factors may include exchange processes related to affection, eroticism, rage, and aggression (Larson & Maddock, 1986).

Trepper and Barrett (1986c) presented a framework for assessing families' vulnerability to incest by discussing certain areas of family life that may contain clues to vulnerability. These areas include the family of origin of the parents, family members' personality characteristics, family system factors, and socio-environmental factors.

Alexander (1985) examined incest from a general systems point of view and suggested that treatment of these families may be maximized by viewing the incest as a symptom of closed, enmeshed, and undifferentiated families. If the abuse is pictured in this context, treatment may be approached in such a way as to focus on the environmental and family structures that might eliminate the need for this particular symptom.

The limitations of systems theory in the treatment of sexual abuse. Despite the important contributions that the systems approach can have on the problem of sexual abuse, there are also drawbacks that must be recognized. One
limitation of family systems theory, and its influence on the study and treatment of sexual abuse, is that the approach has concerned itself primarily with father-daughter incest (Finkelhor, 1986). Research has shown that this type of abuse accounts for less than a quarter of reported sexual abuse, with the largest category being perpetrated by persons the victim knows but is not related to (Finkelhor, 1986). Another limitation to the systems approach, that Finkelhor addressed, is the limited research involving male victims. Most of the literature deals strictly with female abuse victims. And finally, systemic theory maintains the belief that most of the incest offender's abusive characteristics can be explained in the context of family interaction. This is an excellent place to start, but may preclude the study of offender characteristics that have been found to maintain themselves outside of family interaction. Recent research indicates that incestuous offenders are not as different from extrafamilial offenders as was first thought (Finkelhor, 1986; Fish & Faynick, 1989).

Programs That Include Systemic Treatment for Sex Offenders

Despite its relatively small influence on the theory
and practice of treating sex offenders, systems theory is gaining popularity in a small number of treatment programs across the country. Many programs exist to treat the problems associated with incest, but only a handful are established around the principles of family systems theory (Trepper & Barrett, 1986b).

**Systemic components of treatment.** MacHovec (1994) described his systemic approach to sex offender therapy as including the two major goals of "normalization and resocialization" (p. 98). Normalization (which is an intrapersonal process) includes understanding what is and what is not appropriate sexual behavior. It also involves self-concept and normal development. The interpersonal process called resocialization involves educating offenders in appropriate social behaviors. Machovec described this therapeutic process as consisting of three steps: awareness, understanding, and change.

Treatment programs that focus on the needs of each individual family member, the family as a whole, and society are few and far between. One such program exists at Midwest Family Resource in Chicago (Barrett, Sykes, & Byrnes, 1986). The authors of this model maintain that the center's ability to treat the many systems and subsystems involved in familial abuse makes it much more comprehensive than
traditional methods. As in other systemic treatment programs, this one emphasizes the importance of interagency cooperation in maintaining close contact with the legal and state systems involved in cases of abuse. Family sessions address dysfunctional interaction maintaining the abusive cycle. Individual, marital, and sibling sessions are also important interventions. Co-therapy teams and ongoing supervision are key elements in providing useful services (Barrett et al., 1986). When the abuse of a child has taken place, Benjamin and Benjamin (1993) have asserted that their model involving such systemic interventions as parent-child and sibling sessions proves to increase the effectiveness of the overall treatment plan.

Fish and Faynick (1989) presented a structural approach to treating incest families in which the father had been temporarily removed from the family. These authors discussed different treatment stages (including the crisis stage, the grief and reorganization stage, and the father re-entry stage) and explained how they can be used as powerful tools to restructure the rigid family system in the temporary absence of the father. This model also recognizes the important influence of larger systems outside the family and how they can contribute to restructuring. Other structural techniques, such as role-playing, sculpting, and
letter-writing, are also used in systemic therapy with sex offenders (Dwyer & Myers, 1990).

The majority of systemic treatment programs for sex offenders still deal specifically with incestuous families, neglecting the need for systemic treatment for the large group of extrafamilial abuse offenders (Finkelhor, 1986). An expanded model of treatment is offered by Finkelhor, who proposed that four preconditions "have been found to contribute to the occurrence of sexual abuse both within and outside the family" (p. 58). These preconditions include a motivation to abuse, the absence of inhibitions that would prevent the abuse, the removal of external obstacles, and the undermining of a child's resistance to the abuse. This model acknowledges dynamics within the offender as well as those within the family.

Intermountain Specialized Abuse Treatment Centers. The sex offender treatment program at Intermountain Specialized Abuse Treatment Centers (ISAT) includes several systemic interventions in the overall treatment plan for sex offenders. ISAT is an outpatient program that operates eight offices throughout Utah. Perpetrators and victims of sexual abuse, as well as their families, are treated at these centers. Treatment for the court-ordered, adult male pedophile follows a treatment plan that includes an intake
process, assessment, treatment, and relapse prevention. Requirements of the program include the following:

1. Successful completion of the 4 level ISAT Sex Offender Treatment Program
2. Individual session weekly
3. Group session weekly
4. Minimum of 6 education classes
5. Psychological evaluation
6. Progress plethysmograph
7. Reorientation if necessary
8. Polygraph evaluation
9. Transition plan

(ISAT, 1991, p. 13)

Court-ordered treatment for sex offenders in the state of Utah has recently expanded to include a minimum of one collateral therapy session a month. This innovation is particularly noted at ISAT. Court-ordered sex offenders attending weekly individual and group therapy sessions at ISAT offices are now more involved in marital and family therapy during their treatment.

Sex offenders involved in treatment at ISAT participate in a variety of therapeutic services ranging from weekly appointments to intensive treatment. Individual as well as group therapy encourages the development of responsibility
for the crime, assertiveness and empathy training, psychoeducation, and so forth. The offender treatment program includes four levels, with the initial level designated as Level 1.

As treatment progresses and assignments are completed, level reviews are scheduled with the clinical director. During this review, the client’s progress is evaluated and a determination is made regarding advancement to the next level. Offenders are expected to complete each of the four levels within a specified time frame, which varies from level to level.

Adjunctive to the emphasis on individual and group therapy is involvement with a support network, which may include family members, spouses, or other significant individuals in the life of the client (e.g., partners, friends, or clergy). Therapists of the offenders utilize these collateral resources to facilitate treatment, inviting one or more significant others to participate in collateral sessions. The purpose of the collateral session is to assess the client's social support network and to provide any needed treatment to enhance the supportive abilities of those systems. ISAT has adopted an agencywide policy recommending the inclusion of collateral sessions into the therapeutic regimen.
Evaluating the Effects of Systemic Therapy in the Treatment of Sex Offenders

When systemic treatment, or any treatment, is added to an already existing treatment plan, how do we evaluate its effects? Furthermore, why is it important to evaluate the effects? In treating sex offenders, every element of treatment becomes a possible safeguard against recidivism and is therefore worthy of our scrutiny and careful examination. It is absolutely critical that we treat sex offenders as effectively as possible. "Successfully treating sex offenders is a major sexual abuse prevention task and more necessary than ever with today's rising victim rates" (Prendergast, 1991, p. 220).

Evaluating Treatment

Evaluating treatment is easier said than done. Although there continue to be a number of recidivism and treatment outcome studies done in sex offender research, many fall short of examining the particular effects of certain treatment components (Quinsey, Harris, Rice, & Lalumiere, 1993). Most are conducted as a broad outcome study of a program that includes many different treatment modalities and many different types of offenders. Oftentimes, the effectiveness of a treatment program is
based on recidivism rates. Quinsey et al. argued that sex offender recidivism research has not adequately demonstrated the effectiveness of treatment in reducing recidivism. They suggested that outcome research needs to be much better controlled and is best evaluated with meta-analysis (1993). Marshall et al. (1989) agreed with these criticisms:

Perhaps the most pressing problem facing clinicians in this field is the need to develop indices of treatment effectiveness. As a first step to this process, future treatment evaluations need to go beyond a simple appraisal of outcome, by providing information on changes produced by treatment on the detailed features of sexual preferences, social competence, and cognitive distortions. (p. 382)

Hanson, Steffy, and Gauthier (1993) provided a review of recidivism research and question the link that is often made between recidivism and treatment effectiveness. They argued that because of the lack of long-term recidivism studies in general, and because other research has been too weak to draw any real conclusions about the link between treatment and recidivism, treatment efficacy still remains an important unanswered question. Their own study examined long-term recidivism rates of sex offenders. They found that several factors related to increased recidivism. These
factors were (a) whether or not the offender was an incest offender, (b) which sex he offended against, (c) whether or not he had ever been married, and (d) previous sex offenses. Treatment modality was not a factor. These authors remind us that most recidivism research has focused on fixed variables. Studying the connection between recidivism and changeable risk factors is the next step to be taken if we are to learn anything about treatment effects (Hanson et al., 1993).

Lakey (1994) also agreed that more longitudinal studies, including the comparison of different treatment methods, would yield stronger outcome research. Small (1992) reviewed the current legal issues surrounding the treatment of sex offenders and argued that an understanding of the legal system of the client is crucial to the evaluation of treatment and its outcomes. Linden and Wen (1990) presented a review of therapy outcome studies and their legal ramifications, suggesting that insufficient and weak research continues to block our ability to conduct outcome studies that directly affect policy.

Freeman-Longo and Knopp (1992) discussed program efficacy and recidivism by proposing the following:

Sex offender program evaluation can be divided into two categories, process evaluation and outcome evaluation.
Process evaluation is the measurement of a client's progress as he advances through the treatment process (e.g. pre/post testing [Sic], measurements of skills etc.). Outcome evaluation is the measurement of overall program effectiveness in treating sex offenders. (p. 149)

Although these authors agree that both types of evaluation should take place, outcome evaluation should not be measured solely on the basis of recidivism rates.

One important aspect of treatment evaluation is the theory underlying the treatment. Eysenck (1994) advised that what separates science from technology is theory, and that without considering the theory that underlies the treatment, it is impossible to invent criteria by which the treatment can be evaluated.

Evaluating Systemic Components of Sex Offender Therapy.

Evaluating the effects of systemic components of sex offender therapy (i.e., collateral sessions involving family members, etc.) is just as difficult as evaluating any other treatment method. Because of the complexities involved in treating a system, the task of determining the efficacy of
systemic treatment may seem insurmountable. Outcome studies in the area of systemic therapy have come up against many of the same problems as the treatment outcome studies mentioned above. There is a recognized lack of process and outcome research that is both methodologically sound and clinically relevant (Eysenck, 1994; Jacobson, 1985; Kniskern, 1985). Jacobson discussed the fact that clinical relevance is often overlooked when outcome studies focus primarily on statistical significance. He suggested that the effect size statistic and other descriptive statistics which display the size of the treatment effect be included in outcome studies (1985).

It is evident that effective evaluation of sex offender treatment must include careful consideration of the many treatment components involved. These components (including systemic elements of therapy) should be evaluated both on a process and an outcome level, with tests that hold clinical relevance for those providing therapy and for those receiving it.

Research Hypothesis

The sex offender treatment program at ISAT includes several systemic interventions in the overall treatment plan for sex offenders. This research project focused on
collateral therapy sessions provided there.

Null Hypothesis

There is no relationship between the number of collateral therapy sessions and the client's ability to complete treatment levels within a specified time frame.
CHAPTER 3

METHODOLOGY

Sample

Data from a convenience sample of 27 adult male pedophiles were collected with the permission of the Intermountain Specialized Abuse Treatment Centers (ISAT) and the Utah Department of Corrections. ISAT operates eight offices in Utah, with the Salt Lake City office as the headquarters. Six of the eight offices were selected on the basis of the number of eligible subjects attending therapy. Participating ISAT offices were Salt Lake City, Vernal, Farmington, Provo, Logan, and Ogden. The target population was all adult male pedophiles who had been clients at ISAT during 1996. All clients of these offices who qualified were invited to participate in the study. Twenty-seven offenders consented and 3 declined to participate. One offender was dropped from the study because over 50% of the data needed to complete the instrument was missing from his file.

A summary of sample characteristics shown in Table 1 lists continuous demographic variables that describe the sample.
Table 1

**Summary of Sample Characteristics**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>37.92a</td>
<td>36.00</td>
<td>12.47</td>
<td>19-73</td>
</tr>
<tr>
<td>Time incarcerated in months</td>
<td>5.04a</td>
<td>3.50</td>
<td>5.78</td>
<td>0-27</td>
</tr>
<tr>
<td>Years of education</td>
<td>11.68b</td>
<td>12.00</td>
<td>2.10</td>
<td>6-16</td>
</tr>
<tr>
<td>Current number of legal charges</td>
<td>1.56b</td>
<td>1.00</td>
<td>0.77</td>
<td>1-3</td>
</tr>
<tr>
<td>Prior number of legal charges</td>
<td>0.56b</td>
<td>0.00</td>
<td>1.04</td>
<td>0-4</td>
</tr>
<tr>
<td>Number of victims</td>
<td>2.58a</td>
<td>2.00</td>
<td>2.34</td>
<td>1-10</td>
</tr>
<tr>
<td>Years of reported abuse</td>
<td>5.44b</td>
<td>1.00</td>
<td>8.60</td>
<td>1-33</td>
</tr>
</tbody>
</table>

a\(n = 26\)  b\(n = 25\) (data missing for one participant)

Characteristics described by the remaining noncontinuous variables are found in Appendix I. The mean age for participants in this study was 37.92. The large range in age (19-73) suggests that this sample adequately represents adult male pedophiles attending treatment at ISAT. The time participants spent incarcerated had a mean of 5.04 months. The standard deviation, which measures the distance between the distribution of scores around the sample parameter, was 5.78 months. Closer examination of Table 1 suggests that with a range of 0-27 months for this
variable, the median, or "middle" value (3.50 months), is a more accurate measure of central tendency. When a large range and outlying scores are present, the median gives a more precise picture of where the midpoint of the distribution is located (Weisberg, 1992).

The mean for education was 11.68 years. Education ranged from 6-16 years with a median of 12.00 years and a standard deviation of 2.10.

The current and prior number of legal charges for this sample range from 1-3 and 0-4, respectively, with a mean of 1.56 current legal charges and a mean of 0.56 prior legal charges.

The number of victims reported by participants in this sample had a mean of 2.58. Number of victims ranged from 1-10 with a standard deviation of 2.34 and a median of 2.00. Years of reported abuse had a mean of 5.44. However, the standard deviation of 8.60 and range of 1-33 years suggest that the median of 1.00 years is a more accurate measure of central tendency than the mean. The sample characteristics listed in Table 1 illustrate the sample's diversity and large range of characteristics.
Procedures

Clinical Directors

Clinical directors at each participating ISAT office were contacted and provided a letter of intent, and an outline of the research proposal (see Appendices A and B).

Procedures for subject selection. A packet containing a copy of the instrument, the informed consent letter, a letter of instruction relating to subject selection, and a list of criteria for subject selection was sent to each clinical director (see Appendices C, D, E, and F). Clinical directors were charged with selecting qualified participants from their respective offices. Each clinical director retained copies of all letters and forms distributed in his or her respective office.

Criteria for subject selection. In order to identify a relatively homogenous sample, each participant was required to meet the following qualifications:

1. Diagnosed as a pedophile according to the DSM IV
2. Court-ordered to treatment at ISAT
3. Working on Level 3 or 4 (or completed in 1996)
4. An adult male (18 or over)
5. Heterosexual orientation
6. Fluent in English
ISAT Therapists

Procedures for eligible clients attending therapy at ISAT. Subjects who met the criteria for inclusion were invited by their respective therapist to participate. Individual therapists of those attending ISAT who were eligible to participate were sent a letter of instruction concerning informed consent procedures (see Appendix G). Subjects, prior to making a decision about involvement, read and discussed the informed consent form with their therapist. Clients who volunteered to participate signed the informed consent form. Due to the nature of the sample and desire to maintain confidentiality, the therapist served as witness to the signing of the informed consent.

Procedures for eligible clients who had completed ISAT. One former ISAT client who had completed the program during 1996 was invited to participate. Although the invitation was extended (see Appendix H), and the informed consent form was sent to his address to be signed and returned to the ISAT office by mail, he declined to participate.

Data Collection

The principal investigator collected from each office the signed informed consent forms and set up appointments for on-site data collection. To ensure confidentiality, the
following procedures were followed:

1. All subject's names were coded so names could not be associated with the data.

2. Only the primary researcher had access to files for the purpose of collecting data. Data collection occurred on-site, and no files were taken from ISAT offices.

3. Once the data were coded, they were kept in a locked file cabinet in a locked room, separate from the informed consent forms.

4. Data were analyzed as a group, with any published results describing group findings only.

Instrument

Clinical directors, staff therapists at ISAT, as well as experts in the field of treating sex offenders contributed to the design of this instrument and the variables included, thus increasing relevance and face validity. The purpose of the instrument was to extract information that may have had an effect on an offender's ability to move from one treatment level to the next, with primary focus on the role of collateral therapy.

The instrument had three parts consisting of 23 total questions (see Appendix C). The introductory paragraph included client ID and 4 questions about the offender's
relationship to the victim and time spent in incarceration. Part one consisted of eight questions about the participant's demographic background that could be obtained from a client's intake packet. Part two included four questions about the nature and extent of the abuse and could be obtained from any of the client's quarterly reports. Part three included seven questions pertaining to dates the client began working on each level of the program and the number and type of sessions attended. This information could be obtained from the client's offender level book and the margins of the casenotes (which specify whether the session was individual or collateral).

Reliability

The instrument used in this study was standardized and required little or no subjective judgement for data collection. Items on the instrument called for dates, numbers, and straightforward yes or no answers. Because the student researcher was the only person collecting data from client files, interrater reliability was not calculated.

Face Validity

Face validity refers to the extent that an instrument appears to be measuring the subject matter it was designed to measure. Face validity of the instrument used in this
study was enhanced by ISAT clinical directors, staff therapists, and experts in the field of treating sex offenders, who have contributed significantly to the design of the instrument by determining which variables should be included in light of the research question.

Analysis

Univariate Analysis

The criteria for subject selection established a relatively homogenous sample, facilitating the use of descriptive statistical analyses. The dependent variables, T1 and T2, represent the time offenders spent on the first and second levels of their treatment (T1 and T2, respectively) in number of days. The 23 independent variables, including number of collateral sessions attended on each level of treatment, were analyzed for each participant. Analyses describing central tendency were computed for each continuous variable using the SPSS statistical computer package. Frequencies were run on non-continuous demographic, treatment, and sexual offense related variables. Only continuous variables were used in the following analyses.
Correlational Analyses

Two separate analyses involving Pearson correlation coefficients were run in order to determine the degree of association between the variables. First, correlations were computed for all of the variables to assess for multicollinearity. The second correlation analysis, which was central to the research question, examined the relationship between the presence of collateral sessions on treatment levels 1 and 2 (Coll 1 and Coll 2) and the dependent variable, time spent on treatment levels 1 and 2 (T1 and T2), in number of days.

Tests of Statistical Significance

The t test. A t test was employed to further examine the relationship between collateral sessions and the amount of time it takes for clients to progress from one level to the next in their therapeutic program. A separate t test was run for each level of treatment. In each level of treatment participants were collapsed into two groups, those who had participated in one or more collateral sessions, and those who had not participated in any collateral therapy sessions. The t test was run to compare means on the primary independent variable, collateral sessions, for these two groups.
Multiple regression. A stepwise multiple regression analysis was then performed. First the dependent variable, time, was regressed on the secondary independent variables (e.g., age, family profile, education, time spent in incarceration, etc.) to determine the amount of variance they accounted for in the time taken to complete a level. Once these variables had accounted for their contribution to the overall variance, the next step was to include the primary independent variable, number of collateral sessions. Using this stepwise procedure, the amount of variance accounted for by the primary independent variable, number of collateral sessions, was estimated, while controlling for the influence of secondary independent variables that may interact directly or indirectly with the primary independent variable.

These tests of statistical significance, combined with the univariate and correlational analyses, provide information appropriate for the description of this sample, namely, adult male pedophiles receiving treatment at the participating ISAT offices in Utah. The results of this study cannot be generalized beyond this specific ISAT population.
CHAPTER 4
RESULTS

The primary focus of this research was to examine whether the use of collateral therapy was related to the number of days it took a client to complete the requirements necessary to move from one therapeutic level to the next.

Results of Descriptive Analyses

Central Tendency Data for Independent Variables

Results of central tendency analyses run on continuous independent variables that describe the sample are discussed in Chapter 3, and listed in Table 1. These variables include age, education, number of months incarcerated, current and prior number of legal charges, number of victims, and years of abuse.

Central Tendency Data for Collateral Sessions and Time

Table 2 displays central tendency data for the overall number of days spent on Level 1 and Level 2 and the number of collateral sessions on each treatment level.
Table 2

Number of Days Spent on Level 1 and Level 2 and Number of Collateral Sessions on Each Level

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Median</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total days</td>
<td>246.72</td>
<td>194.00</td>
<td>190.25</td>
<td>49-943</td>
</tr>
<tr>
<td>Total collateral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sessions</td>
<td>0.92</td>
<td>0.00</td>
<td>1.55</td>
<td>0-6</td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total days</td>
<td>225.60</td>
<td>188.00</td>
<td>114.61</td>
<td>89-516</td>
</tr>
<tr>
<td>Total collateral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sessions</td>
<td>1.36</td>
<td>1.00</td>
<td>2.08</td>
<td>0-7</td>
</tr>
</tbody>
</table>

*Note. n=25*

The mean number of days participants spent on Level 1 was 246.72, with a range of 49-943 days and a standard deviation of 190.25 days. The median number of days spent on Level 1 was 194.00. As with Level 1, Level 2 also displayed a large range (89-516 days), with a mean of 225.60 days (SD = 114.61) and a median of 188.00 days.

Table 2 also displays central tendency data for collateral sessions attended on each level. The mean number of collateral sessions on Level 1 (Coll 1) was 0.92 with a standard deviation of 1.55, and the mean number of
The number of collateral sessions on each level (Coll 1 and Coll 2) was collapsed into two groups, those who attended one or more collateral sessions and those who attended no collateral sessions. This was done because there were 16 participants who had no collateral sessions on either level and the other 9 participants had one or more collateral sessions on each level. Table 3 includes a comparison of measures of central tendency for participants...
who had and those who had not participated in collateral therapy.

Table 3 represents descriptive data, suggesting that the mean number of days to move from Level 1 to Level 2, for those clients involved in collateral sessions, was 215.78 days (SD = 140.92), whereas it took 264.13 days (SD = 215.46) for those involved in no collateral sessions. An examination of the standard deviation for those not involved in collateral sessions suggests considerable variation.

Table 3

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Median</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 to 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collateral</td>
<td>9</td>
<td>215.78</td>
<td>140.92</td>
<td>155.00</td>
<td>112.00</td>
</tr>
<tr>
<td>Noncollateral</td>
<td>16</td>
<td>264.13</td>
<td>215.46</td>
<td>202.50</td>
<td>139.00</td>
</tr>
<tr>
<td>Level 2 to 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collateral</td>
<td>13</td>
<td>189.00</td>
<td>111.45</td>
<td>146.00</td>
<td>89.00</td>
</tr>
<tr>
<td>Noncollateral</td>
<td>12</td>
<td>265.25</td>
<td>108.69</td>
<td>228.50</td>
<td>147.00</td>
</tr>
</tbody>
</table>
This variation appears to be due to two outlying scores (49 and 943 days), which are considerably different from the others in the sample. As such, it was determined that the median would be the more accurate measure of central tendency. Medians for the collateral versus the noncollateral subjects were 155.00 days and 202.50 days, respectively. This data suggests that for this sample, clients involved in one or more collateral sessions took 47 days less to make the transition from Level 1 to Level 2. A similar finding was noted with regard to the movement from Level 2 to Level 3 (also in Table 3) with this sample: clients moved from Level 2 to Level 3 in 83 days less (medians of 146.00 versus 228.50) when they included collateral therapy as an intervention.

The results of these analyses indicate a distinct, though moderate difference in the number of days it took to complete a level when the sample was divided into collateral versus noncollateral participants.

Questions which evolved from the results of these analyses were:

1. What is the relationship between collateral therapy and time?

2. Is the reported difference in days it takes to complete a level for those who are involved in collateral
therapy versus those who are not, statistically significant?

In light of these questions and the results of the analyses discussed above, the following correlations and statistical tests were run in order to examine the research question in greater detail.

Results of Correlational Analyses

Correlation Coefficients for Collateral Sessions and Time

To investigate the relationship between collateral therapy and time, correlations were run for the time spent on Levels 1 and 2 with the presence or absence of collateral sessions on Levels 1 and 2. A negative correlation was found between the presence of collateral sessions during Level 1 and the time spent on Level 2 ($r = -0.38, p = 0.06$). In other words, when one or more collateral sessions were attended during treatment on Level 1, less time was spent in treatment on Level 2 (see Table 4). The presence of collateral sessions on Level 1 was positively correlated with the presence of collateral sessions on Level 2 ($r = 0.42$) statistically significant at the $p < 0.05$ level. This meant that when a participant attended one or more collateral sessions on Level 1, he was more likely to
Table 4

Correlation Coefficients: Number of Collateral Sessions on Level 1 and Level 2 Correlated with Time Spent on Level 1 and Level 2

<table>
<thead>
<tr>
<th>Variable</th>
<th>Presence of collateral sessions on Level 1</th>
<th>Presence of collateral sessions on Level 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time spent on Level 1</td>
<td>-.13</td>
<td></td>
</tr>
<tr>
<td>Time spent on Level 2</td>
<td>-.38</td>
<td>-.34</td>
</tr>
</tbody>
</table>

*p < .05

Participate in collateral sessions on Level 2. The results of this analysis, as shown in Table 4, illustrate the relationship between collateral therapy and time across levels of treatment.

Serendipitous findings in bivariate correlations for independent variables. One variable showed a statistically significant correlation with the primary independent variable, collateral sessions. The number of reported victims was negatively correlated with the presence of collateral sessions on Level 2 ($r = -.53; p < .01$). The results of bivariate correlations also indicated a positive correlation between age and the number of reported years of abuse ($r = .47; p < .05$). Years of education was negatively correlated with prior number of legal charges ($r = -.41; p <$
Number of years of reported abuse was positively correlated with number of reported victims ($r = .70; p < .01$). No other independent variables approached a statistically significant correlation with the dependent variable, time.

The following results were derived from the correlational analyses:

1. An inverse relationship was found between the presence of collateral sessions and time spent on ISAT treatment levels. When one or more collateral sessions were attended, less time was spent on each level.

2. An inverse relationship was found between the presence of collateral sessions on Level 1 and the time it took to complete Level 2. A modest inverse relationship was found between the presence of collateral sessions on Level 1 and the time it took to complete Level 1.

Findings from the descriptive and correlational analyses show that participants involved in collateral therapy progressed more rapidly to the next level of treatment than those who were not involved in collateral therapy. This trend was first noted in the difference in medians for number of days to complete a level (see Table 3) when the sample was divided into collateral versus non-collateral participants. The results of the correlational
analyses supported these findings by illustrating an inverse relationship between collateral sessions and the time it took to complete a level of treatment (see Table 4). The next step in exploring this trend included additional tests of statistical significance.

Tests of Significance

The following tests of significance were applied to further examine the relationship between collateral sessions and time:

1. The t tests were run to examine the difference in group means between those who had collateral therapy and those who did not.

2. Multiple regression was used to determine the amount of variance collateral sessions accounted for while controlling for the influence of secondary independent variables.

Using t Tests for the Dependent Variable and Collateral Sessions

A t test was used to determine if the number of days it took to move from Level 1 to 2, and from Level 2 to 3 were significantly different for those who had collateral
sessions and those who did not. Two subjects were dropped from this analysis, one because of missing data, and one because he was allowed to begin the program on Level 2, so zero time was spent on Level 1. Table 5 illustrates the results of the t tests.

Table 5

Results of t Tests: The Mean Number of Days Required for Participants to Move from Level 1 to 2 and from Level 2 to 3 Based on Whether There Was Collateral Therapy

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>E.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1 - Level 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No collateral sessions</td>
<td>16</td>
<td>264.13</td>
<td>215.46</td>
<td>0.22</td>
</tr>
<tr>
<td>One or more collateral sessions</td>
<td>9</td>
<td>215.78</td>
<td>140.92</td>
<td></td>
</tr>
<tr>
<td>p = .55</td>
<td></td>
<td>t = 0.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2 - Level 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No collateral sessions</td>
<td>12</td>
<td>265.25</td>
<td>108.69</td>
<td>0.70</td>
</tr>
<tr>
<td>One or more collateral sessions</td>
<td>13</td>
<td>189.00</td>
<td>111.45</td>
<td></td>
</tr>
<tr>
<td>p = .10</td>
<td></td>
<td>t = 1.73</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Results of the t-tests indicate no significant difference in the number of days it took to move from Level 1 to Level 2 between collateral and noncollateral participants.

The final question derived from these results was: Does collateral therapy account for a greater proportion of the variance than does noncollateral participation when selected independent variables are controlled? A stepwise multiple regression was run to address this question.

Results of Multiple Regression

A stepwise regression analysis was performed using data collected on continuous independent variables, including the primary independent variable, number of collateral sessions. First, the secondary independent variables were entered into a regression equation to determine the amount of variance they accounted for in the time taken to complete a level. Independent variables included in the equation were age, education, time spent in incarceration, number of reported victims, number of reported years of abuse, current number of legal charges, and prior number of legal charges.

The next step was to include the primary independent variable, number of collateral sessions. This procedure was
utilized to estimate the amount of variance accounted for by collateral sessions while controlling for the influence of the secondary independent variables. However, due to small sample size, the results of the regression analyses indicated that the use of multiple regression was not successful in predicting the amount of variance accounted for by the independent variables entered.
While decreasing recidivism among sexual offenders is of social significance with broad ramifications, treatment effectiveness and efficiency are of critical importance. This study examines one potential factor that may be related to treatment efficiency, specifically the use of collateral therapy as an integral aspect of the overall treatment protocol.

An Examination of Treatment Efficiency

The primary focus of this research was to examine whether the use of collateral therapy in the treatment of adult male pedophiles attending intensive outpatient therapy at Intermountain Specialized Abuse Treatment Center would be related to the number of days it took a client to complete the requirements necessary to advance from one level of treatment to the next.

Descriptive and Correlational Analyses

Results of the descriptive analyses show that for this sample, clients involved in collateral sessions during treatment took 47 fewer days to make the transition from
Level 1 to Level 2 and 83 fewer days going from Level 2 to Level 3. This initial examination of the data raised questions about the relationship between collateral sessions and time, warranting further investigation and testing.

Results of the correlational analysis revealed an inverse relationship between participation in collateral therapy and the time it took to complete a level of treatment. This inverse relationship was particularly noted between collateral sessions on Level 1 and the time spent on Level 2, suggesting that one or more collateral sessions on Level 1 may decrease the amount of time spent on Level 2.

One factor that may contribute to the inverse relationship reported in the results of the correlational analyses has to do with early involvement in collateral sessions. Clients who are involved in collateral sessions early in their treatment may be establishing a momentum in therapy that begins to show up as fewer days in treatment by the time they reach Level 2. Clients who are not used to collateral sessions and begin them later during treatment may take time to adjust to dealing with the issues that arise in collateral therapy, thus interrupting an established momentum. Further investigation is needed to separate out elements of treatment that may be related to the amount of time a client spends on each level.
Tests of Statistical Significance

While there was not a statistically significant difference reported in the t tests, it is important to examine the difference between the two groups from a clinical standpoint. Specifically, fewer days were spent on each level if collateral therapy was part of the treatment protocol.

The use of multiple regression to control for other confounding variables was unsuccessful. The number of independent variables combined with small sample size resulted in a negative adjusted R². However, the results of the descriptive and correlational analyses combined with the results of the t test suggest a modest relationship between collateral therapy and the reduction of overall time in treatment.

In conclusion, this study suggests that for adult male pedophiles in intensive outpatient therapy at ISAT, participation in collateral therapy may enhance a client's ability to complete levels of treatment in a timely manner.

Limitations and Recommendations

Sample Size

The predominant limitation of this study was the small
sample size. Though roughly 90% of the target population was represented by this sample, the N of 26 reduced the power of each statistical test. Sample size was limited when strict requirements for participation were agreed upon to enhance the homogeneity of the sample. The n became even smaller when split into two groups for the t tests.

Instrument

The instrument was developed from an accumulation of ideas and hypotheses based on the experience and suggestions of ISAT clinical directors, staff therapists, and experts in the field of sex offender therapy. Clearly, the reliability and validity of the instrument depend on its further development and use in future studies.

Because of the problems with objectively measuring clients' "progress" and "treatment outcome," this initial study did not attempt to measure either of these variables. Instead, the instrument was designed to gather information necessary in breaking down the different components of treatment (e.g., individual sessions and collateral sessions) and investigating the relationship between collateral sessions and the time it took participants to move from one treatment level to the next.
Number of Collateral Sessions

Another important limitation that must be addressed relates to the total number of collateral sessions subjects participated in. The policy at ISAT requires at least one collateral session per month; however, most participants had no collateral sessions at all. Participants spent 6 to 7 months on each level with an average of one collateral session per level. Number of collateral sessions ranged from zero to six on Level 1 and from zero to seven on Level 2. A comparison of the total number of sessions with the total number of collateral sessions makes it clear that the results of this study must be interpreted with caution (see Table 2).

Mediating Variables

The importance of a support network. One important variable that may contribute to differences between offenders that participate in collateral therapy and those who do not is the presence of support. Even the presence of just one collateral session means that there is someone to attend therapy with the offender, giving evidence that some support exists. This presence or absence of support could have an influence on the relationship between collateral sessions and the time it takes to complete treatment.
Differences in therapist style. An obvious limitation involved the differences in therapist style, which present numerous problems with controlling variables that confound results. Each ISAT therapist follows a written treatment plan with the same requirements for each client on each level. However, the differences in personal style, individual treatment goals outside of the required treatment plan, and the "fit" between client and therapist have a definite impact on the time it takes to move through levels of treatment, all of which are beyond the scope of this research.

The nature of the sexual offense as it relates to treatment procedures. Another limitation involves the nature of the sexual offense as it relates to whether a client is involved with others in collateral sessions. Sometimes clients on Level 1 are not allowed to participate in collateral sessions until they have progressed to a certain level in therapy as determined by their individual therapist and clinical director. This is most often the case when incest has occurred and the victims are also not ready to participate with the offender in collateral sessions. In situations where this has been the case, it is possible that this group is different from other clients who are allowed to participate in collateral therapy but choose
not to themselves or have persons in their support network who choose not to participate with them.

Other mediating variables. There are other mediating variables that may have an association with the amount of time it took participants to finish levels of treatment which were beyond the scope of this research. These might include type of pedophilia, personality, beliefs and values held by the systems the offender belongs to, and so forth.

The independent variables included in this study were by no means comprehensive. This study raised many questions about the different components of sex offender treatment that future research should address.

Effectiveness and Efficiency

It was the intent of this study to evaluate the relationship between collateral sessions and the amount of time it took for a client to move from one level of treatment to another. This initial study did not attempt to make inferences about "progress" in treatment or the quality of the interventions being provided.

Achieving efficiency in the treatment of sex offenders, however, should never preclude the goal of achieving effectiveness. The findings of this study should not be
considered without careful attention to their relationship with and differences from treatment effectiveness.

Implications for Future Research

**Studying the Effects of Systemic Therapy**

The question of whether there is a relationship between a client's participation in collateral therapy sessions and the amount of time it takes to complete treatment is a legitimate question. Future research needs to focus on how collateral sessions are related to time in treatment, conducting similar studies with a larger sample size and finding effective ways to control for mediating variables. However, participation in collateral therapy is only one way to measure whether systemic types of treatment are being administered. There is a need to operationalize other facets of systemic therapy, making it possible to measure its effects.

**Systemic Therapy in Varied Treatment Settings**

Making the case for systemic treatment in varied treatment settings and with differing populations is an important task. Outcome studies focusing on different
components of treatment and their effects on progress for different populations are necessary to provide the best services for each type of client. Sex offenders belong to the court-ordered population, a group that approaches systemic therapy in a different way than a client who is self-motivated to present at therapy.

Future research needs to focus on operationalizing different components of treatment (including systemic approaches) and measuring their effects. This approach, which centers on different parts of treatment and the whole package, may be a way of structuring future research that is methodologically sound and clinically relevant.

Social and Clinical Significance

Reducing the time it takes to meet treatment goals. The findings of this study suggest that the number of days required to move from Level 1 to Level 2, and from Level 2 to Level 3 are fewer when one or more collateral sessions are included in the treatment process. This difference, although not statistically significant, is clinically significant. Participants with one or more collateral sessions spent 47 fewer days on Level 1 of their treatment and 83 fewer days on Level 2. Clinically speaking, this is a significant reduction in treatment time.
As previously stated, treatment effectiveness must always be of primary concern. However, when considered in conjunction with treatment effectiveness, any treatment protocol that demonstrates an ability to meet overall treatment goals more rapidly clearly achieves clinical significance. Effectively treating sex offenders in a timely manner is crucial to increasing the safety and well-being of those around them and is of great social importance and clinical relevance.

The results of this study suggest that there may be a relationship between participation in collateral therapy and time spent in treatment. Future research must address this question, making further inquiries as to whether collateral therapy reduces treatment time for clients at ISAT and for others in similar settings. Clinical programs and social policy may be altered as a result.

**Legal considerations.** For clients who are on therapy leave from jail, a reduction in treatment time may very well influence a reduction in jail time. A client who participates in collateral therapy demonstrates that he has a support network, which is crucial to the rehabilitation process. A legitimate reduction in jail time certainly has significant social and economic impact.

**Economic impact on client and provider.** Researching
treatment efficiency becomes especially important when the economic impact on the client and provider is considered. The reduction in the number of treatment sessions necessary to complete therapy can make a difference of $100.00 or more in just one week. Though the sex offenders in this sample were all court-ordered to treatment, economic factors often influence the processes involved in actually attending therapy and continuing to receive services from the provider. For clients paying for legal fees, fines, and other related costs, a reduction in therapy costs may encourage clients to seek more immediate treatment and may also decrease the dropout rate.

The cost to the agency providing treatment must also be considered. Court-ordered clients often pay on sliding fee scales, leaving the provider and/or other agencies to pick up the remaining costs. Clearly, the economics of treatment play a significant role in establishing acceptable treatment programs for pedophiles. Future studies that address the different components of treatment effectiveness and efficiency are needed in order to provide the best treatment possible for this population.
Implications for the Field of Marriage and Family Therapy

The implications of this study for the field of marriage and family therapy are broad. As traditional treatment protocols for sex offenders change to include more collateral sessions and more marital and family therapy, the presence of family therapists in treatment settings will be a valued asset.

Training and supervision. As the efficacy of systemic treatment for sex offenders increases, more family therapists may seek out contracts to treat sex offenders. This will increase the need for family therapists to receive specialized training in dealing with this population. Training programs need to focus more on the particulars of abuse in general, providing therapists with a solid background in abuse issues in the family and society.

Training programs for aspiring marriage and family therapists would do well to include more in-depth training on the issues involved in treating the court-ordered client and to provide opportunities for practicum placement in agencies whose clients are court-ordered to treatment. Interagency cooperation is of paramount importance when dealing with the many social and legal systems involved in a sex offender's life. Therapists who treat this population
must be trained in the ins and outs of working with other professionals in the mental health and law enforcement fields. Networking with other professionals is an important skill when working with this population.

Reunification issues in the incest family. In cases of incest, the offender is often removed from the home in order to protect the victim(s) from further abuse while the offender begins treatment. Several important treatment goals should be met before the offender is allowed to re-enter the home or have any contact with the victim(s). The therapist must have ample collateral sessions with family members so that a satisfactory assessment of family relationships can be performed. Relationship areas that the therapist feels must be dealt with before reunification can be assessed. Reunification goals include: (a) ensuring that proper communication lines between the therapist/agency and the family are in place; (b) ensuring that social support network can adequately provide a safety plan if the need arises; (c) ensuring that individual family members who need treatment are receiving services; (d) ensuring that the issues surrounding the abuse and the family's intentions for future functioning are being addressed; and (e) ensuring that family and therapist work together as new issues arise as the offender is put back in the home.
The benefits of systemic treatment for victim and offender. In the past, victims of sexual abuse were often treated in an entirely different kind of agency, with limited communication between therapists treating victim and offender. Issues surrounding the abuse and the limited viewpoint that each therapist got in working with only one person involved in the abuse did not facilitate open communication and often put therapists at odds with each other. Systemic treatment broadens the view of all those involved, facilitating intervention on the level of the system, not just at the individual level. The benefits of systemic treatment cannot be underestimated, especially in cases of incest.

Future research. Future research in the field of marriage and family therapy needs to include the study of its impact on traditionally individual treatment areas, including treatment for sex offenders. As new policies evolve, like Utah's mandate to include a required number of collateral sessions in the treatment protocol for sex offenders, research needs to be conducted to evaluate its effects, validate its use, and point the way to improved treatment protocols. In order for this to happen, collateral therapy needs to be consistent in treatment programs so objective research methods are more easily
The benefits of systemic treatment for victim and offender. In the past, victims of sexual abuse were often treated in an entirely different kind of agency, with limited communication between therapists treating victim and offender. Issues surrounding the abuse and the limited viewpoint that each therapist got in working with only one person involved in the abuse did not facilitate open communication and often put therapists at odds with each other. Systemic treatment broadens the view of all those involved, facilitating intervention on the level of the system, not just at the individual level. The benefits of systemic treatment cannot be underestimated, especially in cases of incest.

Future research. Future research in the field of marriage and family therapy needs to include the study of its impact on traditionally individual treatment areas, including treatment for sex offenders. As new policies evolve, like Utah's mandate to include a required number of collateral sessions in the treatment protocol for sex offenders, research needs to be conducted to evaluate its effects, validate its use, and point the way to improved treatment. In order for this to happen, collateral therapy needs to be consistent in treatment programs so objective research methods are more easily employed.
As systemic theory takes hold in a number of societal domains, the influence of family therapy will most certainly be realized in all areas of the mental health professions. Systemic treatment for sex offenders can then be realized as not only a legitimate part of treatment, but as a fundamental way of providing treatment.

Conclusions

The most significant benefit of this research is an understanding of whether collateral therapy is related to a client's progress through his treatment program. Research in this area can impact both intervention protocols as well as have implications for other similar agencies and social policy. Results of this study are limited to the population from which the data were taken, namely, adult male pedophiles receiving treatment at ISAT. Thus, the reader is cautioned in making broad generalizations regarding the findings of this study. The implications of this study will hopefully be the foundation for further research questions concerning the efficiency of sex offender treatment. The results may have widespread impacts on future treatment protocols and affect the way we look at collateral therapy as an integral part of treatment for sex offenders.
REFERENCES


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APPENDICES
Letter of Intent

Julie Bennion  
Department of Family and Human Development  
Utah State University  Logan, Utah

Dear ISAT Clinical Director,

I am completing a Master's degree at Utah State University in Marriage and Family Therapy. For my Master's thesis, I am conducting a research study examining the relationship between collateral therapy sessions and time spent in treatment for court-ordered adult male pedophiles. I became interested in this population while completing my advanced clinical practicum at the Logan ISAT office. This study, entitled, "The Relationship Between Collateral Therapy and the Adult Pedophile's Ability to Advance Through Levels of Treatment" will not involve you, the therapists at your agency, or your clients directly, nor will it affect the nature of your clients' treatment programs. Rather, the data that I will collect is currently in the client's file. My project has been approved by the USU Institutional Review Board as well as Dr. C.Y. Roby and Ed Bingham, who have sent your office a letter concerning the agency's cooperation with this project.

I will be working closely with your office manager to identify my sample and distribute informed consents. I will be contacting the clients in your office that are eligible to participate through their individual therapists. Then I will personally collect all the data from the client files. I would greatly appreciate your help in getting started. I would ask that you discuss the following procedures of my project with your staff, who will be communicating the details to their clients:

1. Neither the therapist nor the client will be directly involved in the study. Information from the client's file at ISAT will be used as statistical data in examining the effects of collateral sessions on their treatment at ISAT.

2. All data will be coded with names removed. There will be no way of associating data with the participant's name following the collection process. Published data will
report only group results.

3. Data will be collected by the primary researcher only, and no files will leave the ISAT office.

4. There are no risks involved with participating. The client's treatment will not be effected in any way, and a participant may withdraw at any time without consequence.

5. The decision to participate is voluntary.

I have enclosed copies of the following items for your information:

1. My proposal and the instrument I will use to collect data.
2. A letter to your office manager outlining the study and detailing the criteria for identifying my sample.
3. A letter to the individual therapist of clients eligible to participate outlining the study and detailing the guidelines for explaining the informed consent.
4. The informed consent.
5. A letter to former clients of ISAT that are eligible for the study that will be sent to them with the informed consent.

You do not have to distribute any of these forms. These copies are for your personal use. I will be in contact with your office manager to begin identifying my sample. The involvement of your staff will require very little time or effort. I am excited to begin and hope that the information gained from this study will be valuable to your agency. If you or your staff or clients have further questions about this study, please feel free to contact me by leaving a message at the Logan ISAT office at (801) 753-5411.

Thank you for your help.

D. Kim Openshaw, Ph.D., LCSW, MFT  Julie Bennion, B.S.
Principal Investigator  Student Researcher
Utah State University  Utah State University
Appendix B
Proposal Outline

Introduction

Court-ordered treatment for sex offenders in the state of Utah has recently expanded to include a minimum of one collateral therapy session a month. This innovation is particularly noted at the Intermountain Specialized Abuse Treatment Centers (hereinafter referred to as ISAT). Court-ordered sex offenders attending weekly individual and group therapy sessions at ISAT are now more involved in marital and family therapy during their treatment. This research project examines the relationship between collateral therapy sessions and the client’s ability to complete treatment within a specified time frame.

Sex offenders involved in treatment at ISAT are involved in a variety of therapeutic services ranging from weekly appointments to intensive treatment. Individual, as well as group therapy encourages the development of responsibility for the crime, assertiveness and empathy training, psychoeducation, etc. The offender treatment program includes four levels, with the initial level designated as Level 1.

As treatment progresses and assignments are completed,
level reviews are scheduled with the clinical director. During this review, the client’s progress is evaluated and a determination is made regarding advancement to the next level. Offenders are expected to complete each of the four levels within a specified time frame which varies from level to level.

Adjunctive to the emphasis on individual and group therapy is involvement with a support network which may include, family members, spouses, or other significant individuals in the life of the client (e.g., partners, friends, or clergy). Therapists of the offenders utilize these collateral resources to facilitate treatment, inviting one or more significant others to participate in collateral sessions. The purpose of the collateral session is to assess the client's social support network and to provide any needed treatment to enhance the supportive abilities of those systems. ISAT has adopted an agency-wide policy recommending the inclusion of collateral sessions into the therapeutic regimen.

The overriding purpose of this study is to examine whether the implementation of collateral therapy sessions influences the progress of a client from level to level.
Methodology

Sample. With permission of ISAT and the Utah Department of Corrections, data from a convenience sample of heterosexual adult male pedophiles will be collected. Offender data will be collected from files of clients who have been or are participating in the ISAT program.

Procedures. Subjects will be identified by the office manager as meeting the criteria. Those subjects selected for inclusion will be invited to participate by their respective therapist. Subjects, prior to making a decision about involvement, will read and discuss the informed consent with their therapist. Therapists will be sent a letter of instruction concerning these procedures. Those agreeing to participate will sign and return the informed consent to the therapist. Due to the nature of the sample and desire to maintain confidentiality, the therapist will serve as the witness to the signing of the informed consent.

Subjects eligible to participate that have already completed their treatment at ISAT will be sent a letter inviting them to participate, along with the informed consent, which they will sign and return to the ISAT office by mail. The informed consent, the letter of instruction to the therapist, and the cover letter that will be sent to clients who have already completed treatment are attached.
The office manager will provide a list of the files of those participating to the Researcher. Data from these files will be used to evaluate the treatment effect of collateral sessions. Subjects will not be personally involved in this study, but may request at the conclusion, a copy of the results. Procedures for collecting data from the file will include:

1. Collection of demographic information (i.e., age, education, offense, relationship to victim, and so forth). It is important to note that no subject's name will be connected with the information taken from the file. No files will be taken from the center. Thus, confidentiality will be protected.

2. Only the primary researcher will have access to the files for purposes of collecting the data. Once the data has been coded, it will be kept in a locked file cabinet in a locked room, separate from the informed consents.

3. All data will be analyzed as a group, with published results describing group findings only.

**Instrument.** The instrument has three parts consisting of 23 questions. Part one consists of questions about the participant's demographic and educational background that can be obtained from a client's intake packet. Part two includes questions about the nature and extent of the abuse
and can be obtained from any of the client's quarterly reports. Part three of the instrument asks for the dates that the client began working on each level of the program and the number of sessions attended and can be found in the client's offender level book and the margins of the casenotes (which specify whether the session was individual or collateral). The survey has been designed to be completed by the student researcher.

**Analysis.** Statistical analysis will be conducted in order to evaluate the relationship between participation in collateral sessions and the offender's ability to complete levels 1 and 2 in a timely manner. The dependent variable is the time it takes for each offender to complete a level. The independent variables tested will be the number of collateral sessions, as well as demographic variables (e.g., age, family profile, education, time spent in incarceration, and so forth). Each of the independent variables obtained from the survey will be included in the analysis to see what relationship they have (alone and in combination) with the dependent variable.
OFFENDER SURVEY

Client ID: ____________

Circle one: Incest pedophilia       non-incest pedophilia

Circle one: Is the client living with his victim(s)?

yes       no

Time spent in incarceration: (in number of months) ________

Relationship to Victim: ____________________________________________

PART ONE

Found on page 5 of "Client Social History" form, offender intake packet.

1) Age:
2) Last school grade completed or highest degree:

The following are found on page 7 of "Client Social History" form, offender intake packet.

3) Previous Mental Health Treatment: YES      NO

4) PURPOSE: ________________________

5) Family Profile: (check one)
Current Status: single___
               Married and living with spouse___
               Married and separated from spouse (client out of the home)___
               Widowed___
               Divorced___
               Living together___
The following are found on page 8 of "Client Social History" form, offender intake packet.

6) **Current Legal Action or Charges:** (Juv. and Dist. Court ---- dates)

7) **Prior Legal Action or Charges:** (include dates)

The following is found in the *psychological evaluation*, offender intake packet

8) **Diagnosis:**  
   Axis I: ____________________________  
   Axis II: ____________________________  
   Axis III: ____________________________  
   Axis IV: ____________________________  
   Axis V: ____________________________

**PART TWO**

The following questions are taken from *any* Quarterly Progress Report form of the client's.

1) **Start Date:** (date of initial session at ISAT)

   ____________________________
2) Time frame, Extent, and Nature of Abuse:
   # of victims ______ 
   # of years of perpetration ______ 
   Type of Abuse ___________________

PART THREE

The following questions are taken from the offender's level booklet

1) Date client began working on level I assignments 

2) Date client began working on level II assignments 

3) Date client began working on level III assignments 

The following questions are about "collateral sessions" attended by the client on each level. The number of collateral sessions can be found on the quarterly reports and in the margins of the casenotes in the client's file. "Collateral sessions" include sessions where family, friends, or others in the client's support network (including the victim) were in attendance at the client's individual therapy session

4) Number of collateral sessions on level I ____
   Total number of sessions on level I ____

Number of collateral sessions on level II ____
Total number of sessions on level II____
Appendix D

Informed Consent

You have been invited to participate, with other ISAT clients, in a research study examining the relationship between collateral sessions and time spent in treatment at Intermountain Specialized Abuse Treatment Centers (ISAT). You have been identified by the office manager as meeting the criteria for participation in this study. This study, entitled, "The Relationship Between Collateral Therapy and the Adult Pedophile's Ability to Advance Through Levels of Treatment" will not involve you directly, nor will it affect the nature of your treatment program. Rather, data to be collected is currently in your file.

The purpose of this study is to examine the relationship between collateral therapy sessions and the time it takes to complete a level of treatment at ISAT. "Collateral" refers to sessions with the individual therapist, in which other people are invited to attend with the client (e.g., spouse, partner, family member, clergy etc). The researcher intends to evaluate the relationship collateral sessions have with the client's ability to move from one level of treatment to another within the designated time frame.

Procedures

You have been asked to read, with your therapist, this informed consent. If you agree to participate in the study, data from your file will be used to evaluate the relationship between collateral sessions and time spent on treatment levels. You will not be personally involved in this study, but may request at the conclusion, a copy of the results. Procedures for collecting data from the file will include:

1. Collection of demographic information (i.e., age, education, offense, relationship to victim, and so forth). It is important for you to know that your name will be in no way connected with the information taken from your file. No files will be taken from the center. Thus, your confidentiality will be protected.

2. Only the primary researcher will have access to the files for purposes of collecting the data. Once the data has
been coded, it will be kept in a locked file cabinet in a locked room, separate from the informed consents.

3. All data will be analyzed as a group, with published results describing group findings only.

**Risks and Benefits**

There are no foreseeable risks involved in this study. You will not be directly involved in the study, nor will this project alter the treatment program you are currently involved in. The most significant benefit is an understanding whether collateral therapy helps clients progress through their treatment program more efficiently. If data suggests a positive influence, this may impact both intervention protocols per se, as well as have implications for other similar agencies and social policy. Your treatment program, however, is determined by ISAT and your therapist independent of the results of this study.

**Exclusion of Data**

Data may be excluded from analyses should any file be missing pertinent data.

I understand that participation in this study is voluntary, and refusal to participate will result in no penalty or loss of benefits to which I am otherwise entitled. I understand that participation in this study will not affect the nature of my treatment, nor will it affect my legal status with the courts. I may withdraw consent and terminate participation at any time without consequence. If I decide to withdraw from this study, I may contact the researcher and verbally request that the data be taken out of the study. I understand that I need to provide, within 72 hours a written request of withdrawal.

I understand that by signing this form I am giving my consent to be a participant in this research project. If I have additional questions about this study or my rights, I can contact Ms. Julie Bennion, B.S. at the Logan ISAT office (801) 753-5411 or Dr. D. Kim Openshaw at 753-6365.

I have read and understand this consent form and I am willing to participate in the study.
Name of participant

Signature of participant
Date

Name of Witness

Signature of Witness
Date
Appendix E

Letter to Office Manager

Julie Bennion
Department of Family and Human Development
Utah State University
Logan, Utah

Dear ISAT Office Manager,

I am conducting a research study examining the relationship between collateral therapy sessions and time spent in treatment for court-ordered adult male pedophiles. I will be using clients who are receiving treatment at your office in my sample. My project has been approved by the USU Institutional Review Board as well as Dr. C. Y. Roby and Ed Bingham, who have sent you a letter concerning the agency's cooperation with this project.

I need your help in completing the following steps in the research process:

1. Identifying which clients in your office are eligible to participate in the study.
2. Distributing and collecting informed consents.

Your help with these two important processes will be greatly appreciated! I have enclosed a list of the qualifications a client must meet in order to participate in the study (see attached).

When the list of eligible clients is compiled, I will give you the informed consents to distribute to the individual therapists of these clients. The study will not involve the client or therapist directly, nor will it affect the client's treatment in any way. The study will use information that is already in the client's file as statistical data for the project.

When all informed consents are signed and returned to you, I will schedule an appointment with you to come to your office to pull those files for data collection. NO files will leave your office; all data will be collected there. All data will be coded with names removed to protect the
confidentiality of your clients.

I will be contacting you by phone this week to help you get started and to answer any of your questions. Your help with this project is greatly appreciated, and I look forward to working with you. I can be reached at (801) 752-2697, or by leaving a message for me at the Logan ISAT office (801) 753-5411. Thank you for your help.

D. Kim Openshaw, Ph.D., LCSW, MFT  Julie Bennion, B.S.
Principal Investigator  Student Researcher
Utah State University  Utah State University
Appendix F

Criteria for Subject Selection

The following is a checklist of qualifications a client must have in order to be eligible to participate in the research study. Please compile a list of all the clients in your office who fit the criteria. To qualify for the study, and offender must be on level 3 or 4, or have already completed the program within the last year.

CHECKLIST

___ Client has been diagnosed as a pedophile
___ Client is on Level 3 or above
___ Client has been court-ordered to treatment at ISAT
___ Client is an Adult Male (18 or over)
___ Client is Heterosexual
___ Client is fluent in English
Appendix G

Letter to Therapist

Julie Bennion
Department of Family and Human Development
Utah State University
Logan, Utah

Dear ISAT Therapist,

Your client has been identified as meeting the criteria to participate, along with other ISAT clients, in a research study examining the relationship between collateral sessions and time spent in treatment at ISAT. This study, entitled, "The Relationship Between Collateral Therapy and the Adult Pedophile's Ability to Advance Through Levels of Treatment", will not involve you or your client directly, nor will it affect the nature of your client's treatment program. Rather, data to be collected is currently in your client's file. You have been asked to read and discuss the attached informed consent with your client and to serve as the witness to the signing of that form should your client choose to participate in this study. We ask that you stress the following important points as you discuss the informed consent with your client:

1. Neither you nor your client will be directly involved in the study. Information from the client's file at ISAT will be used as statistical data in examining the relationship between collateral sessions and time spent in treatment at ISAT.

2. All data will be coded with names removed. There will be no way of associating data with the participant's name following the collection process. Published data will report only group results.

3. Data will be collected by the primary researcher only, and no files will leave the ISAT office.

4. There are no risks involved with participating. The client's treatment will not be affected in any way, and a participant may withdraw at any time without consequence.

5. The decision to participate is voluntary.
Please read and discuss the informed consent with your client and sign it at the bottom if your client chooses to participate. **Give the signed informed consent form to the office manager.** If you or your client have further questions about this study, please contact Julie Bennion at the Logan ISAT office at (801) 753-5411.

Thank you for your help.

D. Kim Openshaw, Ph.D., LCSW, MFT
Principal Investigator
Utah State University

Julie Bennion, B.S.
Student Researcher
Utah State University
Appendix H

Letter to Former Clients

Julie Bennion
Department of Family and Human Development
Utah State University
Logan, Utah

Dear __________________________,

As a former client of Intermountain Specialized Abuse Treatment Center, you are eligible to participate in a research study examining the relationship between collateral sessions and time spent in treatment at ISAT. **This study will not involve you directly.** If you choose to participate, only information from your file at ISAT will be used as statistical data for this study. Other current and former ISAT clients are participating in this study.

The purpose of this study is to examine the relationship between collateral therapy sessions and the time spent in treatment. If you agree to participate in this study, data from your file will be used to evaluate this relationship.

Procedures for collecting data from the file will include:

1. Collection of demographic information (i.e., age, education, offense, relationship to victim, etc.). It is important for you to know that your name will be in no way connected with the information taken from your file. No files will be taken from the center. Thus, your confidentiality will be protected.

2. Only the primary researcher will have access to the files for purposes of collecting the data. Once the data has been coded, it will be kept in a locked file cabinet in a locked room, separate from the informed consents.

3. All data will be analyzed as a group, with published results describing group findings only.
If you agree to participate, please read and sign the enclosed consent form, and mail it to the ISAT office in the postage paid envelope. If you have any further questions about this study, you may contact Julie Bennion at the Logan ISAT office (753-5411). Thank you.

D. Kim Openshaw, Ph.D., LCSW, MFT  
Principal Investigator  
Utah State University

Julie Bennion, B.S.  
Student Researcher  
Utah State University
## Appendix I

### Summary of Sample Characteristics for Noncontinuous Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Subvariable</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Secondary Diagnosis</strong></td>
<td>None</td>
<td>7</td>
<td>26.9</td>
</tr>
<tr>
<td></td>
<td>Mood disorders</td>
<td>10</td>
<td>38.5</td>
</tr>
<tr>
<td></td>
<td>Anxiety disorders</td>
<td>3</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td>Substance abuse</td>
<td>3</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td>Sexual disorders</td>
<td>3</td>
<td>11.5</td>
</tr>
<tr>
<td><strong>Type of Abuse</strong></td>
<td>Incest (in same household)</td>
<td>13</td>
<td>50.0</td>
</tr>
<tr>
<td></td>
<td>Non-incest (not same household)</td>
<td>10</td>
<td>38.5</td>
</tr>
<tr>
<td></td>
<td>Both types of abuse</td>
<td>3</td>
<td>11.5</td>
</tr>
<tr>
<td><strong>Relationship to Victim</strong></td>
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<td>23.1</td>
</tr>
<tr>
<td></td>
<td>Grandfather</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>Brother</td>
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<td>7.7</td>
</tr>
<tr>
<td></td>
<td>Stepfather</td>
<td>3</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td>Stepbrother</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td>Uncle</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td></td>
<td>Friend/Neighbor</td>
<td>4</td>
<td>15.4</td>
</tr>
<tr>
<td></td>
<td>Brother-in-law</td>
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<td>3.8</td>
</tr>
<tr>
<td><strong>More than one relationship:</strong></td>
<td>including incest</td>
<td>2</td>
<td>7.7</td>
</tr>
<tr>
<td></td>
<td>not including incest</td>
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<td>3.8</td>
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<tr>
<td><strong>Previous Mental Health Treatment</strong></td>
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<td>12</td>
<td>46.2</td>
</tr>
<tr>
<td></td>
<td>No</td>
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<td>46.2</td>
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<tr>
<td></td>
<td>Missing data</td>
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<td>7.7</td>
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<td>46.2</td>
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<td></td>
<td>For sexual abuse</td>
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<tr>
<td></td>
<td>Depression</td>
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<tr>
<td></td>
<td>Marriage counseling</td>
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</table>
### Summary of Sample Characteristics for Noncontinuous Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Subvariable</th>
<th>n</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Profile</strong></td>
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<td>23.1</td>
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<tr>
<td></td>
<td>Married</td>
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<td>46.2</td>
</tr>
<tr>
<td></td>
<td>Divorced, widowed, separated</td>
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<td><strong>Current Legal Charges</strong></td>
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<tr>
<td></td>
<td>2nd degree felony</td>
<td>15</td>
<td>57.7</td>
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<tr>
<td></td>
<td>3rd degree felony</td>
<td>5</td>
<td>19.2</td>
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<tr>
<td></td>
<td>Misdemeanor</td>
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<td>3.8</td>
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<tr>
<td></td>
<td>Sentence suspended</td>
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<td>No formal charges</td>
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<td>3.8</td>
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<tr>
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<td>No formal charges</td>
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<tr>
<td></td>
<td>Missing data</td>
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<td>3.8</td>
</tr>
</tbody>
</table>