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Sexual offenders' parental and adult attachments and preferences
for therapists' interpersonal qualities

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Abstract

This study explored sex offenders' parental and adult attachment difficulties and assessed the extent to which these were associated with preferences for therapists' interpersonal qualities. One-hundred and twelve adult male child sexual offenders were invited to provide self-report data on their attachment histories, adult attachments and preferences for therapists' interpersonal qualities. A weak relationship between childhood and adulthood secure attachment was found, suggesting that attachment at the time of offending may be more relevant than childhood attachment to the etiology of sexual offending. Participants valued a range of therapists' qualities previously identified as important for positive treatment change. Therapist trust and genuineness were perceived as particularly important by those with attachment difficulties, demonstrating the need for these qualities in offender programmes where attachment difficulties would be expected. There were some differences in the preferences for therapists' qualities between participants with different adult attachment types, highlighting the importance of responsivity factors in treatment.

Keywords: Attachment; child-sex offenders; therapist interpersonal qualities; sex offender treatment programmes; responsivity

Introduction

Attachment theory focuses primarily on the infant-parent attachment bond and its potential impact on a child's emerging concept of self, the social world and his/her interactions (Collins & Read, 1990). Early childhood experiences result in a cognitive representation of the self in relation to others and the environment, and thus provide the foundation from which individuals perceive and evaluate interpersonal relationships and regulate attachment-related behaviours throughout the lifespan (Bartholomew & Horowitz, 1991; Bowlby, 1980).

Although attachment is most essential in early life and attachment orientations are first formed with primary caregivers, Bowlby (1988) argued that it is active throughout life and the quality of relationships with attachment figures at any age can change a person's attachment orientation. Thus attachment schemas and behaviours, although relatively enduring under stable developmental conditions, are not impervious to change (Davila, Burge, & Hammen, 1997; Fuller & Fincham, 1995; Lewis, Feiring, & Rosenthal, 2000; Vaughn, Egeland, Sroufe, & Waters, 1979; Weinfield, Sroufe, & Egeland, 2000).

Many theoretical models of sexual offending implicate childhood and adult attachment problems in the development, onset and progression of sexually abusive behaviours (Beech & Mitchell, 2005; Burk & Burkhart, 2003; Marshall & Marshall, 2000; Marshall, Hudson, & Hodgkinson, 2003; Smallbone, 2005, 2006; Smallbone, Marshall, & Wortley, 2008; Smallbone & Cale, 2015; Ward & Beech 2006; Ward, Hudson, Marshall & Siegert, 1995). This is despite equivocal evidential support. The majority of studies in which childhood attachment has been investigated reveal that insecure attachments to parents are more prevalent among sex offenders than in other offender or non-offender populations (Marsa et al., 2004; McCarthy, 2004; Smallbone & Dadds, 1998). Marshall, Serran and Cortoni (2000), however, did not find differences in attachment insecurity between sexual and nonsexual offenders. Similarly, McCormack, Hudson and Ward (2002) found no consistent differences between sex offenders

and other offender groups. They did, however, find that rapists shared similar attachment experiences with violent offenders, compared to child sexual offenders and non-violent offenders; their fathers were less responsive than the fathers of other groups and both parents enforced looser boundaries. Problematic paternal attachment histories have also been identified in two separate samples of Australian sex offenders (Smallbone & Dadds, 1998; Smallbone & Wortley, 2000). Smallbone and Dadds (2000, 2001) demonstrated that insecure childhood attachment, particularly paternal attachment was linked to antisociality, aggression and sexually coercive behaviour in two separate samples of undergraduate students.

Greater proportions of sex offenders report insecure adult attachment styles compared to non-offenders (Baker & Beech, 2004; Jamieson & Marshall, 2000; Marsa et al., 2004; Sawle & Kear-Colwell, 2001; Smallbone & Dadds, 1998) or normative non-offender data (Stirpe, Abracen, Stermac, & Wilson, 2006; Ward, Hudson, & Marshall, 1996). This was only observed for non-familial sex offenders who had abused children in Jamieson and Marshall's (2000) study, with no differences demonstrated between incest offenders and community controls, suggesting a complex relationship might exist in relation to adult attachment and different groups of sex offenders. Stirpe et al. (2006) found that child molesters were more likely to have preoccupied insecure attachments, while incest offenders and rapists were more likely to have dismissing insecure attachments. Ward et al. (1996) found that child molesters were more fearful or preoccupied and less dismissive than rapists, who were similar to violent offenders. However, Smallbone and Dadds (1998) observed no differences between rapists and intra-familial or extra-familial child sexual abusers. With the exception of two studies (Lyn & Burton, 2005; Marsa et al., 2004), differences between sex offenders (e.g., adult-victim and child-victim offenders) and other groups of offenders have not been consistently observed in the majority of studies (Baker & Beech, 2000; Jamieson & Marshall, 2000; Smallbone & Dadds, 1998; Stirpe et al., 2006; Ward et al., 1996). Thus, insecure adult

attachment might be a general criminal vulnerability factor that increases the propensity to engage in antisocial (and for some sexually abusive) behaviours.

Bowlby (1988) argued that therapists can fulfil the three criteria he specified for attachment figures (Bowlby, 1982): they can be targets of proximity maintenance; provide a physical and emotional safe haven; and provide a secure base. Hence, “a therapist can serve as a safe haven and a secure base from which clients can explore and reflect on painful memories and experiences.” (Mikulincer, Shaver, & Berant, 2013, p.607) The development of a secure therapeutic relationship, therefore, may provide an otherwise insecurely attached individual with a safe place from which to explore and challenge maladaptive relational schemas and behavioural responses (Baker & Beech, 2004; Lyon, Gelso, Fischer, & Silva, 2007; Stirpe et al., 2006). In this regard, Smallbone and McHugh (2010) demonstrated in a sample of incarcerated adult male sex offenders a significant increase in secure attachment, and a decrease in fearful-avoidant attachment from pre to post-treatment, although no differences were found for preoccupied-anxious or dismissive-avoidant attached individuals.

In the general clinical/therapeutic literature, the importance of attachment to therapeutic processes and outcomes has been convincingly demonstrated (for a review see Mikulincer et al., 2013). Secure attachment to the therapist has been strongly, positively correlated with the therapeutic alliance (Bachelor, Meunier, Laverdière, & Gamache, 2010; Goldman & Anderson, 2007; Mallinckrodt, Gantt, & Coble, 1995; Mallinckrodt, King, & Coble, 1998; Mallinckrodt, Porter, & Kivlighan, 2005; Satterfield & Lyddon, 1998), which in turn is a good predictor of successful therapeutic outcome (e.g., Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Luborsky, 1993) accounting for, on average, about a quarter of the variance (Horvath & Symonds, 1991). Individuals with fearful-avoidant attachment styles tend to have the lowest therapeutic alliance ratings (Eames & Roth, 2000; Satterfield, & Lyddon, 1998).

Knowledge of how therapists' characteristics affect the therapeutic relationship is scarce and little research exists where the process issues of offender rehabilitation (compared to conventional psychotherapy) have been examined (Ross, Polaschek, & Ward, 2008). In a unique investigation of the association between therapists' behaviours in sex offender group treatment sessions and in-treatment changes (Marshall, Fernandez, Serran et al., 2003; Serran, Fernandez, Marshall & Mann, 2003), the personal characteristics of warmth, empathy and genuineness, and the professional characteristics of rewardedness and directiveness were associated with good client progress. These findings reflect those reported in the general psychotherapy literature (Ross et al., 2008). Aggressive, as opposed to collaborative, confrontation had negative effects on clients' progress (Serran et al., 2003). What is not known is how these factors relate to variations in the attachment styles of clients, particularly offenders, or those who have histories of insecure attachment relationships. Ross et al. (2008) discussed the potential difficulties of developing therapeutic relationships with offenders (when compared to more 'traditional' therapist-client relationship) and proposed the Revised Theory of the Therapeutic Alliance that is relevant to therapists who work to reduce future risk of criminal behaviour. In this model, the attachment styles of both the therapists and clients are included, along with the professional and interpersonal skills of the therapist.

The provision of sex offender intervention in many jurisdictions (e.g., Australia, Canada, New Zealand, UK and USA) is underpinned by the risk-needs-responsivity principles. According to the responsivity principle, programmes should be matched to clients' learning styles, levels of motivation, and personal and interpersonal circumstances (Andrews & Bonta, 2003). Specific responsivity relates to the individual characteristics of clients that make them more or less likely to respond to treatment, and general responsivity relates to treatment issues in relation to the match between these and the clients' learning styles (Andrews & Bonta, 2003). Andrews (2001) divided these factors into internal responsivity,

matching the delivery and pace of therapy to clients' attributes; and external responsivity, relating to a range of general and specific issues, as such consideration of clients' life circumstances, cultures and so on and the methods used in treatment. External responsivity can also be sub-divided into staff and treatment setting characteristics. Hence, consideration of the attachment styles of offenders and the characteristics of therapists is important for operationalising the responsivity principle, particularly, since it could be assumed that offenders' preferences for particular therapists' interpersonal qualities may differ depending on their attachment experiences.

Although there is some research on how the attachment styles of therapists affects their alliances with clients (see Mikulincer et al., 2013), very little is known about associations between sex offenders' attachment experiences and their preferences for the interpersonal qualities of their treatment therapists. As Marshall, Fernandez, Serran et al. (2003, p.207) have argued, "some effectiveness is likely to be attributed to differing styles of the therapist or in therapist' abilities to create conditions that maximise the full and effective participation of clients". Researchers (e.g. Horvath, 2000) have suggested that it is the clients' perceptions of therapist behaviours and interactions that determine treatment outcomes, rather than what the therapists actually say or do. Our aim, therefore, was to examine both the parental and adult attachments of sexual offenders who had abused children and the extent to which these were associated with preferences for therapists' interpersonal qualities. We expected that insecure childhood and adult attachments would be positively associated with ratings on all qualities except confrontational style. This is because all the qualities except confrontation can be argued to be positive and supporting. More specifically, we hypothesized that anxious attachment types would place higher importance on qualities that would provide reassurance about themselves and the state of the therapeutic relationship (e.g. therapist warmth, genuineness, optimism, acceptance) and those with avoidant attachments would

place importance on qualities that reduces the perception of rejection and judgment (therapist trust, genuineness, warmth). Finally, given the controversies regarding the impact of confrontational styles on client engagement and outcomes (see for example, Marshall & Moulden, 2006), we were also interested to examine offenders' perceptions of this quality and how this might differ according to each attachment orientation.

Method

Participants

Participants were 112 adult males serving a custodial sentence in Queensland, Australia for at least one sex offence against a child¹. Offenders were invited to participate in a confidential survey about their sexual offending histories and their experiences with the police, court system, and prison treatment programmes. Official demographic and offence history data were also collated directly from offenders' correctional files.

The average age of offenders at the time of participation was 45.01 years ($SD = 12.23$, range 20 - 84 years). Most (76%, $n = 85$) were aged between 30 and 60 years; 8% ($n = 9$) were under 30 and 16% ($n = 18$) were over 60 years of age. Most (87%) identified as non-Indigenous Australian, 10% as Indigenous Australian, 2% as Asian and 1% as New Zealand Maori. The majority of participants (46%) had completed some secondary education (up to grade 10; 15-16 years of age); 14% had a primary education only (i.e., to 12-13 years of age); 14% had completed secondary education (i.e., at 17-18 years of age) and 25% had completed tertiary level education (i.e., university or technical college). On average, participants were serving a sentence of 7.95 years ($SD = 6.05$, range 9 months to 30 years), most commonly for indecent treatment of a child (77%), maintaining a sexual relationship with a child (48%) and rape (41%). Other convictions included incest (10%), unlawful carnal knowledge of a child

¹ Victims aged under 16 years

(9%), indecent assault (3%), sexual assault (3%) and sexual homicide (2%)². The number of current sexual offences ranged from 1 to 116 ($M = 12.05$, $SD = 16.49$). One-quarter (25%) were serving a concurrent sentence for nonsexual offences. Just over one-quarter (28%) had previous sexual offence convictions and half (50%) had previous nonsexual offence convictions. Most participants ($n = 94$, 90%) reported that they committed their first sexual offence when they were adults (18 years or older), with 10% ($n = 10$) reporting that they committed their first sexual offence as adolescents (range, 11 to 17 years of age).

Measures

Participants completed a comprehensive 52-page self-report survey, only part of which is relevant to the current study. The measures used in this study are described below.

Childhood Attachment Questionnaire (Hazan & Shaver, 1986, cited by Collins & Read, 1990). Each participant was provided with three descriptions consistent with Ainsworth, Blehar, Waters, and Wall's (1978) three primary childhood attachment styles (secure, anxious/ambivalent, and avoidant) and was asked to rate separately for each parent the degree to which each description matched the parent's attitudes, feelings, and behaviour toward him as he was growing up. Ratings were recorded on a seven-point Likert scale ranging from 1 (not at all like my mother/father) to 7 (very much like my mother/father). This measure has previously demonstrated moderate to high test-retest reliability (range $r = .51$ for paternal avoidant to $r = .93$ for paternal secure) in a sample of incarcerated sexual offenders (Smallbone & Dadds, 1998). Moderate stability³ was also demonstrated in this sample (range $r = .70$ for paternal secure to $r = .87$ for maternal secure), with the exception of the maternal

² Many offenders were serving sentences for more than one offence; hence the percentages do not total 100%.

³ Test-retest data were calculated using a sub-sample of 25 offenders who completed the survey a second time on average six months following the initial survey administration.

and paternal anxious attachment measures ($r = .47$ & $r = -.07$ respectively), which were subsequently excluded from further analyses.

Experiences in Close Relationships Inventory (Brennan, Clark, & Shaver, 1998).

This 36-item self-report measure was used to assess adult attachment. The inventory yields scores on two attachment orientation subscales: (1) *attachment avoidance* - discomfort with interpersonal closeness, dependence, and intimate self-disclosure; and, (2) *attachment anxiety* - fears of abandonment and strong desires for intimate contact. Participants indicated how well each of 36 items described their typical feelings and orientation in adult romantic relationships on a 7-point Likert scale ranging from 1 (disagree strongly) to 7 (agree strongly). Low scores on both scales indicate a secure attachment orientation. Adult attachment styles were also derived using Brennan et al.'s (1998) computational guidelines: secure (low anxiety, low avoidance); preoccupied-anxious (high anxiety, low avoidance); fearful-avoidant (high anxiety, high avoidance); dismissive-avoidant (low anxiety; high avoidance). Test-retest coefficients for the sample in the present study were $r = .69$ for anxious and $r = .76$ for avoidant attachment, which are similar to those found by Lopez and Gormley (2002) among non-offender samples ($r = .68$ & $r = .71$ respectively). The construct validity and internal consistency of the subscales (avoidance $\alpha = .94$; anxiety $\alpha = .91$) were demonstrated by Brennan et al. (1998). Similar internal consistency results were obtained for the sample in the present study (avoidance $\alpha = .94$; anxiety $\alpha = .93$).

Therapists' interpersonal qualities. Several therapist interpersonal qualities (see Table I for the definitions of each item) identified from the literature as being particularly influential for therapeutic alliance, engagement and positive outcomes (Marshall, Fernandez, et al., 2003; Serran et al., 2003) were included in this study. Participants were asked to reflect on their experiences in treatment before rating the importance of each therapist interpersonal quality on a 7-point Likert-type scale ranging from 1 (not at all important) to 7 (extremely

important). We were not interested in gauging their views on therapy more generally. Rather our focus was to elicit participants' perceptions of therapist interpersonal qualities that they considered most important to them when participating in sex-offence specific treatment designed to prevent them from committing further sexual offences.

The measure demonstrated adequate internal consistency ($\alpha = .75$), with corrected item-total correlations for all scale items above the recommended cut-off of .4 (DeVellis, 2003). For shorter scales, like this, it is recommended that the mean inter-item correlation is also inspected (Pallant, 2011). The correlation for the sample in this study was .32, which falls between the optimal range of .20 to .40 recommended by Briggs and Check (1986). Significant positive correlations among the variables (see Table II) demonstrated construct and convergent validity.

[INSERT TABLE I ABOUT HERE]

[INSERT TABLE II ABOUT HERE]

Marlowe-Crowne Social Desirability Scale - Short Form C (MC-C) (Reynolds, 1982). This 13 true/false item measure was derived from the original 33-item Marlowe-Crowne Social Desirability (Crowne & Marlowe, 1960). Total scores range from zero (low) to 33 (high social desirability). The MC-C has demonstrated good internal reliability ($r_{kr20} = .76$; Reynolds, 1982) and strong correlations have been reported between the M-C Form C and the original Marlowe-Crowne scale by both Reynolds ($r = .93$) and Fischer and Fick (1993) ($r = .97$). Andrews and Meyer (2003) demonstrated the psychometric properties of the MC-C and its utility for measuring biased self-presentation on self-report measures within forensic contexts.

Procedure

Appropriate university ethics and corrections research approvals were obtained prior to conducting the study. Participants were initially approached by corrections staff and invited to participate in the study. Those who consented were then individually approached by a member of the research team to complete a detailed self-report survey. All participants were asked to provide details on their developmental histories, first and subsequent sexual contacts with children (whether or not these incidents had been the subject of criminal charges), and their experiences with the police, courts and correctional (including treatment) services. Participation was confidential and voluntary. As participants were asked to provide information on offences they may not have been convicted for, they were assured complete anonymity. However, participants were invited to provide their names for the purposes of follow-up contact to enable the second administration of the survey by 25 participants for the purposes of calculating test-retest reliability on relevant measures. Official demographic and offence history data were also collated directly from participants' correctional files. As some data had non-normal distributions, despite attempts at data transformation, Spearman's ρ correlations were used for determining significant relationships among these variables and nonparametric Kruskal-Wallis and Mann-Whitney U tests were used to assess differences in perceptions of therapists' interpersonal qualities between attachment types.

Results

Social desirability

The mean score for social desirability in this sample was higher ($M = 5.87, SD = 2.26$) than for the general population ($M = 5.37, SD = 3.13$), $t(105) = 2.26, p = .03$ but significantly lower than reported forensic norms ($M = 7.61, SD = 3.32$), $t(105) = -7.92, p < .001$, including those specific to child-sex offenders ($M = 7.03, SD = 3.45$), $t(105) = -5.29, p < .001$. This

indicates a relatively low response bias within the sample (Andrews & Meyer, 2003). As such, we did not control for socially desirable responses in this study.

Childhood attachment

Most ($n = 108, 97\%$) participants reported that their mothers were present in their formative years. Slightly fewer ($n = 101, 90\%$) reported that their fathers were present during this time. The bivariate correlations between maternal and paternal secure and avoidant attachment measures are shown in Table II. As would be expected maternal secure attachment was significantly, negatively correlated with maternal avoidant attachment ($\rho = -.69, p < .001$) and paternal secure attachment was similarly correlated with paternal avoidant attachment ($\rho = -.64, p < .001$). Maternal secure attachment was positively correlated with paternal secure attachment ($\rho = .35, p < .001$) and maternal avoidant attachment positively correlated with paternal avoidant attachment ($\rho = .27, p = .008$). Only a small negative correlation was found between maternal avoidant and paternal secure at a marginal level of significance ($\rho = -.17, p = .094$), while the correlation between maternal secure and paternal avoidant was not significant ($\rho = -.10, p = .324$).

Childhood secure and insecure attachment types were derived from participants' self-report ratings and are shown in Table III. Two-fifths ($n = 39$) were insecurely attached to both parents, while a quarter ($n = 23$) were securely attached to both parents. One-quarter ($n = 25$) were securely attached to their mothers but insecurely attached to their fathers, with the smallest group ($n = 12$) being insecurely attached to their mothers and securely attached to their fathers.

[INSERT TABLE III ABOUT HERE]

Adult attachment

Nearly all ($n = 106$, 96%) offenders reported having experienced an adult intimate relationship and therefore completed the adult attachment measure. Attachment classifications were computed from participants' ratings. Almost one-quarter ($n = 25$, 24%) were classified as secure; two-fifths ($n = 43$, 41%) as fearful-avoidant; a quarter ($n = 26$, 25%) as preoccupied-anxious; and one-tenth ($n = 12$, 11%) were classified as dismissive avoidant.

Childhood and adult attachment relationships

The bivariate correlations between childhood and adult attachment measures are shown in Table II. Only one small significant correlation was found: Paternal secure attachment was negatively correlated with adult avoidant attachment ($\rho = -.21$, $p = .04$). Upon examination of the categorical attachment variables, insecure childhood attachment demonstrated more stability into adulthood than secure childhood attachment into adulthood. As shown in Table IV, of participants who reported an insecure maternal attachment style, 84% reported an insecure adult attachment style; however, only 31% of those reporting a secure maternal attachment style also reported a secure adult attachment style. Similarly, 81% of those reporting an insecure paternal attachment style also reported an insecure adult attachment style, but only 33% of those reporting a secure paternal attachment style also reported a secure trait adult attachment style.

Therapist qualities

Means and standard deviations for therapists' qualities are shown in Table I. Participants rated *Trustworthy* as the most important quality, with *Genuineness* and *Optimistic* rated similarly as the next most important. *Warmth* was rated as the least important. Most of the average ratings were greater than 5 (with Warmth being close to 5 at 4.62). In the seven

point scale, five equated to ‘very important’, which demonstrates the importance ascribed by participants to these qualities.

Attachment style and therapist qualities

Childhood attachments. As shown in Table II, several significant, though small, correlations were found among childhood attachment measures and therapists’ qualities ratings. Therapist trustworthiness was negatively correlated with secure maternal attachment ($\rho = -.19, p = .04$) and positively correlated with avoidant maternal attachment ($\rho = .20, p = .04$). Therapist genuineness was negatively correlated with secure paternal attachment ($\rho = -.27, p = .006$) and positively correlated avoidant paternal attachment ($\rho = .21, p = .03$). Thus, those with less secure maternal and paternal attachment histories placed greater importance on therapist trustworthiness and therapist genuineness respectively.

Adult attachment. One small, positive correlation was found (see Table II) between attachment anxiety and therapist optimism ($\rho = .22, p = .02$) and a small, negative correlation between avoidance and therapist genuineness ($\rho = -.20, p = .04$). This indicates that preferences for therapist optimism were higher in anxiously-attached individuals, and that avoidant-attached individuals cared less for therapist genuineness.

We compared offenders’ ratings of therapists’ interpersonal qualities between maternal secure and insecure, paternal secure and insecure and across the four adult attachment types (see Table V). Mann-Whitney *U* tests revealed no statistically significant differences between the preference ratings of the securely and insecurely attached for either maternal or paternal attachments. Kruskal-Wallis tests indicated a statistically significant difference in preferences for therapist genuineness between the four adult attachment types ($\chi^2 = 9.39, df = 3, p = .025$). Mann-Whitney *U* tests were then conducted to evaluate pairwise differences among the four groups. A revised alpha level ($p = .01$) calculated using the

Bonferroni approach was employed to control for Type I error across tests. The results indicated significant differences between the fearful-avoidant (mean rank = 30.44, $n = 43$) and preoccupied anxious groups (mean rank = 42.54, $n = 26$), $U = 363.00$, $z = -2.64$, $p = .008$, $r = .32$), but not between fearful-avoidant and secure groups ($U = 421.50$, $z = -1.57$, $p = .12$, $r = .19$), or dismissive-avoidant group ($U = 166.50$, $z = -1.99$, $p = .047$, $r = .27$).

Kruskal-Wallis tests also indicated a statistically significant difference between preference for therapists' trustworthiness between the four adult attachment types ($\chi^2 = 12.42$, $df = 3$, $p = .006$). Pairwise comparisons indicated a significant difference between fearful-avoidant (mean rank = 29.73, $n = 43$) and preoccupied-anxious groups (mean rank = 43.71, $n = 26$), $U = 332.50$, $z = -3.32$, $p = .001$, $r = .40$, and between preoccupied-anxious (mean rank = 29.96, $n = 26$) and secure groups (mean rank = 21.88, $n = 25$), $U = 222.00$, $z = -2.54$, $p = .01$, $r = .36$. No significant differences were found between preoccupied-anxious (mean rank = 19.92, $n = 26$) and dismissive-avoidant groups (mean rank = 18.58, $n = 12$), $U = 145.00$, $z = -0.588$, $p = .56^4$, $r = .10$. Overall these findings indicate that, of the four adult attachment groups, preferences for therapist trustworthiness and genuineness were lowest in the fearful-avoidant group and valued most significantly by individuals in the preoccupied anxious attachment group.

Discussion

Insecure attachments in both childhood and adulthood characterised the majority of the offenders in this sample. Three-quarters of the sample reported insecure attachments to one or both of their parents and three-quarters insecure adult attachments. The rates of insecure attachment are higher than would be expected in the normal population and although the rates vary between the small samples in previous studies (Marsa et al., 2004; McCarthy,

⁴ Corrected for ties

2004; Smallbone & Dadds, 1998), support the contention that insecure attachment is a vulnerability factor for sexual abuse. Given that one-quarter of the offenders reported secure attachments in childhood or adulthood, attachment difficulties alone cannot explain sexual offending, and since many who experience insecure attachments, do not sexually offend, attachment vulnerabilities must interact with a range of other variables as suggested in contemporary models of sexual offending (Smallbone, Marshall, & Wortley, 2008; Smallbone & Cale, 2015; Ward & Beech 2006).

It might be assumed that individuals with secure childhood attachment histories would also demonstrate secure adult attachments. However, this is not demonstrated in this study. Only one-third of offenders who reported secure maternal attachments also reported secure adult attachments; similarly a third of those who reported secure paternal attachments also reported secure adult attachments. This reinforces the argument that other (more proximal) factors play a role in sexual offending. For example, when offending starts in adulthood, as was reported by the majority of this sample, other factors potentially lead to difficulties in adult attachment/adult relationships with situational variables (such as access to children and opportunities to offend) playing a role in the onset of abuse (see McKillop, Brown, Smallbone, & Pritchard, 2015; McKillop, Smallbone, Wortley, & Andjic, 2012; Smallbone & Wortley, 2000). Since, as Bowlby (1988) argued, attachment security can change throughout a person's life, it is perhaps more important to consider the quality of attachments to key figures in the lead up to sexual offending. For example, childhood attachment problems may be more important in offending that starts in adolescence, whereas adult attachment problems may be more significant in offending that starts in adulthood. As far as we know, this is not a dynamic that has been investigated to date but would be of interest in order to more fully understand the role of attachment in the development of different types of sexual abuse and/or the development of sexual offending at different stages during the life-course.

The therapist qualities of trustworthiness, genuineness, optimism, acceptance, empathy, confrontation and warmth were rated highly by the participants in this study, highlighting the importance of these in treatment providers. These characteristics have been demonstrated to be associated with positive sex offender treatment change (Marshall, Serran et al., 2003; Serran, Fernandez, Marshall & Mann, 2003) and the current study highlights the importance of the perception of these qualities by offenders. Aggressive confrontation (rather than collaborative confrontation) has been found to be associated with negative treatment progress (Marshall, Serran et al., 2003; Serran, Fernandez, Marshall & Mann, 2003) and perhaps the confrontation that was valued by the participants in the present study would be collaborative; perhaps 'challenging' would be a better description of this quality, although more research would be needed to examine this in more detail. It seems from the current study that individuals value confrontation/challenge in treatment (which might not be expected), with previous studies indicating that care should be taken in the way in which this is done to ensure a supportive/collaborative environment to maximise positive treatment outcomes.

We expected that insecure childhood and adult attachments would be related to preferred therapists' qualities, specifically that anxious attachment types would place higher importance on qualities that would provide reassurance and avoidant attachment types on qualities that reduce perceptions of rejection and judgment. This pattern was not consistently demonstrated in our study, perhaps because all the therapists' qualities were so highly valued. No differences in preference ratings were found between childhood attachment types, although trustworthiness was associated with maternal attachment and genuineness with paternal attachment. This suggests that it is important for offenders with maternal attachment difficulties for the therapist to 'say and do what they say they will do' and for therapists to be 'sincere and genuine' for offenders with paternal attachment difficulties. Since many

offenders experience both maternal and paternal difficulties and that these qualities are not mutually exclusive (i.e. it should not be difficult to be both trustworthy and genuine), the importance of these should be stressed in treatment programmes and treatment provider training.

Higher levels of attachment avoidance in adulthood were inversely related to preferences for therapist genuineness. Conceptually this makes sense as avoidance can be defined as the extent to which individuals are uncomfortable relying on attachment figures to provide support in times of need. It was also demonstrated that fearful-avoidant individuals placed less importance on therapist genuineness than the preoccupied anxious group. These individuals are likely to enter into treatment with the fear of rejection as they see themselves as unworthy and see others as rejecting and unreliable. They find it difficult to trust others although desire to be close, but are fearful of rejection and abandonment and therefore are not likely to feel safe. They are sensitive to cues of rejection and are likely to see others as disingenuous, which might explain why they then to have low therapist alliance ratings.

The preoccupied-anxious group rated trustworthy as more important than both the fearful-avoidant and secure groups. This group needs an attachment figure (i.e. a treatment provider) to say and do what they say they will; otherwise they are likely to feel rejected and to disengage (from treatment). Anxious adult attachment was positively correlated with therapist optimism, operationalised as 'the therapist believes that you will be able to improve your life'. As attachment anxiety is defined as the degree to which individuals are sensitive to cues of potential abandonment and rejection by attachment figures, anxiously attached individuals hold positive views of others and negative views of themselves and so look for optimism in others.

Overall, preferences for trustworthiness and genuineness were related to both childhood and adult attachment difficulties, suggesting that these two qualities are particularly

important. For these qualities to have an impact on engagement and the development of positive therapeutic alliances, it is vital that these qualities are *perceived* by treatment clients. Therapists' skills and qualities are often overlooked, or given limited focus in the provision of sex offender treatment and greater efforts should be made to ensure treatment providers display appropriate skills/qualities. Ensuring that treatment providers portray trust and genuineness to those receiving treatment, for example, could help to increase engagement in treatment and develop strong therapeutic alliances that in turn should be linked to positive treatment outcome. In this regard, assessing adult attachment in offenders could provide valuable information to treatment providers and, in keeping with the responsivity principle, treatment delivered in accordance with attachment needs.

There were variations in the preferences of individuals with different adult attachment types, which raises issues with sex offender treatment programmes, particularly those provided in groups, the most common form of delivery. In groups, the responses of other group members can be as important, perhaps more important, than those of the therapists and so group members will be anxious/avoidant/fearful about other group members in addition to the treatment providers. Groups are likely to include members with a range of adult attachment types, which is likely to lead to complex interactions and a range of potential attachment difficulties. A strong attachment to a treatment provider could perhaps be significantly impaired by negative responses/attachments to group members. On the other hand, it is possible that the interpersonal interactions occurring among group members might instill a sense of belonging and attachment to others. These within-group member relationships could therefore be used systematically to promote "remedial growth" (Frost, Ware & Boer, 2009, p.27), especially if such processes are facilitated by skilled therapists who are aware of, and effectively navigate through, the attachment difficulties present among group members. Fostering group cohesion, allowing social connections, inclusion and

bonding among group members in safe environments, therefore, cannot be discounted as a potential vehicle for positive change (Jennings & Sawyer, 2003). Further research is needed to determine whether these needs can be managed effectively in group programmes – for example, would it be more effective to have mixed groups of attachment types, or should groups be made up of individuals with similar attachment needs? Can treatment providers adapt their responses, and perhaps counter the potential negative impact of responses from group members, in accordance to the attachment needs of each individual with a group programme? Can group cohesion potentially enhance connectedness and attachments among groups members? Can strong therapeutic alliances be developed in group programmes with two or more treatment therapists? Responsivity issues have been frequently overlooked in the provision of sex offender treatment and a greater focus should be given to these. This might mean that treatment should be provided on a one-to-one (or two-to-one) basis, rather than in the current, most common group format, in order that treatment can be specifically tailored and adapted for each individual, and to enhance therapeutic alliances, maximise responsiveness and therefore treatment outcomes. Conversely, it might mean that the relationships between group members should be considered a therapeutic asset, for example in providing a range of possible targets of proximity maintenance, safe havens and/or secure bases.

This study is the first, to our knowledge, that considers offenders' preferences for therapists' qualities and links these to attachment needs. However, our sample size is modest, particularly when the sample is split into sub-groups, (e.g. in relation to the four types of adult attachment) and so the findings require replication. The participants were adult males incarcerated for sexual offences against children in Australia and so the findings may not be generalisable to other populations; however, since many sex offender programmes are delivered during incarceration, the findings of this study do raise the importance of greater

consideration of responsivity factors in treatment provided in this context, at least in Australia. The assessments of attachment were made on the basis of participants' self-reports, with the usual difficulties and potential problems associated with this. Socially desirable responding in this sample was higher than would be expected for the general population but lower than that expected for forensic populations, and test-retest correlations were comparable with data from non-offending samples. Finally, despite adequate reliability and validity checks for the therapists' interpersonal qualities measures, we acknowledge the narrow range of differentiation observed across these variables. This may, in part, be related to the nature and size of the sample. As such, we remain tentative in our conclusions and encourage replication of this research with a larger sample of adult male child sexual offenders to further evaluate offenders' perceptions of these qualities.

The aim of this study was to examine sex offenders' attachment difficulties and assess the extent to which these were associated with preferences for therapists' interpersonal qualities. In line with previous research findings, we found high levels of insecure childhood attachment histories and high levels of adult attachment problems. A strong relationship between childhood and adulthood secure attachment was not identified, suggesting that attachment to key figures at the time of the onset of offending may be of most importance, which requires greater consideration in the development of our understanding of the role of attachment difficulties and offending. Participants valued a range of therapists' qualities that had previously been identified as important for positive treatment change, highlighting the importance of these values being *perceived* by treatment clients, in order to enhance treatment engagement. Trust and genuineness were rated as particularly important by those with attachment difficulties, demonstrating the need for these in programme providers where attachment difficulties would be expected (e.g., in offender programmes). There were some differences in the preferences for therapists' qualities with participants with different adult

attachment types, highlighting the importance of responsivity factors in treatment and raising questions about how best to take account of differing attachment needs in group treatment.

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Table I: *Definitions, means and standard deviations of therapists' interpersonal qualities*

Quality	Definition	Mean	SD
Trustworthy	The therapist does what he or she says he or she will do	6.38	1.00
Genuineness	The therapist is sincere and genuine with you	6.02	1.44
Optimistic	The therapist believes that you will be able to improve your life	6.01	1.18
Accepting	The therapist accepts you for the person you are	5.93	1.41
Empathy	The therapist shows an understanding of how you are feeling	5.80	1.46
Confrontational	The therapist confronts you if you say or do something that the therapist disagrees with	5.23	1.87
Warmth	The therapist shows warmth to you and behaves warmly towards you	4.62	1.78

Table II: *Correlations between childhood and adult attachments and ratings of therapists' interpersonal qualities*

	2	3	4	5	6	7	8	9	10	11	12	13
1 Maternal secure attachment	-.69***	.35***	-.10	-.14	-.15	-.09	-.13	-.14	.12	-.19*	.08	-.04
2 Maternal avoidant attachment		-.17^	.27**	.08	.14	.14	.14	.10	.01	.20*	.10	.03
3 Paternal secure attachment			-.64***	-.16	-.21*	-.12	.05	-.27**	.09	-.18^	.02	-.01
4 Paternal avoidant attachment				.14	.12	.13	-.06	.21*	.10	-.19^	.04	.02
5 Adult anxious attachment					.25**	.17^	.19^	.01	.22*	.15	.17^	-.08
6 Adult avoidant attachment						-.12	-.05	-.20*	-.10	-.15	-.07	-.13
7 Empathy							.51***	.61***	.38***	.36***	.41***	.25**
8 Warmth								.37***	.31***	.21*	.35***	.31***
9 Genuineness									.29***	.67***	.37***	.36***
10 Optimism										.47***	.59***	.38***
11 Trustworthy											.44***	.39***
12 Accepting												.31***
13 Confrontational												

^ p < .10, * p < .05, ** p < .01, *** p < .001

Table III: *Attachment classifications in childhood (%)*

	Paternal	
Maternal	Secure	Insecure
Secure	23.2	25.3
Insecure	12.1	39.4

Table IV: *Attachment classifications in childhood and adulthood (%)*

Childhood Attachment		Adult Attachment	
		Secure	Insecure
Maternal	Secure	30.6	69.4
	Insecure	16.4	83.6
Paternal	Secure	33.3	66.7
	Insecure	19.4	80.6

Table V: Mean (SD) ratings of the importance of therapists' interpersonal qualities across attachment types

	Childhood Attachment Type			
	Maternal			Paternal
	Secure <i>n</i> = 50	Insecure <i>n</i> = 58	Secure <i>n</i> = 35	Insecure <i>n</i> = 65
Trustworthy	6.33 (0.93)	6.48 (1.05)	6.39 (0.90)	6.43 (1.05)
Genuineness	5.98 (1.42)	6.05 (1.49)	5.78 (1.55)	6.15 (1.40)
Optimistic	6.04 (1.20)	6.03 (1.17)	6.31 (0.92)	5.88 (1.32)
Accepting	6.02 (1.22)	5.91 (1.54)	6.14 (1.31)	5.92 (1.43)
Empathy	5.75 (1.38)	5.83 (1.56)	5.72 (1.54)	5.80 (1.49)
Confrontational	5.41 (1.64)	5.10 (2.08)	5.72 (1.49)	5.11 (1.99)
Warmth	4.51 (1.78)	4.75 (1.77)	4.77 (1.78)	4.48 (1.84)

	Adult Attachment Type			
	Secure	Fearful-Avoidant	Preoccupied-	Dismissive-
	<i>n</i> = 25	<i>n</i> = 43	Anxious <i>n</i> = 26	Avoidant <i>n</i> = 12
Trustworthy**	<u>6.28 (0.98)</u>	6.21 (0.91)	<u>6.88 (0.33)</u>	6.67 (0.78)
Genuineness*	6.20 (1.19)	<u>5.63 (1.60)</u>	<u>6.46 (1.14)</u>	6.50 (1.00)
Optimistic	6.04 (1.14)	5.83 (1.15)	6.35 (1.29)	5.92 (1.24)
Accepting	5.72 (1.65)	5.81 (1.37)	6.31 (1.12)	6.33 (1.37)
Empathy [^]	5.84 (1.21)	5.49 (1.56)	6.27 (1.37)	5.83 (1.75)
Confrontational	5.44 (2.02)	4.91 (1.94)	5.38 (1.92)	5.75 (1.36)
Warmth	4.33 (2.04)	4.33 (1.85)	5.15 (1.46)	5.25 (1.82)

[^] $p < .10$, * $p < .05$, ** $p < .01$

Underlined values indicate significant differences between pairs, $p < .01$; bold values indicate significant differences between pairs, $p = .001$