Components underlying sex offender treatment refusal: An exploratory analysis of the Treatment Refusal Scale - Sex Offender Version

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Components underlying sex offender treatment refusal: An exploratory analysis of the Treatment Refusal Scale - Sex Offender Version.

Around half of sexual offenders in prison and community settings refuse to participate in sex offender treatment programmes; however the reasons for this remain largely unexplored. This pilot study used the previously untested Treatment Refusal Scale - Sexual Offender Version (Marshall, Mann & Webster, 2009) in an English prison, with 72 adult males (63 treatment accepters and 9 treatment refusers) imprisoned for sexual or sexually motivated offences. Principal Factors Analysis revealed three factors within the scale: 'Pressured to take part in programmes'; 'Fear of negative effects'; and 'Programme is not relevant to/appropriate for me'. Treatment refusers scored more highly than treatment accepters on the first and last components, whilst there was no statistically significant difference in the scores of the two groups on the 'Fear of negative effects' component. Suggestions for further development of the Scale are discussed along with the practice implications of these findings.

Keywords: sex offender; treatment acceptance; treatment refusal scale; motivation to change; treatment readiness; treatment engagement

Introduction

In 2002 it was estimated that around half of the prison sex offender population in England and Wales refused treatment (Offending Behaviour Programmes Unit, 2002). In Canada a similar proportion of 778 community based sex offenders assessed from 1996 to 2003 expressed a desire for treatment, with two-fifths actually attending treatment, though these proportions declined significantly in the later decades (Langevin, 2006). In a US prison sample, Clegg, Fremouw, Horacek, Cole & Schwartz (2011) found that 38% refused treatment, with 39% initially accepting treatment but later during treatment becoming non-compliant. Whilst it might be tempting to believe that sex offenders are more likely than others to refuse treatment, such refusal rates are not unusual; for example, Melamed and Szor (1999) reported that in all areas of medicine, including mental health/psychotherapy, that 40 to 50% of patients fail to comply with treatment, with only one-third complying fully with treatment. One-third may occasionally/partially comply, whilst one-third do not comply at all. Understanding why sex offenders refuse treatment should help to increase the numbers of offenders who engage with treatment programmes, and could have wider benefits, as it is likely that some of the issues might have relevance to other groups of offenders and patients.

Despite the potential of increased engagement with treatment and rehabilitation efforts, there is a dearth of research investigating why sex offenders refuse treatment. Some offenders refuse treatment because they deny their offence(s) but many others acknowledge at least some aspects of their sexual offending and refuse treatment. When treatment non-completion is examined, it tends to be a comparison of those who *complete* treatment with those who do not, i.e. those who start treatment and later *drop-out* (Clegg et al., 2011; Langevin, 2006; Nunes, Cortoni & Serin, 2010). Very few studies have compared offenders who refuse to engage with treatment, or who fail to start it with those who start, or complete it.

In 1993, Thornton and Hogue, who were experienced HM Prison Service (England and Wales, UK) affiliates, discussed treatment refusal explaining that it was related to offenders' concerns over judgements being made of their levels of risk, fears regarding the possibility of making 'damaging revelations' in treatment, and fears concerning other offenders being able to identify them as sexual offenders. Thornton and Hogue also proposed that the prison regime may have an impact upon offenders' decision making, suggesting that prisoners may be reluctant to transfer to a prison offering treatment if they viewed that it offered fewer privileges than the current prison. The authors also commented on prisoners being exposed to gossip (pro or anti-treatment) that may affect offenders' views about treatment, and ultimately their acceptance or refusal of it. Whilst these suggestions seem logical, this discussion (Thornton & Hogue, 1993) was largely anecdotal and was not empirically based. Furthermore, the paper was published only two years after sex offender treatment programmes were systematically introduced into prisons in England and Wales. At this time treatment programmes were still relatively novel in prisons in the UK and this might have had a bearing on refusal rates/reasons at that time. Later research by Mann (2009), a number of years after sex offender treatment programmes were introduced into prisons, found that prisoners who were not well informed about treatment had drawn cynical conclusions about its aims. Hence it could be considered that lack of information about treatment may affect treatment acceptance.

Most studies examining the issue of treatment compliance compare groups of treatment completers, with groups of offenders who start treatment but who fail to complete it. Research that specifically investigates the issue of treatment 'willingness' is scarce. Jones, Pelissier and Klein-Saffran (2006) conducted research exploring factors predictive of sex offenders volunteering for and then entering treatment, using a USA based samples of sex offenders who offended against minors incarcerated in Federal prisons. They found that the likelihood of volunteering for treatment was significantly increased if the individual had higher motivation to change scores (assessed using Prochaska &

DiClementa's (1986) measure), had received treatment for sexual deviance prior to incarceration and if a judge had recommended treatment. The likelihood was significantly decreased if the offender had a substance use problem. Jones et al. found that the only predictor of refusing treatment after consenting and being placed on the waiting list, and of being refused entry to treatment by staff, was the internal motivation of offenders, with those having lower motivation to change scores being more likely to be rejected for treatment and to refuse it once on the waiting list.

Clegg et al. (2011) included three groups of offenders incarcerated in a medium secure State prison (USA) in their study: compliant (never refused treatment and in the later stages of treatment), noncompliant (those who dropped out or were expelled) and refuser (those who had never accepted treatment). Whilst noting the limitation in the study design that the compliance group might have dropped out of treatment prior to its completion, these researchers found significant differences between the three groups. For example, treatment refusers scored more highly on the social desirability scale within the Minnesota Multiphasic Personality Inventory–2 (MMPI) compared to treatment accepters. Clegg et al. also observed that a significant predictor of treatment refusal was increased time until parole eligibility. Having entered a not-guilty plea in court was the only significant predictor of noncompliance among those who initially accepted treatment. The authors suggest that an impending parole hearing may provide sufficient motivation to start treatment but that those who start for this reason are not able to complete, highlighting an external factor in relation to motivation for treatment.

Theodosi and McMurran (2006) explored motivation as a dynamic factor affecting treatment refusal. They examined the effect an adapted semi-structured motivational assessment would have on treatment refusers' motivation for treatment in a small (n=9 in both treatment and control groups), white, British sample of sexual offenders incarcerated in a Special prison for sex offenders

in Wales, including both denying and non-denying treatment refusers. The authors found that more participants in the group who had the motivational assessment showed a positive motivational shift towards treatment (n=5) than the control group (n=2) who did not receive the assessment. Whilst Theodosi and McMurran accept that the small sample size limits the reliability of these findings, they find support for the role of the motivation assessment in shifting offenders towards treatment, though more research is needed to establish if these shifts actually resulted in treatment completion.

These prison-based studies consider different variables, so it is difficult to draw firm conclusions from them, although motivation is observed as a factor in two studies (Jones et al., 2006 & Theodosi & McMurran, 2006), one conduced in the USA and the other the UK, suggesting that this is a factor that deserves more research attention and the wider uses of motivation strategies in practice. The use of motivational interviewing is supported, for example, with the impressive results of Anstiss, Polaschek & Wilson (2011) who found that brief (four hour) intervention had a significant impact on increasing prisoners' (moderately high risk sample of mixed prisoners in New Zealand) readiness for change and reducing reconviction (by 21%) and re-imprisonment (17%) rates (mean time at liberty was 445 days) compared to prisoners treated as normal.

It is possible that factors associated with treatment refusal differ between prison and community settings, though only one study to date (Langevin, 2006) has investigated this issue in a community sample of sex offenders, and so it is difficult to assess such differences comprehensively. Langevin (2006), with the sample discussed at the start of this paper, conducted a quantitative empirical study exploring the link between desire for treatment and treatment attendance with a number of demographic/observable and psychological factors that had been identified in the literature as distinguishing treatment completers from treatment drop-outs. 'Treatment' was any type of treatment and so the findings are not specific to any particular approach. Langevin found that younger offenders were more willing to engage with treatment, and single men were more likely

than married men to actually start treatment (no difference in levels of desire for treatment). It is of note that these characteristics are not amenable to change and Langevin notes that the links are statistically weak such as to have little practical impact. Perhaps not surprisingly offenders who were not charged on apprehension provided they entered treatment, were the most likely to state a desire for treatment and enter treatment, though even here, only half this group actually entered treatment (two-thirds claimed a desire for treatment). Sex offence recidivists were more likely than non-recidivists to both desire and enter treatment; whilst offenders who had previously been to prison were more likely to claim a desire for treatment but they were not equally likely to attend treatment compared to those with no prior period of incarceration. Langevin also concluded that those denying their offences and those denying having sexual disorders were less likely to want or participate in treatment.

So far this paper has focussed on treatment *refusal*; however, treatment refusal is a concept closely linked to motivation to change, treatment engagement and treatment readiness. These concepts are linked and these terms are sometimes used interchangeably. Treatment refusal can be seen as the absence of motivation to change, an extreme lack of engagement, and/or a lack of readiness to change. Serin, Kennedy, Mailloux and Hanby (2010, p. 19) described treatment readiness as:

> a domain that captures an individual's willingness to engage in the treatment process. For some, they see themselves as having few problems that require therapeutic intervention and do not have any desire to make changes. These individuals tend to be forced into treatment and are reluctant to put forth any effort into changing.

Serin, Mailloux and Kennedy's (2007; see also Serin et al., 2010) Treatment Readiness Scale has eight factors: problem recognition; benefits of treatment, treatment interest, treatment distress, treatment goals, treatment behaviours, motivational consistency, and treatment support. The Treatment Readiness Scale is reliable (Serin et al., 2010) and in unpublished research (discussed by Serin et al., 2010) can distinguish between offenders in terms of programme attrition (Stewart, 2005; Watson & Beech, 2002) and recidivism (Lee, 2005); however it does not appear to have yet

been validated with treatment refuses and treatment accepters. Despite the important of the concept of readiness to change, to work with offenders who refuse to participate in treatment and to enhance engagement and motivation in treatment, this area/these areas of research is/are still rather embryonic.

In recognition of research findings such as those discussed here, Ward, Day, Howells and Birgden's (2004; see also Day, Casey, Ward, Howells & Vess, 2010) proposed in their Multi-factor Offender Readiness Model (MORM) that treatment readiness is a function of person, programme and contextual factors. Moreover, they argued that by understanding and addressing such factors an individual may engage better with treatment. The authors pointed out that there has been little attempt to distinguish between three related but distinct concepts: motivation, responsivity and treatment readiness. Whilst motivation refers to whether an individual wants to enter treatment and the extent to which they are willing to change, *responsivity* (Andrews, Bonta, & Hoge, 1990; Andrews, Bonta & Wormith, 2011) focuses on the use of a style and mode of treatment that is most appropriate, most engages an individual (i.e. designing/adjusting treatment delivery to maximise learning) and has been demonstrated to be effective (e.g. cognitive-behavioural therapy), and *readiness* is concerned with the presence of conditions that are required for such engagement and, therefore are likely to enhance therapeutic change (for more information about these three concepts, see Day et al., 2010).

Howells & Day developed their interest in treatment readiness during work evaluating the impact of anger management problems in Australian prisons, which led to their 2003 paper (Howells & Day, 2003) identifying seven impediments to readiness for anger management (see also Ward et al., 2004; Day et al., 2010). This work was expanded and applied to all forms of offender rehabilitation programmes in the MORM (Ward et al., 2004). The key assumption underpinning this model is that treatment readiness is a function of both internal (person centred factors: cognitive, affective,

volitional, behavioural and identity factors) and external (context factors: circumstances, location, opportunity, resources, support, programme and training) factors. Both types of factors combine to increase likelihood of treatment engagement. Those who are ready to enter a specific programme, are seen as possessing a number of core psychological features that enable them to benefit from treatment, as they are able to engage at least minimally in the programme. The MORM's internal and external factors are expected to have a direct relationship with treatment engagement and performance, which in turn should lead to reductions in risk levels, recidivism rates. Despite the development of the MORM, the authors' call for more research addressing these factors and the apparent importance for interventions with a wide range of offenders/clients, further studies exploring these internal and contextual factors were not plentiful and what these factors are remains unclear and untested.

Ward et al. (2004) noted that a starting point in working with offenders regarded as 'resistant', 'untreatable' or 'challenging' would be to first identify the internal and external MORM conditions that are required for treatment engagement; and then to work on increasing readiness by modifying the client, therapy/programme and/or setting. Ward et al.'s intention was to provide a conceptual framework for practitioners involved in treatment delivery/engagement. This framework/model was used by Marshall, Mann and Webster (2009) to conceptually/theoretically develop the Treatment Refusal Scale – Sexual Offender Version (TRS-SO). This was designed to explore why sex offenders refused treatment and was developed following research in prisons in England and Wales that explored sex offenders' explanations for their refusal to engage in treatment (Mann & Webster, 2002; Mann, 2009). These reasons included offenders' lack of trust in professionals, and beliefs that treatment would cause distress and only focus on the details of the offence.

The TRS-SO has not to date been empirically validated and the aim of this study was to conduct a pilot study to investigate the factors underlying sex offenders' refusal; that is the factorial structure of the TRS-SO. The scale (available at www.rockwoodpsyc.com) includes questions relating to context as well as person factors, and directly asks participants their views about sex offender treatment. By the very nature of their refusal to engage with treatment professionals, treatment refusers are a difficult group to research in sufficient numbers to ensure statistical rigour. This study compares a small sample of treatment refusers with a larger sample of treatment accepters and although the sample size is far from ideal, the study explores the factorial structure of the TRS-SO, investigates the reliability of the resulting sub-scales and then compares the scores of both groups of offenders on the resulting scales. It was hypothesised that there would be statistically significant differences in the two groups' responses on these sub-scales.

To our knowledge this is the first empirical assessment of the scale and the aim was to conduct a pilot study to assess whether the scale would be useful for practitioners, requires further development and/or merits further research. Like Theodosi and McMurran (2006), denying treatment refusers and non-denying treatment refusers were included in the treatment refuser group and in line with Clegg et al. (2011) treatment accepters included those who completed treatment, as well as those who consented but were yet to completed treatment.

Method

Participants

Participants in this quasi-experiment were selected depending on pre-identified characteristics (adult male prisoner convicted of a sexual offence either accepting or refusing treatment, regardless of whether the offences were denied or not). The observable independent variable was treatment status (treatment accepters consisting of treatment completers and consenters; and refusers consisting of deniers and non-deniers). Prison records at an English prison with a population solely

consisting of prisoners with at least one conviction for a sexual or sexually motivated offence were accessed and the treatment status of prisoners was identified from this. Prisoners who had refused or accepted sex offender treatment were identified.

The whole population of treatment refusers at the prison (totalling 69 prisoners) were sent the call for participation/participant information sheet. In addition, a random sample of 168 men was selected from the 771 treatment accepters in the prison. In both groups, offenders who responded to the call for participation and later consented to take part in the research became the research participants (9 refusers and 63 accepters). Thus 13% of the prison population of refusers and 38% of the population of accepters took part in the research. The low percentage of refusers agreeing to take part in the research is unfortunate and it is difficult to engage this group in research, so it is likely to be a factor in similar future studies. The published studies that have investigated this issue to date have used routinely collected/recorded data and retrospective archival designs, whereby the 'participants' have no active role in the research process. This study required all participants to complete the TRS-SO and so it is not possible to ascertain whether this is a 'typical' response rate for such a group of offenders.

Seventy two adult male convicted sex offenders took part in the study. All had been assessed as being suitable for the 'Core' sex offender treatment programme and so would have IQs above 80 and an ability to understand the requirement of the standard programme (i.e. learning difficulties/disabilities should not be a feature of this group). Of the nine treatment refusers, six participants were known to be maintaining their innocence in relation to their current offence and three were not maintaining their innocence. Of the 63 treatment accepters, 52 had completed treatment, while 11 had consented and were waiting to be assigned to a group. Table 1 details the demographic information of the sample. There was a significant difference in age between

treatment group, such that refusers had a significantly higher age than accepters (t(70)=2.204, p=0.031). Although there was a large difference in the sizes of the two groups, analyses were conducted to see if there were significant differences between the groups in the other variables listed in Table 1. As the small numbers meant that the cell frequency minimums for Chi-squared analyses were violated, Fisher's exact tests (FET) were conducted. There was no significant difference in respect of: ethnicity (p=0.688; FET); number of previous convictions (p=0.220; FET); victim type (p=0.855; FET); victim age (p=0.760; FET) and victim gender (p=1.000; FET). There was a significant difference in sentence type (p=0.031; FET) whereby more accepters than refusers had Indeterminate Public Protection (IPP)[1] sentences and more refusers than accepters had determinate sentences[2].

Table 1 about here

Materials

Treatment Refusal Scale – Sexual Offender Version (TRS-SO; Marshall et al., 2009). This was administered in the form of a booklet (which also included demographic questions to provide sample details as outlined above). The treatment survey begins with 10 yes/no response questions

[1] The Indeterminate Sentence for Public Protect (IPP), which came into effect in England and Wales in April 2005, has two parts. Prisoners serve a period of imprisonment set by the judge (e.g. 5 years), the 'tariff', which is the minimum time the prisoner will serve. When the tariff ends, release is determined by the Parole Board and prisoners can serve considerable periods of time in prison beyond the tariff period: there is no automatic right to be release at a specific date, or after a specific period of time. IPP prisoners are released on license in the community (supervised by the probation service and subject to recall to prison for a number of reasons including breach of license conditions, and/or further offence). After 10 years, IPP prisoners can apply to the parole board for the license to be removed. IPP sentences are usually given to someone who has been convicted of a serious specified violent or sexual offence, for which the maximum sentence is 10 years or more and who, in the court's view, poses a significant risk of serious harm to the public.

[2] A determinate sentence has a fixed period of time set by the judge. In England and Wales, depending on a number of factors, e.g. the type of crime committed, length of sentence, part of this time will be served in prison and the remainder on licence in the community (supervised by the probation service and subject to recall to prison for a number of reasons including breach of license conditions, and/or further offence). Some prisoners serve the entire sentence in prison and are released when the fixed period has been served. If released on licence, the license ends at the end of the fixed period (e.g. an offender sentence to four years may serve two years in prison and then two year on licence in the community, or four years in prison).

that assess whether the individual has been asked to complete a prior offence-related programme, has completed a prior programme, denies his current offence, and the reasons why he might enter a programme (e.g. would you enter an offence-related group programme only if it would help you get earlier parole?). Since the questions were categorical, they were not included in the analysis of the TRS-SO scale, which refers to the 40 questions assessed using a 1 (completely false) to 5 (completely true) likert scale. Questions assessed individuals views on a number of factors related to treatment completion, e.g. 'I have had bad experiences with professionals', 'I feel like people put a lot of pressure on me to enter offence-related group programmes', 'Prison programmes don't address the issues that will actually help me'. The reliability and validity of the scale is not known as this is the first analysis of this tool. The scale was scored by adding up individual item scores within sub-scales once the sub-scales were identified.

Procedure

Ethical clearance to conduct this study was obtained from the Governor of the prison and the relevant ethics boards. All participants were given full information about the study prior to consenting to take part, which stressed that participation was voluntary and provided information about avenues for withdrawal from the study. In addition, offenders were provided with debrief information after completing the research. Prisoners who responded to the call for participants were seen individually in a designated room and asked to read the participant information sheet and then sign the consent form if they wished to participate in the study. Following this, participants were given the booklet to complete, which took approximately 15 minutes per person. Offenders were able to ask questions if they so needed. Data was entered into a Predictive Analytics Software (PASW®) file for analysis using principal factors analysis with orthogonal (varimax) rotation and MANOVA.

Results

The scale was scrutinised to determine which items should be reversed scored. As item 10 (I spend a lot of time thinking about the future (e.g. what I will do when I get out)) did not clearly indicate a view that would either support or reject treatment completion, reflected in a variable pattern of positive, negative and lack of correlations with the other factors in the scale, it was excluded. Items 12 (My family and friends want me to take part in an offence-related group programme), 30 (The benefits of participating in offence-related groups have been explained to me) and 32 (I can think of a number of problems I would like to address in an offence-related group) were reverse scored, such that higher overall scores on the scale indicate thoughts/attitudes that support treatment refusal.

Initial analysis of the data (there were no missing values) for the 39 items (item 10 excluded) indicated high internal reliability using Chronbach's (1951) alpha (alpha = 0.846). The mean score for the entire sample (n=72) was 87.6 (sd=17.2) [the minimum score is 39 and maximum score 195, which would indicate that the average response was not overly negative in respect of treatment completion; a score of 78 would indicate the choice of 'somewhat' false (score of 2) to most of the statements]. The mean response for treatment accepters was 86.4 (sd=15.1; minimum score 57; maximum score 125), while the mean for treatment refusers was 95.9 (sd=27.6; minimum score 53; maximum score 134), though there was not a statistically significant difference between the two groups (t=-1.01; df=8.7; p=0.170).

The correlation matrix was examined and items 5 (There are many people in prison who will take advantage of, or bully, other inmates), 6 (I am looked up to by other inmates), 7 (I would be more interested in offence related groups if they were aimed at helping me have a better life), 18 (Since I have been in prison I have had experiences that have made me feel unsafe), 30 (as above) and 33 (I would enter an offence-related group that didn't just focus on offences) and 36 (One-to-one counselling is better than a group programme) were excluded as they did not correlate with the

other questions, had negative correlations with other questions, mixed patterns of correlations and/or the correlated item-total correlation was 0 or a negative correlation. The Chronbach's alpha for the remaining 32 items was 0.878. The mean score for the entire sample was 65.6 (sd=16.9) [the minimum score for the 32 item scale is 32 and the maximum score 160]. The mean response for treatment accepters was 63.9 (sd=15.0; minimum score 39; maximum score 103), while the mean for treatment refusers was 77.4 (sd=25.0; minimum score 38; maximum score 112). There was not a statistically significant difference (t=-1.59; df=8.84; p=0.074 between the scores of the two groups on the 32 item scale.

Data was subjected to principal factors analysis with orthogonal (varimax) rotation, with the number of factors extracted restricted to those with Eigenvalues greater than 1 (i.e. Kaiser's (1960) criterion). Items 13, 16, 17 and 35 were dropped from the analyses as they had individual KMO values of less than 0.5. The analysis of the remaining 28 items suggested the extraction of 8 factors that explained 67.3% of the variance for the whole sample (n=72), with Bartlett's Test of Sphericity reaching statistical significance at the $p<0.001$ level, thus demonstrating the factorability of the correlation matrix. The KMO measure of sampling adequacy was adequate for factor analysis (KMO= 0.780) with the small residuals indicating that the solution was a good one.

Inspection of the scree plot revealed that only three factors were appropriate. To aid in the interpretation of these three, orthogonal (varimax) rotation was performed. The rotated solution (see Table 2) revealed the presence of a simple structure, with all three factors showing a number of strong loadings. The three components together explained 43.2% of the total variance in the responses to the final 24 items. Where items loaded onto more than one factor, priority was given to the higher loading.

Table 2 about here

As Table 2 shows, 14 items 2, 8, 11, 12, 14, 15, 20, 21, 22, 25, 29, 34, 38 and 40 loaded onto Factor 1. This factor had high internal reliability (alpha = 0.822), explained 28.7% of the total variance and was subsequently interpreted as 'Pressured to take part in programmes'. In addition, eight items 1, 3, 4, 19, 26, 27, 28 and 31 loaded onto Factor 2, with good internal reliability (alpha = 0.785) and accounted for 8.0% of the total variance. This component was interpreted as 'Fear of negative effects'. A further six items 9, 23, 24, 32, 37, 39 loaded onto Factor 3 and accounted for 6.5% of the total variance. The alpha was less impressive for this component with an alpha of 0.546. This factor was interpreted as 'Programme is not relevant to/appropriate for me'.

A score was calculated for each of the three sub-scales based on the three factors and the means, standard deviations, minimum and maximum scores are shown in Table 3 for the refusers and accepters and the total sample. A one-way multivariate analysis of variance (MANOVA) was conducted to determine the effect of treatment status (accepter and refuser, independent variable) on the three subscales in the TRS-SO. The sample size was such that differences between non-denying treatment refusers' and denying treatment refusers' scores on the scales could not be analysed. Box's M was not statistically significant, indicating a lack of evidence of violation of the homogeneity of variance-covariance matrix assumption. The multivariate test of differences between treatment status (accepter or refuser) on the combined dependent variable was significant ($F(3, 68) = 9.203$, $p < 0.001$; Pillai's Trace = 0.289; partial $\eta^2 = 0.289$, with Pillai's Trace used due to relatively low sample size). An analysis of each individual dependent variable showed that there was a significant difference in respect of sub-scale 1 ($F(1,70) = 4.327$, $p=0.041$, partial $\eta^2 =0.058$) with refusers scoring more highly on this sub-scale than accepters. There was no significant difference in the scores of the two groups on sub-scale 2, 'fear of negative effects' ($F(1,70) = 0.439$,

p=0.510, partial η^2 =0.006). There was a significant difference for sub-scale 3, (F(1,70) = 26.912, p<0.001, partial η^2 =2.78) such that treatment refusers scored significantly higher than accepters.

Table 3 about here

The final scale with these three sub-scales has 28 items, with a good internal reliability (0.883). The means for the refusers (68.6) was considerably higher than the mean for the accepters (54.8) (see Table 3); however, an independent samples t-test revealed that there was not a significant difference between the total scores of the groups (t=-1.77; df=8.85; p=0.056). This is close to significance and the differences in scores between the two groups would have been statistically significant (p=0.007) if we had been able to assume equal variances between the two groups, which might suggest that the scale would differentiate between refusers and accepters if larger sample sizes and analyses with sufficient power were conducted.

Discussion

This exploratory study aimed to assess the validity/value of the TRS-SO Scale (Marshall et al., 2009) and revealed that it requires revision before it can be used reliably to assess offenders' beliefs in relation to treatment acceptance/refusal. Twelve questions had to be omitted from the original scale for a number of reasons during the analysis and whilst the resulting 28 item Scale and two of the sub-scales, 'Pressured to take part in programmes' and 'Fear of negative effects', demonstrated good internal reliability; the third sub-scale, 'Programme is not relevant to/appropriate for me', did not. Furthermore, the first sub-scale derived from Factor l, although internally consistent, seems to contain two elements: negative views of treatment programmes; and pressure to complete programmes. Work to revise the Scale, with a larger sample of treatment refusers, should consider if

this is actually two separate elements that could be developed into two sub-scales; and develop questions related to the third sub-scale, such that this scale demonstrates good internal reliability.

The 28 item scale developed as a result of this study could be used in work with offenders to encourage treatment acceptance. The sub-scale scores will identify offenders' key areas of concern, which can be used to plan the most effective strategy for each offender. For example, offenders scoring highly on the pressure to take part in programmes sub-scale need a strategy that does not make them feel that even more pressure is being applied; perhaps an intervention that provides more information about treatment and treatment successes and/or discussion with offenders who have completed the programme and found it to be useful (especially if they were initially sceptical about taking part). The Scale needs further development, however, before it can be used as a formal assessment or screening tool.

A second aim of this study was to identify a component based model within the TRS-SO (Marshall et al., 2009). The analysis revealed a three factor model, with the identified constructs being: 'Pressured to take part in programmes'; 'Fear of negative effects'; and 'Programme is not relevant to/appropriate for me'. The 'Fear of negative effects' component supports Thornton and Hogue's (1993) views that offenders had concerns regarding the negative effects of treatment and links to several of the findings of Mann (2009) who identified concern about side effects, stigma and expectation of hostile responses from others as barriers to treatment. However, this study revealed that treatment accepters and treatment refusers did not differ on the sub-scale linked to this component, which would suggest that although offenders have concerns about these issues, they in themselves are not enough to deter offenders from taking part in treatment. This finding needs replication and further investigation, as some of the negative effects are related to others knowing the individual has committed a sexual offence, as discussed by Thornton and Hogue (1993); an effect that would have been minimised in this study as the participants were located in a sex

offender only establishment. This component contains questions regarding negative experiences of professionals, which in Mann's (2009) study treatment refusers cited as a barrier to treatment. In the present study, accepters and refusers scored similarly on the entire sub-scale that included questions related to mistrust of professionals. This issue needs further investigation, as it might be that issues related to treatment professionals are cited as barriers in those who refuse treatment, though they do not actually deter treatment acceptance, and remain a concern in offenders who engage in treatment.

The negative views about treatment identified as part of Factor 1 in this study have been identified by others. Mann (2009) found that prisoners were not well informed about treatment and had drawn cynical views about it, and Thornton and Hogue (1993) suggested that prisoners were exposed to gossip about treatment that affected their views about it and in both cases, it was argued that these views affected offenders' acceptance/refusal of treatment. Whilst this study did not investigate how offenders had obtained their views regarding treatment, the 'Pressured to take part in programmes' component would appear to support the conclusions of these previous studies, and was linked to treatment refusal as refusers scored more highly on this sub-scale than treatment accepters.

Since sex offender treatment programmes are embedded into the Criminal Justice System in England and Wales and the participants in this study were located in a sex offender specific establishment, where sex offender treatment programmes are an integral part of the establishment, it is perhaps surprising that offenders hold these negative, perhaps cynical views. In this analysis, this element was contained in a component whereby offenders felt pressurised to take part in treatment and perhaps this is the key element in this construct, in that offenders who do not wish to take part in programmes and who perceive a constant 'pressure' to do something against their wishes, develop cynical attitudes about the programmes. Although prisoners are not compelled to participate in sex offender programmes, it cannot be said that their decisions in this regard are free

of external influences. This component suggests that pressure to complete treatment can be perceived as removing choice leading to a feeling of lack of autonomy. Without further research it is difficult to form conclusions of the origins of this view, or indeed how to intervene; however this could link with the type of sentence a prisoner has (with those on parole based sentences feeling pressure to demonstrate reduction in risk), or it could link to the way in which sex offender programmes are promoted to prisoners in the prison system. It is recommended that further research be conducted that includes analysis of this scale with sentence type to examine any effect of sentence on responses, linking with Clegg et al.'s (2011) research findings in relation to parole.

Caution is needed in developing interventions with prisoners who refuse treatment and score highly on questions in this component, as it is likely that the intervention will be perceived as further 'pressure' and could have the effect of increasing offenders' resistance to treatment. Intervention could consist of peer-mentoring and the promotion of the aims of treatment in a way that projects the benefits that might not be obvious to offenders who have no experience of treatment; for example, how the treatment could positively affect family/friend relationships and other future aims and goals as well as discussion of offending behaviour. This links with Theodosi and McMurran's (2006) finding that a motivational intervention exploring how offenders' aims may be affected by treatment refusal resulted in a positive motivational shift. Treatment providers may benefit from any such interventions taking a positive focus such as exploring the conditions required to maximise engagement rather than exploring barriers to treatment, in line with Ward et al.'s (2004) view of how to maximise engagement in treatment.

The third component revealed in this analysis is 'Programme is not relevant to/appropriate for me' and was linked to treatment refusal since treatment refusers scored higher on this component than treatment accepters. This component lacks internal consistency and contains questions that indicate that treatment refusers believe that group programmes are not relevant to their needs (e.g. I have no

problems that need to be dealt with in an offence-related group programmes, Prison programmes don't address the issues that will actually help me), and also questions that address other issues (e.g. My reputation is important to me, I have had no contact with the group providers) that might suggest an uncomfortableness with treatment itself, or the group nature of treatment. Further research is needed in relation to this component. It might be linked to cognitions in that offenders who deny or minimise their sexual offending may feel that programmes are not appropriate for them given their offences/circumstances. Langevin (2006) concluded that those denying their offences and those denying having sexual disorders were less likely to want or participate in treatment. Denial and minimisation have previously been associated with lack of motivation or readiness to change (e.g. Tierney & McCabe, 2002) and perhaps this component is an indicator of readiness to change, or lack of readiness to change in refusers.

Despite the important of the concept of readiness to change in work with offenders who refuse to participate in treatment and to enhance engagement and motivation in treatment, these areas of research have developed in different, independent trajectories and needs further research attention and a more co-ordinated approach in future years. Some of the factors included in Serin et al's Treatment Refusal Scale, for example, are also identified in this analysis and Serin et al.'s explanation of treatment readiness provides a good fit with the components of refusal identified here. Given this, the findings of this study are likely to be of relevance to those developing measures in all these domains; and those wishing to investigate treatment refusal and develop the Treatment Refusal Scale further should examine the scales developed in relation to these other concepts. A study that compares the responses of treatment accepters and refusers on scales of Treatment Refusal, Treatment Readiness and motivation to change would enhance our understanding of the links between these concepts, though it might be extremely difficult to engage sufficient numbers of treatment refusers in a study that requires the completion of a battery of

tests/scales. However, if achievable, such a study would help develop the measurement of these concepts further and inform the development of strategies that can 'prime', engage and motivate reluctant and difficult to engage offenders/patients.

To our knowledge, this is the first study exploring the reliability and component structure of Marshall et al.'s (2009) TRS-SO and it has identified interesting findings of relevance to treatment providers and suggestions for improvement/revision of the Scale; however the sample size is small, particularly in relation to the treatment refuser group. Tabachnick and Fidell (2007) cite Comrey and Lee (1992) in suggesting that as a rule of thumb, a minimum of 10 observations per variable is necessary to avoid computation difficulties, further that a sample size of 200 is fair, 300 good. Obvioulsy these requirements were not achieved in this study and our sample size is between very poor and poor according to these criteria, which is likely to have affected both the nature and reliability of the constructs identified. The treatment refuser group was difficult to recruit and clearly a larger sample should be recruited in future analysis and development of the TRS-SO. However, this is a difficult group to work with and engage in research due to their 'refuser' status and perhaps associated negative attitudes to treatment and research addressing this intervention. This poses a difficulty for both researchers and practitioners in understanding this group and their needs more fully. A larger sample size with treatment refusers varying in levels of denial would allow further analysis to explore the extent to which the issues identified are linked to denial and minimisation, or other aspects (e.g. offence type) linked to treatment refusal, which was not possible in this study.

Although the generalisability of the results of this study in relation to the population within the prison was good; for example, the ethnicity mix of participants was representative of the prison population at the time of sampling, wider generalisability is limited as all participants were from the same, sex offender only prison. This may affect the generalisability of the results to sex offenders in

mixed-offence prisons; for example, Thornton and Hogue (1993) discussed sex offenders fearing other prisoners finding out they had committed a sexual offence as a reason for treatment refusal. In a sex offender only site, this is not likely to apply. Future research involving the Treatment Refusal Scale should include a larger sample size of treatment refusers to inform extraction of constructs that underlie treatment refusal, and samples from mixed offence sites and community settings to address these issues.

In this study the same sample was used to determine the factors and the associated scale sub-scales, and to compare treatment accepters and treatment refusers scores on these sub-scales. This considerably limits the validity of these findings and follow-up studies using the revised scale and sub-scales should be conducted to establish the validity of these findings. It is also possible that responses to the scale were affected by social desirability, dissimulation and comprehension. The offenders were not deemed to be appropriate for a programme specifically designed for men with learning difficulties/disabilities; yet the Scale has not to our knowledge been tested for comprehension. Future studies and those developing these and similar scales should consider measuring a range of factors, e.g. denial, minimisation, motivation, treatment readiness, risk, comprehension and social desirability to more fully establish the validity of the scale and the comparability of the groups of treatment accepters and treatment refusers included.

Conclusions

This exploratory study aimed to assess the TRS-SO Scale (Marshall et al., 2009) and its usefulness for practitioners, and revealed that it requires further development before it can be used reliably as an assessment or screening tool. The Scale may currently have some merit in one-to-one work with offenders who refuse treatment to identify areas to address in interventions to engage offenders in treatment and establish the best strategy for such an intervention, taking particular care not to make

offenders already feeling pressured to take part in programmes feel even more pressure in this regard. A second aim of the study was to explore the component structure of the scale. Three components were identified and developed into sub-scales in the TRS-SO: 'Pressured to take part in programmes'; 'Fear of negative effects'; and 'Programme is not relevant to/appropriate for me'. Treatment refusers scored more highly on the first and last sub-scales but no differences between the groups were identified in the 'Fear of negative effects' sub-scale. This suggests that although these fears may be cited by treatment refusers, they are not in themselves, enough to deter individuals from completing treatment and these issues remain a concern throughout treatment. This study should be augmented by further research including a larger sample of treatment refusers to replicate these findings, and to examine the link between treatment refusal and offence denial. Furthermore, the link between treatment refusal, treatment readiness, motivation to change and treatment engagement should be more fully explored and the scales/measures developed within each of these constructs examined, as knowledge and practice in this area may be enhanced with a more integrated consideration of these linked concepts and the work conducted in each area to date.

References

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior,* 17, 19-52.

Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The Risk-Need-Responsivity (RNR) Model: Does adding the good lives model contribute to effective crime prevention? *Criminal Justice and Behavior,38 (7),* 735-755. doi: 10.1177/0093854811406356

Anstiss, B., Polaschek, D. L. L., & Wilson, M. (2011). A brief motivational interviewing intervention with prisoners: When you lead a horse to water, can it drink for itself? *Psychology, Crime and Law*, 17 (8), 689-710. doi: 10.1080/10683160903524325

Comrey, A. L., & Lee, H. B. (1992). *A First Course In Factor Analysis* (2nd Ed.). Hillside, NJ: Lawrence Erlbaum Associates.

Cronbach, L. J. (1951). Coefficient alpha and the internal structure of tests. *Psychometrika, 16(3)*, 297-334. doi: 10.1007/BF02310555

Clegg, C., Fremouw, W., Horacek, T., Cole, A., & Schwartz, R. (2011) Factors associated with treatment acceptance and compliance among incarcerated male sex offenders. *International Journal of Offender Therapy and Comparative Criminology*, 55 (6), 880-897. doi: 10.1177/0306624X10376160

Day, A., Casey, S., Ward, T., Howells, K., & Vess, J. (2010). *Transitions to Better Lives: Offender Readiness and Rehabilitation.* Cullompton, Devon: Willan Publishing.

Howells, K., & Day, A. (2003). Readiness for anger management : Clinical and theoretical issues. *Clinical Psychology Review, 23*, 319-37. doi 10.1016/S0272-7358(02)00228-3

Jones, N., Pelissier, B., & Klein-Saffran, J. (2006). Predicting sex offender treatment entry among individuals convicted of sexual offense crimes. *Sexual Abuse: Journal of Research and Treatment, 18(1),* 83-98. doi:10.1177/107906320601800106

Kaiser, H. F. (1960). The application of electronic computers to factor analysis. *Educational and Psychological Measurement*, 20, 141-151.

Langevin, R. (2006). Acceptance and completion of treatment among sex offenders. *International Journal of Offender Therapy and Comparative Criminology, 50(4),* 402-417. doi:10.1177/0306624X06286870

Lee, Y. (2005). Personal communication, 30 September 2005; cited in Serin, R. C., Kennedy, S. M., Mailloux, D. L., & Hanby, L. J. (2010). The origins of treatment readiness. In A. Day, S. Casey, T. Ward, K. Howells, & J. Vess. *Transitions to Better Lives: Offender Readiness and Rehabilitation* (pp. 12-26). Cullompton, Devon: Willan Publishing.

Mann, R. E. (2009). Getting the context right for sex offender treatment. In D. Prescott (Ed.), *Building Motivation for Change in Sexual Offenders.* Brandon, VT: Safer Society Press

Mann, R. E., & Webster, S. (2002, October). *Understanding resistance and denial*. Paper presented at the 21st annual research and treatment conference of the Association for the Treatment of Sexual Abusers. Montreal: Canada

Marshall, L. E., Mann, R., & Webster, S. (2009). *The Treatment Refusal Scale-Sexual Offender Version.* Unpublished Manuscript available http://rockwoodpsyc.com/outside/wp-content/uploads/2011/03/TRQ_Full-Package_May-2010.pdf

Melamed, Y. & Szor, H. (1999). The therapist and the patient: Coping with noncompliance. *Comprehensive Psychiatry, 40,* 391-395. doi: 10.1016/S0010-44X(99)90146-3

Nunes, K. L., Cortoni, F., & Serin, C. (2010). Screening offenders for risk of dropout and expulsion from rehabilitation programs: Enhancing correctional outcomes. *Legal and Criminological Psychology*, 15, 341-356. doi: 10.1348/135532508X401887

Offending Behaviour Programmes Unit (2002). *A strategy for Sex Offenders who Refuse Treatment.* London: Offending Behaviour Programmes Unit, HM Prison Service.

Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In Miller, W. R. & Heather, N. (Eds.), *Treating addictive behaviors: Processes of change* (pp. 3-27). New York: Plenum.

Serin, R. C., Kennedy, S. M., Mailloux, D. L., & Hanby, L. J. (2010). The origins of treatment readiness. In A. Day, S. Casey, T. Ward, K. Howells, & J. Vess. *Transitions to Better Lives: Offender Readiness and Rehabilitation* (pp. 12-26). Cullompton, Devon: Willan Publishing.

Serin, R. C., Mailloux, D. L., & Kennedy, S. M. (2007). Development of a clinical scale for offender readiness: Implications for assessment and offender change. *Issues in Forensic Psychology, 7,* 70-80.

Stewart, L. (2005). Personal communication, 15 September 2005; cited in Serin, R. C., Kennedy, S. M., Mailloux, D. L., & Hanby, L. J. (2010). The origins of treatment readiness. In A. Day, S. Casey, T. Ward, K. Howells, & J. Vess. *Transitions to Better Lives: Offender Readiness and Rehabilitation* (pp. 12-26). Cullompton, Devon: Willan Publishing.

Tabachnick, B. G., & Fidell, L. S. (2007) *Using Multivariate Statistics* (5th Ed.) Boston, MA: Pearson Education.

Theodosi, E., & McMurran, M. (2006). Motivating convicted sex offenders into treatment: A pilot study. *The British Journal of Forensic Practice, 8(3),* 28-35.

Thornton, D., & Hogue, T. (1993). The large scale provision of programmes for imprisoned sex offenders. Issues, dilemmas and progress. *Criminal Behaviour and Mental Health, 3,* 371-380.

Tierney, D. W., & McCabe, M. P. (2002). Motivation for change among sex offenders: A review of the literature. *Clinical Psychology Review, 22,* 113-129. doi: 10.1016/S0272-7358(01)00084-8

Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and Violent Behaviour, 9*, 645-673. doi:10.1016/j.avb.2003.08.001

Watson, H., & Beech, A. R. (2002). Predicting treatment drop-out in violent offenders using pre-treatment assessments. Unpublished manuscript; cited in Serin, R. C., Kennedy, S. M., Mailloux, D. L., & Hanby, L. J. (2010). The origins of treatment readiness. In A. Day, S. Casey, T. Ward, K. Howells, & J. Vess. *Transitions to Better Lives: Offender Readiness and Rehabilitation* (pp. 12-26). Cullompton, Devon: Willan Publishing.

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Table 1. Means (standard deviation) or percentages of demographic variables by group

	Accepter (n=63)	Refuser (n=9)	Whole sample (n=72)
Age	46.7 (14.4)	58.2 (16.5)	48.1 (15.1)
Ethnicity (%)			
White British	87	89	88
Non-white British	13	11	12
Sentence Type (%)			
IPP	49	11	44.4
Life	16	11	15.3
Determinate	35	78	40.3
Previous Convictions (%)			
0	49	45	49
1	16	33	18
2-3	22	0	19
4+	13	22	14
Victim Type (%)			
Family/step-family	33	33	33
Stranger	29	45	30.5
Acquaintance	32	22	30.5
Non-contact	6	0	6
Victim Age (%)			
≥16	14	22	25
<16	68	78	58
Both	13	0	11
Non-contact	5	0	6
Victim Gender (%)			
Male	14	11	14
Female	78	89	79
Both	8	0	7

n=72

Table 2. Component loadings, eigenvalues and percentage variance for each component

		Factor and Loadings		
Question		1	2	3
Factor 1: Pressured to take part in programmes				
2	Offence-related group programmes in prison are a waste of taxpayers' money.	.723		
34	When it comes to participating in offence-related group programmes, I don't feel like I am given a choice.	.721	.261	
21	If offence-related programmes are so good for me why do people keep trying to force me to do them?	.700		
8	I feel like people put a lot of pressure on me to enter offence-related group programmes.	.665		
15	Offence-related groups in prison do not work.	.551	.261	.455
25	If the offence-related group programmes didn't take so long I would be more interested.	.526	.202	
38	Treatment is only offered in prisons to make the public feel like the prison service is doing something.	.522	.330	
20	I don't want to be in an offence-related group where we keep talking about the past.	.500		
11	Programme providers don't understand me or my life.	.459		.381
14	Programme providers don't really care about group members.	.431	.377	
22	I have some problems in my life but the offence-related group programmes will not be able to help me with them.	.420	.303	.401
40	I keep telling people that I don't want to take part in an offence-related group programme but no one listens.	.405		
29	If someone explained the possible negative side-effects of being in an offence-related programme, I might be more interested.	.397		.273
12	My family and friends would want me to take part in an offence related programme group programme.	-.361		
Factor 2: Fear of negative effects				
27	I find it hard to trust people.		.605	
1	I have had bad experiences with professionals.	.246	.593	-.317
4	Staff members in prison don't believe that offence-related group programmes work.		.561	
3	I am concerned that taking part in an offence-related group would make me feel worse about myself.		.533	
19	Taking part in a treatment programme would/does make life more difficult for me.	.347	.509	.355
31	People taking part in offence-related groups are easy targets for other inmates.		.473	
28	I have seen other men who were in offence-related group programmes get worse.	.318	.418	
26	It takes a lot of sacrifice to make changes to your life.	.238	.418	
Factor 3: Programme is not relevant to/appropriate for me				
9	I have no problems that need to be dealt with in an offence-related group programme.	.234		.646
23	I only need to focus on how to get through my time in prison.			.620
24	Prison programmes don't address the issues that will actually help me.	.453	.236	.557
37	I have had no contact with group providers.			.401
39	My reputation is important to me.			.333
32	I can think of a number of problems I would like to address in an offence related group.			-.268

Table 3. Descriptive statistics for the Treatment Refusal Scale and sub-scales

Sub-scale	Number of items	Treatment accepter mean (sd) [min/max] n=63	Treatment refuser mean (sd) [min/max] n=9	Entire Sample (sd) [min/max] n=72	Cronbach's alpha
1. Pressured to take part in programmes	14	25.4 (8.4) [14/44]	31.9 (11.6) [15/49]	26.2 (9.0) [14/49]	0.822
2. Fear of negative effects	8	18.4 (6.0) [8/35]	20.0 (10.1) [8/37]	18.6 (6.6) [8/37]	0.785
3. Programme is not relevant/appropriate to/for me	6	11.0 (2.7) [7/19]	16.7 (5.0) [8/24]	11.7 (3.6) [7/24]	0.546
Total Scale	28	54.8 (13.8) [32/95]	68.6 (22.8) [34/97]	56.5 (15.7) [32/97]	0.883