Affective Expression and Behavior in Sex Offenders

Peter F. Rausch

Western Michigan University

Follow this and additional works at: https://scholarworks.wmich.edu/dissertations

Part of the Clinical Psychology Commons, and the Counseling Psychology Commons

Recommended Citation
AFFECTIVE EXPRESSION AND BEHAVIOR IN SEX OFFENDERS

by

Peter F. Rausch

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education
and Counseling Psychology

Western Michigan University
Kalamazoo, Michigan
June 2003
AFFECTIVE EXPRESSION AND BEHAVIOR IN SEX OFFENDERS

Peter F. Rausch, Ph.D.

Western Michigan University, 2003

This analytic variable study examined potential differences that exist among juvenile and adult sex offenders on the emotional expressiveness variables of alexithymia and affective orientation, and three behavior variables including self-defeating behavior, risk taking, and reckless behavior. In addition, the adult sex offenders’ attachment style in current relationships was examined.

Research questions were tested by t-tests. The significance level for all analyses was set at the .05 level. An analysis of variance (ANOVA) was conducted to determine the primary attachment style of the adult sex offenders in current relationships.

Participants in this study were 47 juvenile sex offenders from a Midwestern, residential treatment facility, and 61 adult sex offenders from two community-based treatment programs in the Midwest. This study compared juvenile and adult subjects on five instruments: (1) the Toronto Alexithymia Scale (Bagby, Taylor, & Parker, 1992), (2) the Affective Orientation Scale (Booth-Butterfield & Booth-Butterfield, 1990), (3) the Self-defeating Personality Scale (Schill, 1990), (4) the Adolescent Risk Taking Scale (Alexander et al., 1990), and (5) the Reckless Behavior Questionnaire (Arnett, 1989). In addition, the adult subjects were administered the Relationship
Styles Questionnaire (Griffin & Bartholomew, 1994). Demographic information was also collected on all participants.

The findings of this study indicated that there were no statistically significant differences among the juvenile and adult sex offenders on the variables of alexithymia, affective orientation, and self-defeating behavior. There were significant differences between juvenile and adult sex offenders on the variables of risk taking and reckless behaviors, with the juvenile group reporting a higher degree of these behaviors. Forty-one percent of the adult sex offenders reported a secure attachment style in current relationships. An analysis of variance (ANOVA) was done on the adult sex offenders comparing the severity of their offense to their scores of reported degree of emotional expressiveness. There was a significant difference among the adult subjects on the Twenty-Item Toronto Alexithymia (TAS-20) subscale, Difficulty Identifying Feelings. Adult sex offenders whose offenses were more violent reported more difficulty identifying feelings than those whose offense involved less violence.
ACKNOWLEDGEMENTS

There are a number of people I would like to thank for their help and support over the course of this research project. First I would like to thank the chair of my dissertation committee, Dr. Alan Hovestadt, for his on-going support and guidance with this project and my doctoral studies over the past five years. To my other committee members, Dr. Paul Yelsma, thank you for your assistance with statistics and Dr. John Geisler’s thank you for your diligent editorial help.

I would like to thank a number of individuals for their assistance with the data collection for this project. To my fellow doctoral student Dr. Carin Ness for her assistance with the juvenile data and ongoing support over the course of this study. I owe a large thank you to Maria Molett for her support and assistance with data collection at the Counseling Institute of Texas. I would like to thank Chuck Wilkins and Dave Wingard for their support in data collection at BSA Interventions as well as their supervision and training during my practicum and employment at BSA Interventions. Additionally I would like to express thanks to the client’s who took the time and made an effort to participate in this study.

There are also several people who I would like to thank that were not as directly involved with this research project, however they provided a great deal of support over the past five years of my doctoral studies. I would like to thank my friends Jean and Brian Germain for their on-going friendship, which often provided
Acknowledgements—Continued

an otherwise dry academic life, with meaning. A second thank you to you, Jean, for not only being a friend but also a fellow doctoral student, and enduring the added torment of reviewing several drafts of this study. I would also like to thank one of my many clinical supervisors Dr. Matt Rushlau for his concise but always well timed supportive remarks. I also owe a thank you to my supervisors at Eastern State Hospital, Dr. Jeanne Russell and Dr. Shawn Roberson for their support and encouragement over the past year as I finished this project. Additionally, I would also like to thank my parents for their support and encourage as I completed this project.

Peter F. Rausch
# TABLE OF CONTENTS

**ACKNOWLEDGEMENTS** ........................................................................................................ ii

**LIST OF TABLES** ........................................................................................................... viii

**CHAPTER**

I. **INTRODUCTION** .............................................................................................................. 1

   Background of the Problem ............................................................................................ 1

   Research and Theory .................................................................................................... 4

   Statement of the Problem ............................................................................................. 8

   Purpose of the Study ...................................................................................................... 10

   Research Questions ........................................................................................................ 10

   Definition of Terms ........................................................................................................ 11

   Organization of the Remainder of the Study ................................................................ 13

II. **REVIEW OF RELATED LITERATURE** ........................................................................ 14

   Models of Sexual Aggression ......................................................................................... 14

      Biological Etiological Models ................................................................................... 15

      Cognitive Etiological Models .................................................................................... 16

      Affective Etiological Models ...................................................................................... 16

      Developmental Etiological Models .......................................................................... 18

      Summary of Etiological Models ................................................................................ 19

   Role of Affect and Attachment .................................................................................... 19

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
TABLE OF CONTENTS

ACKNOWLEDGEMENTS............................................................................................................ ii
LIST OF TABLES...................................................................................................................... viii

CHAPTER

I. INTRODUCTION .................................................................................................................... 1
   Background of the Problem................................................................................................. 1
   Research and Theory ......................................................................................................... 4
   Statement of the Problem................................................................................................. 8
   Purpose of the Study....................................................................................................... 10
   Research Questions........................................................................................................ 10
   Definition of Terms......................................................................................................... 11
   Organization of the Remainder of the Study................................................................. 13

II. REVIEW OF THE RELATED LITERATURE .................................................................... 14
   Models of Sexual Aggression .......................................................................................... 14
      Biological Etiological Models....................................................................................... 15
      Cognitive Etiological Models....................................................................................... 16
      Affective Etiological Models....................................................................................... 16
      Developmental Etiological Models............................................................................. 18
      Summary of Etiological Models.................................................................................. 19
      Role of Affect and Attachment .................................................................................. 19
<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affect Regulation and Emotional Expressiveness</td>
<td>22</td>
</tr>
<tr>
<td>Alexithymia</td>
<td>22</td>
</tr>
<tr>
<td>Affect Organization</td>
<td>24</td>
</tr>
<tr>
<td>Types of Behavior</td>
<td>25</td>
</tr>
<tr>
<td>Self-defeating Behavior</td>
<td>25</td>
</tr>
<tr>
<td>Risk Taking and Reckless Behavior</td>
<td>26</td>
</tr>
<tr>
<td>Differences Between Adult and Juvenile Sex Offenders</td>
<td>29</td>
</tr>
<tr>
<td>Literature Review Summary</td>
<td>31</td>
</tr>
</tbody>
</table>

III. METHODOLOGY........................................................................................... 33

Overview................................................................................................. 33
Participants ............................................................................................. 33
Juvenile Subjects .................................................................................. 33
Adult Subjects ....................................................................................... 36
Consent and Approval ............................................................................. 38
Procedures .............................................................................................. 40
Instruments .............................................................................................. 41
The Twenty-Item Toronto Alexithymia Scale (TAS-20) .......................... 42
The Affective Orientation Scale (AOS) ............................................... 43
The Self-Defeating Personality Scale (SDPS; Schill, 1990) ............... 45
Table of Contents—continued

CHAPTER

The Reckless Behavior Questionnaire (RBQ; Arnett, 1989)..............46

The Adolescent Risk Taking Scale (ARTS)..................................47

The Relationship Scales Questionnaire (RSQ)..............................48

IV. DATA ANALYSIS ..............................................................................51

V. DISCUSSION ...................................................................................55

Discussion of Findings..................................................................55

Implications for Treatment...................................................60

Limitations .......................................................................................62

Recommendations for Future Research.................................64

APPENDICES

A. Starr Commonwealth Approval Letter...........................................................66

B. Consent Form for Starr Commonwealth....................................................68

C. The Counseling Institute of Texas Approval Letter.......................................70

D. Consent Form for the Counseling Institute of Texas ..................................72

E. BSA Interventions Approval Letter.................................................................75

F. Consent Form for BSA Interventions.................................................................77

G. Human Subjects Institutional Review Board Letters of Approval.................80

H. Demographic Form for Starr Commonwealth ........................................83

vi

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
APPENDICES

I. Demographic Form for the Counseling Institute of Texas and BSA Interventions ............................................ 85

BIBLIOGRAPHY ........................................................................................................................................ 87
LIST OF TABLES

1. Percentage of Subjects by Attachment Style .................................................. 52
2. Group Means on the TAS-20 Subscales ........................................................... 54
CHAPTER I

INTRODUCTION

Background of the Problem

Sexual violence is a significant societal problem. Psychological research has consistently found that 10% to 27% of adult women report at least one lifetime incident of rape (Kilpatrick, Edmonds, & Seymour, 1992; Koss, 1993; Tjaden & Thoennes, 1998). Sexual assaults against children have been found to occur at a similar rate, with 27% of women and 16% of men reporting being sexually abused during childhood (Finkelhor, Hotaling, Lewis, & Smith, 1990; Gorey & Leslie, 1997). Wang and Harding (1998) estimated that there were 223,000 reports of child sexual abuse in 1997. The significance of these findings is even more profound given that these types of offenses are often underreported (Alksnis, Desmarais, Senn, & Hunter, 2000; Koss, 1992).

The exact percentage of the population that commit sex offenses is difficult to determine, as it is believed that only a small percentage of offenders are apprehended (American Psychiatric Association, 1999). It is generally accepted that males commit the majority of sex offenses (Federal Bureau of Investigation, 1990; Greenfield, 1997; Groth, 1979; Koss et al., 1994). Templeman and Stinnett (1991) found that 5% of a male college student population reported participating in physically coercive
sexual behavior. Marshall (1997) estimated that 2% of the adult population has committed behavior that would constitute a sex offense. Criminal sexual behavior is also not limited to adulthood. Estimates suggest that male adolescents commit 20% of all rapes and between 30% and 50% of child molestations (Becker, Kaplan, & Cunningham-Rathner, 1986; Bourke & Donohue, 1996).

The cost of sexual violence to society is significant. Beyond the emotional impact to the victims, the financial cost for the incarceration and treatment of offenders has been estimated to be as high as $168,000 per offender (Prentky & Burgess, 1992). The magnitude of the problem is further reflected in the dramatic increase in incarcerated sex offenders. In 1997, approximately 10% of state prisoners were sex offenders, costing society approximately $18,000 per year for each offender (Becker & Murphy, 1998; Greenfield, 1997). Post, Mezey, Maxwell, and Wibert (2002) estimated that the national cost of sexual violence was nearly $261.25 billion. Clearly, sexually violent behavior is a widespread and prevalent problem that has a significant emotional and financial cost to society.

The response of society to this issue has varied over time. Sexual aggression has historically been ignored or to a degree even accepted within our society (Scully, 1990; Ward, 1995). In the past 2 decades, there has been an increased acceptance of the existence of sexual violence, but interventions have typically focused on victims. While treatment for victims of sexual violence is needed, it does not reach at the source of the problem, which is the elimination of the perpetration of sexual violence. Society’s response to offenders has recently been more punitive, with a focus on
tougher sentencing and community monitoring, rather than a rehabilitative focus with an emphasis on treatment. Society’s punitive stance has been partially supported due to the questionable success rates of treatment programs (Alexander, 1999; Barbaree, 1997; Furby, Weinrott, & Blackshaw, 1989). Hall (1996) has suggested poor treatment outcomes are partly due to a lack of a clear understanding of the etiology of sexually aggressive behavior. Due to a lack of empirically based theories, treatment providers have had to rely on interventions based on clinical experience instead of a comprehensive theory grounded in the etiology of sexually aggressive behavior.

While there has recently been a significant increase in attention and services for juvenile sex offenders, there has been a lack of empirically based theories to guide treatment. Although significant differences are believed to exist between adult and juvenile sex offenders (Greenfield, 1997; Trivits & Reppucci, 2002), treatment programs for juveniles have typically been modeled after adult programs and have not taken into account the developmental differences between adults and juveniles (Barbaree & Cortoni, 1993; Becker & Kaplan, 1993; Burton, Freeman-Longo & Fiske, 1999; Righthand & Welch, 2001; Vizard, 1997). While clinical inferences may help direct treatment, it seems reasonable to conclude that treatment based on an empirically based theory would stand a better chance of being effective. Further, a clearer understanding of how various types of sex offenders (i.e., adult versus juvenile) differ from each other would allow treatment methods to be more individualized.
Research and Theory

Research has focused primarily on contrasting adult sex offenders with adult non-sex offenders on a number of factors believed to be clinically significant. Findings have shown that sex offenders are more likely to be from abusive families (Groth, 1979; Parker & Parker, 1986), are more likely to have had an insecure attachment to their mothers (Smallbone & Dadds, 1998), experience difficulty recognizing emotional states in others (Hudson et al., 1993), have poor social skills (Segal & Marshall, 1985), are not assertive (Segal & Marshall, 1986), use more cognitive distortions (Neidigh & Tomiko, 1991), have more controlling attitudes towards women (Scott & Tetreault, 1987), use pornography more frequently (Marshall, 1989b), are sexually aroused to deviant stimuli (Looman & Marshall, 2001; Malcolm, Andrews, & Quinsey, 1993; Miner, West, & Day, 1995), have insecure attachments in adult relationships (Ward, Hudson, & Marshall, 1996), report having difficulties establishing intimacy (Seidman, Marshall, Hudson, & Robertson, 1994), experience more loneliness (Seidman et al., 1994), and are more socially isolated than non-sex offenders. However, it remains unclear whether these factors cause sexual violence or are a result of some other unknown root cause.

There are fewer research studies on adolescent sex offenders than there are for adult sex offenders. The research that has been done has typically found juvenile sex offenders to have similar characteristics to juvenile delinquents that have not committed sexual offenses (Becker & Hunter, 1997; Jacobs, Kennedy, & Meyer, 1997;
However, a number of researchers have found some subtle differences between the two groups. Findings have shown that juvenile sex offenders are more likely to have rejecting fathers (Awad, Saunders, & Levene, 1984), to have been sexually abused (Milloy, 1994; Zgourides, Monto, & Harris, 1997), to have lower self-esteem (Monto, Zgourides, & Harris, 1998), to be more emotionally detached (Bischof, Stith, & Wilson, 1992; Porter, 1990), to be shy (DeNatale, 1989), to have fewer social skills (Katz, 1990), to be more socially isolated (Chewning, 1991; Fagan & Wexler, 1988; Kahn & Lafond, 1988; Lonczynski, 1991), to have more difficulty emotionally bonding with peers (Blaske, Borduin, Henggeler, & Barton, 1989), to engage in more reckless behaviors (Ness, 2000), to perceive their families as less cohesive (Bischof et al., 1992), and to perceive their families as more dysfunctional (Wieckowski, Hartsoe, Mayer, & Shortz, 1998) than juvenile non-sexual offending delinquents.

While it is generally accepted that there are differences between types of sex offenders, such as juvenile versus adult and rapists compared to molesters (Barbaree, Hudson, & Seto, 1993; Freund, 1990; Knight & Prentky, 1990; Rubinstein, Yeager, Goodstein, & Otnowa-Lewis, 1993; Trivits & Reppucci, 2002; Williams & Finkelhor, 1990), few studies have examined these factors. The limited findings to date suggest that experiencing a greater degree of sexual or physical abuse may contribute to an earlier onset of sexually offensive behavior (Prentky & Knight, 1993; Righthand & Welch, 2001; Rubinstein et al., 1993). The type of abuse may also be a factor in contributing to the type of offender. Prentky and Knight (1993) found that child
molesters tended to experience more sexual abuse while rapists experienced more physical abuse.

In the past decade, a number of comprehensive theories of sexual offense have been developed (Hall & Hirschman, 1991; Johnson & Knight, 2000; Knight & Sims-Knight, 2002; Marshall & Barbaree, 1990). These theories have ranged from broad comprehensive approaches that attempt to explain the onset and continuance of sexual offending behaviors, to single-factor theories that focus on one contributing factor. Several theorists have suggested that physical and sexual abuse within the family is the initial cause and that other factors are a secondary development (Marshall & Barbaree, 1990; Monastersky & Smith, 1985). Van Ness (1984) has shown that individuals were more likely to become sex offenders if they grew up in homes where violent or sexually abusive behavior occurred. However, not all sex offenders have been victims themselves (Hanson & Slater, 1988; Weeks & Widom, 1998), and the majority of childhood victims do not grow up to become offenders (Finkelhor, 1984; Garland & Dougher, 1990; Kaufman & Zigler, 1987; Prentky & Knight, 1993). This conclusion has led researchers to search for other factors that may set the foundation for future sexually aggressive behavior.

Marshall (1989a, 1993) suggested that the primary factor that contributes to a vulnerability for future sexually aggressive behavior is rooted in the sex offender's poor attachment with parental figures. While physical or sexual abuse almost always results in poor attachment, it can also be a result of neglectful or even ambivalent parenting styles (Bowlby, 1988). The lack of overt abuse in neglectful or ambivalent
parenting styles could explain why some sex offenders do not have a history of sexual or physical abuse. According to this conceptualization, poor attachments between a child and their primary caregiver does not allow the child to develop the social skills necessary to establish peer relationships in adolescence and romantic relationships in adulthood. A lack of relationships leads to emotional loneliness, which then leads to aggression and other self-defeating behaviors (Marshall, 1989a; 1993).

Marshall’s theory (1989a; 1993) has been further expanded, suggesting that the key component within poor attachment that leads to later relational problems, including sexual offending, is the specific style of attachment that individuals develop from their interactions with caregivers (Ward, Hudson, Marshall, & Siegert, 1995). Poor attachment is believed to lead to an avoidant or ambivalent style of relating which results in either the individual not engaging in relationships or at best developing superficial relationships. This learned style of relating is repeated in future relationships in adolescence and adulthood.

While neglectful and/or abusive parenting is likely to cause poor attachment between a primary caregiver and child, it is also likely to lead to deficits in the child’s ability to identify and express emotions. A key ingredient in the development of a secure attachment is the primary caregiver’s ability to respond to the emotional needs of the child (Bowlby, 1988). When the caregiver does not respond to a child’s needs and feelings appropriately, the child then becomes more prone to develop a poor attachment to the caregiver. Crittenden (1994) suggests that when a caregiver’s emotional expression is blunted, the child is prone to become insecurely attached. The
child is also not able to have the opportunity to learn to identify and experience the affective cues and states of others. Nor does the child learn how to identify and modulate his or her own affective states. Barahal, Waterman, and Martín (1981) have shown that abused children were less able to understand subtle and complex social interactions and were particularly less sensitive to socio-emotional contexts. Consequently, if a child does not have the opportunity to learn this process in childhood, they are unlikely to in adolescence and adulthood. Given the importance of emotion in intimate relationships, it is likely that individuals with a deficit in emotional expressiveness would have difficulty establishing peer relationships, as well as romantic relationships.

Statement of the Problem

The literature on factors that contribute to an individual becoming a sex offender has identified numerous factors (Finkelhor, 1984; Hall & Hirschman, 1991; Marshall & Barbaree, 1990). It has generally been accepted that family dynamics play a critical role. However, it is unclear how family dynamics contribute to an individual becoming sexually aggressive (Bischof, Stith, & Whitney, 1995; Howes, 1984; Monastersky & Smith, 1985; Van Ness, 1984).

Marshall (1989a; 1993) suggested that poor attachment between a child and his or her primary caregiver is the key factor within family environments that predisposes an individual to becoming a sex offender. Two studies on attachment have compared incarcerated adult sex offenders to incarcerated non-sexual offenders.
Both studies have shown that sex offenders had poor attachments to their primary caregiver, and also that different types of sex offenders had different styles of attachment. A limitation of these studies was that they were conducted on incarcerated sex offenders. Suggestions for future research emphasized the usefulness of replicating these findings in a sex offender population in a community-based supervision program.

A deficiency in emotional expressiveness is another factor within the family environment that may contribute to an individual becoming a sex offender. Four studies have examined this variable in sex offenders (Hudson et al., 1993; Keltikangas-Jarvinen, 1982; Kroner & Forth, 1995; Ness, 2000). Three of these studies support the hypothesis that sex offenders have a deficit in emotional expressiveness. However, two of the studies did not use a validated measure for emotional expressiveness, and the third study did not distinguish between sex offenders and general offenders. The fourth study only examined juveniles and found no difference in emotional expressiveness between juvenile sex offenders and a non-sex offending juvenile delinquent population. The paucity of studies and the limitations of existing studies indicate a need for further research on emotional expressiveness.

While it is generally accepted that juvenile sex offenders are different than adult sex offenders (Barbaree et al., 1993; Rubinstein et al., 1993), few studies have examined these two groups. The studies that have been done have attempted to make comparisons between these two groups by following juveniles into adulthood or by doing retrospective interviews with adults who started offending in adolescence.
(Prentky & Knight, 1993; Rubinstein et al.). Only two known studies have directly compared adult sex offenders with juvenile sex offenders (D'Orazio, 2002; Miranda & Corcoran, 2000).

Purpose of the Study

The main purpose of this study is to identify differences in emotional expressiveness and behavior that may exist between adolescent sex offenders and adult sex offenders. A second purpose of this study was to examine adult sex offender’s attachment style within current romantic relationships.

The variable of affective expressiveness will be studied by measuring the concepts of alexithymia and affective orientation. The variable of attachment will be studied by measuring the current style of attachment in intimate relationships. The variable of behavior will be studied by three different classifications: self-defeating, risk-taking, and reckless behavior. In addition, demographic variables of age, ethnicity, family system status, abuse history, and offense history will be examined.

Research Questions

This study was designed to address the following six questions:

1. Is there a significant difference in alexithymia scores, as measured by the twenty-item Toronto Alexithymia Scale (TAS-20), between adult and juvenile sex offenders?

2. Is there a significant difference in affective orientation, as measured by the
Affective Orientation Scale (AOS), between adult sex and juvenile sex offenders?

3. Is there a significant difference in self-defeating behavior, as measured by the Self-Defeating Personality Scale (SDPS), between adult and juvenile sex offenders?

4. Is there a significant difference in risk-taking behavior, as measured by the Adolescent Risk Taking Scale (ARTS), between adult and juvenile sex offenders?

5. Is there a significant difference in reckless behavior, as measured by the Reckless Behavior Questionnaire (RBQ), between adult and juvenile sex offenders?

6. Is there a significant difference between three types of adult sex offenders, as measured by the Relationship Scales Questionnaire?

Definition of Terms

Adult Sex Offender (ASO): an individual 18 years of age or older who has been convicted of a sexual offense including rape, familial child molestation, non-familial child molestation, or exhibitionism. It can also be assumed that all these individuals will be males.

Juvenile Sex Offender (JSO): an individual 13 to 17 years of age who has been convicted of a sexual offense including rape, familial child molestation, non-familial child molestation, or exhibitionism. It can also be assumed that all these individuals will be males.

Alexithymia: the inability to be aware of, identify, differentiate, and verbalize feelings. In this study it will be defined as the subject’s score on the Toronto
Alexithymia Scale (TAS; Bagby, Taylor, & Parker, 1992). The higher the score, the lower the level of affect awareness.

**Affective Orientation (AO):** the ability to be aware of emotions and to utilize that to guide interactions with others. In this study it will be defined as the subject’s score on the Affective Orientation Scale (AOS; Booth-Butterfield & Booth-Butterfield, 1990). Higher scores on the AOS reflect higher AO.

**Attachment Style:** the pattern or type of relationships that an individual tends to have with his significant other as measured by the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994). Four different styles (secure, dismissing, fearful, or preoccupied) are identified.

**Self-defeating behavior:** behavior in which an individual participates that is not in his or her best interest. In this study, self-defeating behavior is measured by the Self-defeating Personality Scale (Schill, 1990).

**Reckless Behavior:** defined as behavior that has the potential for negative consequences to the individual displaying the behavior. This behavior is measured by the Reckless Behavior Questionnaire (RBQ; Shaw, Wagner, Arnett, & Aber, 1992).

**Risk-Taking Behavior:** behavior that is defined by the individual as a risk, and that is done for excitement. This behavior is measured by the Adolescent Risk-Taking Scale (ARTS; Alexander et al., 1990). In measuring risk taking in adults, several of the questions on the ARTS are reworded.
Organization of the Remainder of the Study

A review of the related literature is provided in Chapter II followed by a description of the methods and procedures in Chapter III. Data are analyzed and reported in Chapter IV, and discussion and recommendations are summarized in Chapter V.
CHAPTER II

REVIEW OF THE RELATED LITERATURE

The current literature on sex offenders and emotional expressiveness are reviewed in this chapter. First, various models that have been developed to explain sexually aggressive behavior are reviewed. Second, the role of affect and attachment between primary caregivers and children are presented. Third, the concept of affect regulation and emotional expressiveness are discussed. Fourth, three types of behavior are examined: (1) self-defeating, (2) risk-taking, and (3) reckless. Fifth, a summary of the literature on the differences between adult sex offenders and juvenile sex offenders, as well as specific types of sex offenders (i.e., rapists versus child molesters), is presented. Lastly, a summary of the literature review is discussed to provide a foundation for this study.

Models of Sexual Aggression

Previous psychological research has focused on trying to find variables that distinguish sex offenders from non-offenders. A number of models of sexual aggression have been developed based on these findings. Most of these models have focused on a single theoretical explanation (i.e., biological) as leading to sexually aggressive behavior.
Biological Etiological Models

A number of studies have supported the clinical belief that sex offenders are innately more prone to be aroused to deviant sexual stimuli. That is, sex offenders may have a predisposition due to neurological damage. Raine (1993) found that some sex offenders exhibit temporal lobe structural deficits. However, structural deficits were only present in a small percentage of sex offenders. Physiological theories explained sexual aggression as a conditioned response to pornography (Laws & Marshall, 1990; Marshall & Barbaree, 1984). Barbaree and Marshall (1989; 1991) have shown that many rapists and child molesters exhibit high levels of sexual arousal to rape and pedophilic stimuli and that this level of arousal is greater than for men who have not been sexually aggressive. The sexual arousal of most men, aggressive and non-aggressive alike, to stimuli depicting consenting sexual acts is actually greater than sexual arousal to stimuli depicting violent acts such as rape (Baxter, Barbaree, & Marshall, 1986). Therefore it seems unlikely that physiology alone is a sufficient factor to cause sexual aggression.

Ellis (1989) stated that while abnormal arousal may be a component of sexually aggressive behavior, arousal in and of itself does not lead to aggression. The biological model illustrated by Ellis has often been viewed as describing the impulsive type of sex offender, in that no prior planning is necessarily present before the offense. Prentky and Knight (1991) have suggested that while conscious planning may be absent in impulsive sex offenders, the negative affective state may still be present. It seems plausible that the negative affective state may be necessary for the
arousal to be paired with aggressive behavior and then to result in a sexually violent act.

**Cognitive Etiological Model**

In a theoretical study, Pithers, Marques, Gibat, and Marlatt (1983) described what they refer to as a cognitive model of offending. In their model, the experience of a negative affective state (e.g., boredom or depression) initiates a conscious sexual fantasy. In turn, this fantasy leads to the development of a plan to offend and, if not interrupted, results in an individual’s commission of a sexual offense. The authors describe the model as cognitive in that it involves the use of fantasy, conscious planning, and cognitive defense mechanisms to justify offending. A number of studies have provided empirical support of a cognitive component in sexually offensive behavior. Scott and Tetreault (1987) have learned that sex offenders have more negative attitudes towards women compared to non-offenders. Sex offenders have also been shown to use more cognitive distortions than non-offenders (Abel, Becker, & Cunningham-Rather, 1984; Lonsway & Fitzgerald, 1994). However, this model includes more than cognition in that the start of the sequence involves an affective state.

**Affective Etiological Model**

The affective model has two central tenets: (1) there is a deficit in the modulation of emotional states, and (2) alternate behaviors are selected to attempt to
modulate emotional states. When applied to sex offenders the first tenet suggests that
sex offenders are deficient in their ability to modulate their emotional states. Two
major components are involved in the modulation of emotional states. The first com-
ponent of emotional regulation is the ability to identify feeling states. Kroner and
Forth (1995) compared a group of offenders' (incarcerated for sexual and/or violent
offenses) scores on the Toronto Alexithymia Scale (TAS) and found that they did not
have significantly more difficulty identifying their own feelings compared to a normal
sample. However, given that violent and sexual offenders were grouped together, spe-
cific conclusions could not be drawn. The second component to modulating affective
states is the ability to identify emotions in others. Hudson et al. (1993), using a series
of photographs, found that both sex offenders, as well as violent offenders, had more
difficulty identifying emotions in facial expressions than a "normal" control group
did. Compared to violent offenders, sex offenders had more difficulty. Within the
sex offender group, child molesters had more difficulty than rapists.

When applied to sex offenders the second tenet of the affective Model sug-
gests that the sex offense is an attempt to regulate one's emotional state. Several
studies have shown that a negative affective state precipitates sexually aggressive
behavior. Maiuro, Cahn, Vitaliano, Wagner, and Zegree (1988) have shown that
negative affective experiences (e.g., anger or depression) often preceded aggressive
behavior in perpetrators of domestic violence. Hall and Hirschman (1991) reported
that anger is often present in rapists prior to offending, and a depressed state is often
present in child molesters prior to offending. In addition, Proulx, McKibben, and
Lusignan (1996) found that when sex offenders experience negative emotions there is a marked increase in the frequency of deviant sexual fantasies. They suggest that deviant sexual fantasies are utilized as a coping mechanism to deal with negative affective states.

**Developmental Etiological Model**

The developmental model of sexual aggression suggests that aggressive sexual behavior is the result of negative social experiences (Hall & Hirschman, 1991; Marshall, 1989a; 1993). Marshall (1989a; 1993) suggested that poor attachment between children and their primary caregivers is the first negative experience and sets the stage for interpersonal problems. Various empirical studies have demonstrated that criminal offenders in general are more likely to be from abusive families and that sex offenders are more likely to have experienced sexual abuse compared to general criminal offenders (Bischof et al., 1995; Groth, 1979; Parker & Parker, 1986; Van Ness, 1984). Poor attachment often results in a deficit in social skills, which leads to difficulties in developing peer and romantic relationships during adolescence. Awad and Saunders' (1989) research has suggested that non-sexually aggressive males are able to bond to similar peers, whereas sexually aggressive males are not. Poorly attached children are also predisposed to becoming involved in sexual activities at an earlier age than their securely attached peers. Newcomer and Udry (1987) found that boys from broken homes tend to engage in sexual activities at an earlier age. Empirical research has suggested that sex offenders tend to have poor attachments with their
mothers (Smallbone & Dadds, 1998), and then continue to have difficulties establishing intimate relationships as adults (Seidman et al., 1994; Ward et al., 1996). It has been suggested that these experiences of abuse, lack of social skills, and inability to establish appropriate peer and romantic relationships predispose individuals to becoming sex offenders (Barbaree, Marshall, & McCormick, 1998; Marshall, 1989a; 1993).

Summary of Etiological Models

It appears that each model contributes a portion of understanding to a complex inter-related system involving biological, cognitive, affective and developmental components that ultimately results in sexually offensive behavior. While biological factors may be an initial starting point to sexually offensive behavior, these behaviors appear to pertain only to a small percentage of offenders. The underlying precipitant to the majority of sexually offensive behaviors seems to be a negative emotional state, and an attempt to then regulate the emotional state. The following section examines the development of emotional regulation.

Role of Affect and Attachment

A significant, if not causal, factor in all of the four etiological models (biological, cognitive, affective, and developmental) of sexual aggression that have been discussed in the previous section is the experience of a negative affective state. However, the question remains as to why sex offenders have difficulty in coping effectively with negative emotional states. As discussed in the section on
developmental factors, a lack of positive affect within the offender's family of origin may be a significant factor that leads to the offender's difficulty in managing negative emotional states. Certainly, overt abuse could be described as a lack of positive affective experience and research has shown that sex offenders have experienced more abusive family environments than non-sexual offenders (Becker & Hunter, 1997; Bischof et al., 1995; Van Ness, 1984). However, more subtle behaviors may also result in negative affective experiences and interfere with affect development. Howes (1984) has shown that in addition to using more punitive punishment strategies, abusive parents express more negative affect. Delinquent adolescents often come from homes where parents are described as emotionally cold (Brennan & Auslander, 1979; Wieckowski et al., 1998). As a result, individuals who commit sex offenses may not have developed the ability to effectively identify and manage emotions. As discussed earlier, developmental theorists believe that an individual's ability to identify and regulate his emotions are rooted in his early attachment experiences with caregivers. Research has shown repeatedly that sex offenders have difficulties in attachment to caregivers and peers (Awad & Saunders, 1989; Smallbone & Dadds, 1998).

Emotional development is rooted in the early attachment experiences between a child and his primary caregiver. The degree of attachment between a parent and an infant has been shown to be significantly related to the parents' sensitivity to signals from the infant, and their appropriate supportive responses (Ainsworth, 1982). Attachment theorists have suggested that when children's needs and feelings are not responded to appropriately, they do not receive the supportive emotional experience
which allows them to identify and experience the affective cues and states of others (Miller & Eisenberg, 1988). Not surprisingly, abused and neglected children are less able to understand subtle and complex social interactions in contexts (Barahal et al., 1981). This in turn may lead to their difficulty in establishing relationships and in modulating affective states in response to negative environmental experiences. Children typically develop affect tolerance by learning from their parents (Krystal, 1993). Parents who have difficulty modulating their own affect are less able to model appropriate affective states to their children. Taylor (1995) has suggested that when failures in affect development occur, people are prone to experience affect dysregulation, which is commonly seen in psychopathological states.

While the importance of emotion in understanding behavior has often been overlooked, it has received increased attention in recent years (Safran & Greenberg, 1991). In the past, emotions were viewed as a result of behavioral experiences and cognitive processes. More recently, emotions have been viewed as a critical process that co-occurs with behaviors and cognitive processes (Eisenberg, Fabes, & Losoya, 1997). This increased interest in emotion has, in part, been linked to the realization that biological, behavioral, and cognitive models have offered insufficient explanations for behavior. The regulation of affect has increasingly been viewed as a critical aspect to consider in understanding behavior, particularly when psychological trauma is involved (Garber & Dodge, 1991; Grotstein, 1987).
Affect Regulation and Emotional Expressiveness

Affect regulation has been described as consisting of the ability to identify emotions and use them in adaptive ways, as well as to be able to comprehend feelings in others and use them to guide social interactions (Taylor, Bagby & Parker, 1997). Saarni (1997) suggested that the ability to appropriately modulate affect is essential for effective emotional and social functioning. Difficulties in affective regulation often result in psychopathology and poor social functioning (Grotstein, 1987). Two constructs that have been found to be critical components of affect dysregulation and regulation have been alexithymia and affective orientation (AO) (Taylor et al., 1997). These constructs will each be discussed in greater detail.

Alexithymia

Taylor (1994) describes alexithymia as a general personality trait. While initially alexithymia was conceptualized as a distinct communication style in individuals who are deficient in the expression of feelings, it has since been shown to be a multidimensional construct (Taylor et al., 1997). Alexithymia consists of four distinct components: (1) difficulty identifying and describing feelings, (2) difficulty distinguishing between feelings and physical sensations, (3) limited ability to fantasize; and (4) an externally oriented thinking style (Taylor, Bagby & Parker, 1991). While some of these components were first noticed and described 4 decades ago (Horney, 1945) the term “Alexithymia” was first used by Sifneos in 1972. Since then, and with the increased interest in affect, the construct of alexithymia has been studied across a
variety of disciplines, including psychology (Krystal, 1993; Taylor et al., 1991, 1997) psychosomatic medicine (Lolas & von Rad, 1989; Zerbe, 1992), and communication (Yelsma, 1995, 1996). Alexithymia has been shown to be qualitatively different from repression, trait anxiety (Martin & Phil, 1986), and depression (Parker, Bagby, & Taylor, 1991). Taylor (1994) has reported that there is consensus in the literature regarding the alexithymia construct (Acklin & Alexander, 1988; Nemiah, 1977; Sifneos, 1973, 1987; Taylor, 1994). Although distributed across the general population alexithymia has been found to be present to a significant degree in individuals diagnosed with a number of psychiatric disorders, including substance abuse (Bruch, 1982/1983), post-traumatic stress disorder (Flannery, 1978), eating disorders (Krystal, 1968), panic disorder (Krystal & Raskin, 1970), and somatization disorders (Nemiah, 1984). Individuals identified as alexithymic have been described as having difficulties expressing a full range of positive and negative emotions (Krystal, 1982). They have difficulty being aware of the emotional aspects of a situation until the emotional content reaches an abnormally high level at which point individuals who are alexithymic tend to impulsively express their emotions (Krystal, 1990, 1993). Given these findings, it is not surprising that alexithymics are prone towards interpersonal difficulties. In fact, individuals who score high on alexithymia have been found to have fewer close friends than those who were found to score low in alexithymia (Salminen, Saarijarvi, & Aarela, 1995).

There have been few research studies on the relationship of alexithymia and violent offenders. Yelsma (1996) found individuals convicted of domestic violence to
be high in alexithymia. Keltikangas-Jarvinen (1982) studied alexithymia in incarcerated violent adult offenders by using a projective technique. While she found offenders to be alexithymic, the method of measurement she employed, the Rorschach Ink Blot Test, has questionable validity (Lilienfield, Wood, & Garb, 2000). Hudson et al. (1993) found that adult sex offenders were more deficient in their ability to recognize emotions from pictures of individuals' facial expressions compared to non-sex offenders. Kroner and Forth (1995) examined the presence of alexithymia and psychopathology in a group of adult offenders, which included adult non-sexual offenders and adult sex offenders. They found that this mixed group (non-sexual and sexual offender’s group) was not statistically higher in alexithymia than a group of non-criminal subjects. An advantage of their study was that they used a validated measure of alexithymia, the Twenty-Item Toronto Alexithymia Scale. However, their sample included non-sexual offenders as well as sex offenders, therefore the non-violent offenders may have confounded their findings. Ness (2000) compared juvenile sex offenders to a comparison group of juvenile non-sexual offenders and found no significant difference in their scores on the Twenty-Item Toronto Alexithymia Scale. There are no known studies that have specifically examined alexithymia in an adult sex offender population using a validated measurement.

Affect Orientation

Affective orientation (AO) has been defined as “the degree to which individuals are aware of and use affect cues to guide communication” (Booth-Butterfield
& Booth-Butterfield, 1990, p. 451). Individuals high in AO find affect cues during social interactions to be meaningful and use them to guide their interaction. AO differs from alexithymia in that not only does it involve the process of being able to identify and/or express one's own emotions, but it also involves the process of being able to be aware of others' emotions and use this awareness to guide behavior.

Yelsma (1996) has shown that AO and alexithymia are inversely correlated, with high alexithymia representing a deficit in identifying and utilizing emotions. High AO, then, can be seen as representing the ability to identify and utilize emotions.

At this time, no known studies have examined the concept of AO in adult sex offenders. Yelsma (1996) compared domestically violent couples with non-violent couples on AO, and found that domestic violent couples were lower in AO. Ness (2000) found that juvenile sex offenders were not significantly different than juvenile general offenders on AO. Given these findings, further research examining AO in an adult population of sex offenders would help expand the literature and understanding of AO.

Types of Behavior

Self-defeating Behavior

Self-defeating behavior is a concept that has a long history among practitioners within the field of psychology (Freud, 1933/1964; Jenkins-Hall, 1989; Nosshpitz, 1994). While no formal definition has existed until recently, self-defeating behaviors have generally included any behavior in which an individual participates
that is not in his or her best interest. Self-defeating behavior was first formally
defined in 1987 with the publication of the revision of the third edition of the Diag-
nostic and Statistical Manual of Mental Disorders (DSM III-R; American Psychiatric
Association, 1987). The DSM III-R initiated a new provisional personality disorder,
which was called the self-defeating personality disorder. Schill (1990) developed the
self-defeating personality scale to measure this new disorder based on the criteria pro-
posed by the DSM III-R.

Although self-defeating personality has a long history of theoretical specula-
tion, it has not been extensively studied empirically. Yelsma (1993) found that indi-
viduals with low self-esteem correlated positively with self-defeating personalities.
Kisler and Schill (1995) found that individuals with dissociative and eating disorders
had self-defeating personalities. Self-defeating personality has been found to be asso-
ciated with low assertiveness (McCutcheon, 1995; Schill, 1991). A correlation has
also been found between childhood sexual abuse and self-defeating personalities
(Viviano & Schill, 1996).

Risk Taking and Reckless Behavior

Risk taking and reckless behaviors are similar to self-defeating behaviors in
that they are considered dangerous behaviors with no regard for consequences
(Webster’s New World Dictionary, 1982). Viney, Truneckova, Weekes, and Oades
(1997) further defined risk taking as the exposing of oneself to significant conse-
quences that are far outweighed by the immediate pleasure or relief from frustration.
Arnett (1992) defined reckless behavior as behavior that has a potential for negative consequences including arrest and conviction by the legal system. To a degree, reckless behavior may be normal for adolescents and is believed to be a means of establishing independence (Arnett, 1992; Lightfoot, 1997). However, extreme recklessness may be indicative of delinquency and has been found to correlate with dysfunctional family dynamics. Some of these dysfunctional family dynamics include parental neglect and hostility (Dembo, Derke, LaVoie, & Bonders, 1987) as well as deviant sexual experiences (Zuckerman, Tushup, & Finner, 1976).

Cicchetti, Barnett, Rabideau, and Toth (1991) have proposed a theory to explain the development of risk-taking behavior. According to their theory, risk-taking behaviors can develop in a positive direction (e.g., motivation for achievement) or in a negative and self-defeating direction (e.g., drug use and crime). Their theory underscores a moderate level of risk-taking behaviors is normal for adolescents. However, a pattern of negative and ongoing risk-taking behavior is pathological. The direction that the behavior takes is largely influenced by a number of developmental factors. As discussed previously, the primary developmental factors that contribute to risk-taking behaviors are the emotional context of the family environment and the level of attachment between parent and child. In families in which there is a reasonable degree of stimulation and a healthy attachment between the parents and child, the child develops a positive sense of self-esteem and is able to learn to regulate emotions (Stern, 1985). Baker and Baker (1987) suggested that in healthy families children are able to learn moderation in risk-taking behaviors through parental modeling.
Dysfunctional family environments typically involve a poor attachment between parent and child. This can occur as a result of physical or sexual abuse or by neglect, or by a combination of these factors. Cicchetti et al. (1991) suggested that both of the factors of abuse and neglect contribute to the child feeling unaccepted, and lead to a sense of low self-esteem. The level of over-stimulation or under-stimulation that occurs from abuse or neglect also leads to the child having difficulties regulating his or her emotions (Stern, 1985). Wilson and Herrnstein (1985) suggested that an adolescent who feels unacceptable seeks out negative risk-taking behaviors that are congruent with his or her negative sense of self. This adolescent might also seek out behaviors that provide a high level of stimulation. The affiliation with other delinquent risk-taking peers decreases his or her sense of rejection, while the negative behavior maintains a congruent sense of self.

No known studies exist that have examined these three behaviors: self-defeating, risk-taking, and reckless behaviors in adult sex offenders. However, given the possible legal repercussions of sexual offending behavior, it seems reasonable to consider sex offending as self-defeating, risky, and reckless. Ness (2000) found that juvenile sex offenders and juvenile non-sexual offenders scored higher on risk-taking than non-offending juveniles. Sex offenders have also been found to possess a number of factors that have been correlated with these behaviors, including a history of sexual abuse (Van Ness, 1984), non-assertiveness (Segal & Marshall, 1986), low self-esteem (Marshall & Mazzucco, 1995), poor attachment in childhood (Smallbone & Dadds, 1998), and problems with impulse control (Charles & McDonald, 1997).
Differences Between Adult and Juvenile Sex Offenders

While it is generally accepted that juvenile sex offenders are different than adult sex offenders (Barbaree et al., 1993; Rubinstein et al., 1993), few studies have compared these two groups. The idea that differences between the two groups exist is supported by findings that 50% of adult sex offenders report that they started offending prior to adulthood (Becker & Abel, 1985; Longo & Groth, 1983; Miccio-Fonseca, 2000). This finding suggests that there are at least two, possibly three, groups of sex offenders when taking into account the age of the offender at the time in which their sexual offending began. The first group would be sex offenders who started offending in adolescence and continued into adulthood. The second group would be those who did not start offending until adulthood. A possible third group would be those who offended as adolescents but did not continue to offend in adulthood. However, it has been suggested that this third group is not likely to exist, in that without treatment, most juvenile sex offenders are believed to continue to offend during adulthood (Moffitt, 1993; Rivera & Widom, 1990). Therefore, only the first two groups will be discussed.

A review of the literature found only five studies that have attempted to clarify differences between the first group, sex offenders who started offending as adolescents, and the second group, those who did not start offending until adulthood. Rubinstein et al. (1993) followed a group of juvenile sex offenders and a group of juvenile non-sex offending delinquents over an 8-year period. The participants were 16 years old at the beginning of the research and 24 when the research was completed.
Within the sex offender group, those who continued to commit sex offenses into adulthood were more likely to have been sexually abused themselves than those who did not continue to offend. Prentky and Knight (1993) interviewed adult sex offenders and separated them into offenders who started offending as adolescents and those that started offending in adulthood. They found that the juvenile-onset group experienced more abuse during their childhoods than the adult-onset group. Kratzer and Hodgins (1999) studied 7,101 males from childhood until the age of 30. They found that individuals who started committing sexual offenses in their adolescence scored lower on intelligence tests and committed more crimes of various types than those who initiated sexual offending as adults. Miranda and Corcoran (2000) compared a group of adult sex offenders and a group of juvenile sex offenders on offense variables. They found that juveniles committed more intrafamilial sexual offenses and used more force than adult offenders. They concluded that adult offenders are more able to use their authority as adults to coerce victims and to have more access to victims outside of the victim’s homes. D’Orazio (2002) found that juvenile sex offenders scored lower on the Interpersonal Reactivity Index, a measure of empathy, than adult sex offenders. These differences between juvenile and adult sex offenders suggest that juveniles may be more emotionally impaired than adults due to lower IQs and a greater frequency of experiencing abuse.

Another factor of differentiation among sex offenders is the type of offense. Similar to the age of onset of offending, types of sex offenders (rapists versus molesters) are generally considered to be different from one another (Barbaree & Serin,
1993; Freund, 1990; Knight & Prentky, 1990; Williams & Finkelhor, 1990). Few researchers have examined beyond the specific characteristics of the offense when trying to determine differences between types of offenders. Knight and Prentky (1990) found that sex offenders who had become child molesters had experienced more sexual abuse themselves than those that had become rapists. Further, rapists tended to have experienced more physical abuse and neglect than did molesters. Smallbone and Dadds (1998) found that rapists tended to have attachment problems with their fathers, while child molesters had attachment problems with their mothers. Rapists were also found to consistently have had an avoidant attachment style in adulthood, while molesters have had either anxious or avoidant attachment styles as adults. Seidman et al. (1994) found that exhibitionists and familial child molesters experienced less loneliness than rapists and non-familial child molesters.

Literature Review Summary

The review of the literature has provided a foundation for this study. While it is generally accepted that the family of origin plays a critical role in the development of an individual in becoming a sex offender, it remains unclear what factors within families contribute to this phenomenon. The concept of attachment has been studied in adult sex offenders and has been used to distinguish between types of sex offenders. However, attachment has not been studied in sex offenders who are in a supervised community-based treatment setting. Emotional expressiveness may also play a contributing role and there has been some support of the idea that there are deficits in
expressiveness among violent offenders. However, this factor of deficits in emotional expressiveness has not been studied extensively in sex offenders. Finally, several negative behavioral styles have been shown to be present in violent offenders, but have not yet been studied in adult sex offenders.

Studying specific emotional expressiveness constructs, attachment styles, and behavioral characteristics of adult and juvenile sex offenders could help expand the existing developmental theory of sexually offensive behavior. Marshall has suggested that a useful direction for future research would be to examine emotional expressiveness in sex offenders (W. L. Marshall, personal communication, March 19, 1999). While differences are believed to exist between juvenile and adult sex offenders, few studies have compared these two populations. The current study will compare juvenile and adult sex offenders on the variables of emotional expressiveness and related behavioral variables. Further understanding of the differences between juvenile and adult sex offenders could help tailor treatment interventions and could also help direct preventive interventions.
CHAPTER III

METHODOLOGY

Overview

The primary purpose of this study was to examine the potential differences that may exist among juvenile and adult sex offenders on the variables of emotional expressiveness and problematic behaviors. The emotional expressiveness variable was studied by examining the constructs of alexithymia and affective orientation. Problematic behaviors were studied by examining self-defeating behavior, risk taking, and reckless behaviors. It was predicted that adult sex offenders would be different from juvenile sex offenders on the five variables: (1) alexithymia, (2) affective orientation, (3) self-defeating behavior, (4) risk taking, and (5) reckless behaviors. In addition to examining adult and juvenile sex offenders on these five variables, a secondary purpose was to examine attachment styles of adult sex offenders. Attachment style was studied by examining adult sex offenders’ reported style of attachment in current romantic relationships.

Participants

Juvenile Subjects

The juvenile sex offender data was obtained from responses to questionnaires
gathered for a previous research project (Ness, 2000). The data set consisted of 47 voluntary subjects who ranged in age from 12 to 18 years of age with a mean age of 15. Of the 47 subjects, 66% were Caucasian, 25.5% were African-American, 2.1% Hispanic, and 6.4% were Multiracial. Prior to their placement at a sex offender treatment program, 17% of the subjects resided with both their parents, 49% lived in a single parent family, 19% with a blended family, 11% with extended family, and 4% reported living with non-family members. All the subjects had been adjudicated and ordered to treatment for a sex offense involving either fondling or rape.

The juvenile subjects were in treatment at Starr Commonwealth, a private social services agency, which provides residential treatment services for delinquent youths in Michigan and Ohio. The agency’s headquarters is located in Albion, Michigan, which was the site where the juvenile sex offender data was collected. Starr Commonwealth offers residential treatment services to adolescents who have a history of delinquent behavior (i.e., have been adjudicated for committing a crime) as well as those who have exhibited inappropriate sexual behaviors (i.e., engaged in sexual behaviors involving intercourse or fondling with an unwilling participant). Referrals to Starr Commonwealth’s residential programs are made by the courts and social services (Starr Commonwealth, 1998). Clients who are receiving treatment for sexually aggressive behaviors are housed together in four cottages on the grounds of the program. Treatment consists of attending group and individual counseling and is provided by master’s level therapists. Participants are in treatment for a mean of three
years. The Albion residential site had 48 clients in the sex offender treatment program.

Starr Commonwealth’s treatment philosophy is grounded on a psycho-educational milieu that is based on the theory of Positive Peer Culture (PPC) (Vorrath & Brendtro, 1974). PPC theory posits the following ideas: (a) relationships are important, (b) crisis offers an opportunity for new learning, (c) individuals can help themselves by helping each other, and (d) individuals are responsible for other members of their community. Based on this theory a core component of treatment is group counseling. Residents in the program participate in weekly group meetings where they learn to identify and take responsibility for their own problems. A critical component to learning about themselves is the group process and input from peers. PPC also emphasizes that each member of the community is expected to be responsible for all members of the community. All residents’ treatment is based on the PPC model. Residents who have a history of criminal sexual behavior also receive treatment that is specific to their inappropriate behavior. The sex offender treatment components are similar in philosophy as that of PPC theory. This aspect of treatment follows generally accepted treatment protocol for juvenile sex offenders (Becker & Kaplan, 1993) and includes; participants taking responsibility for their offenses, learning their offense cycle, understanding their own past abuse, victim empathy training, and relapse prevention.
Adult Subjects

A total of 62 adults volunteered to participate. The ages of participants ranged from 21 to 65 years of age, with a mean age of 41.9 years of age. The majority of subjects were Caucasian (83.6%), though the sample included African-American (3.3%), Asian-Americans (11.5%), and Hispanic-Americans (1.6%). Fifty-two percent of the subjects were single, 25% were married, and 23% were divorced. The subjects' sexual offense behavior fell into four broad categories with 49% being convicted of fondling, 18% being convicted of digital penetration, 33% being convicted of penal penetration, and 0.6% being convicted of exhibitionism.

The adult subjects were solicited for participation from two treatment facilities, The Counseling Institute of Texas and BSA Interventions. The Counseling Institute of Texas (CIT) is a private community based counseling center located in Garland, Texas. CIT provides a wide range of mental health counseling services to the Dallas County area. One service that is offered is outpatient treatment for adults who have been arrested for criminal sexual behavior (i.e., engaging in sexual behavior with an unwilling participant). Referrals to the program typically come from the courts or Department of Corrections. All of the clients involved in the program are either on parole, probation, or are awaiting adjudication for criminal sexual behavior. Clients who received treatment were typically involved in the program concurrently with the time that they were on probation or parole, which was typically five years. At the time of this study approximately 300 clients were receiving treatment for a criminal sex offense at CIT.
The treatment philosophy at The Counseling Institute of Texas (CIT) follows the standards of the Association for the Treatment of Sex Abusers (ATSA). One licensed doctoral level psychologist and four master’s level therapists provide treatment. Initially clients undergo an intake evaluation including: a clinical interview, personality testing, as well as sexual interest and sexual arousal evaluation. In addition clients undergo a polygraph exam to determine their honesty in discussing their offense. The focus of treatment is partially contingent on the results of the clients’ evaluations. All clients participate in group therapy, which meets weekly for one and half-hours. Group therapy sessions are based on cognitive-behavioral principles and focus on clients: learning to take responsibility for their offense, learning their offense cycle, victim empathy and relapse prevention. Clients also participate in individual therapy as needed. Individual therapy focuses on issues of changing deviant sexual arousal patterns, relationship issues, and substance abuse issues.

BSA Interventions is a private community-based counseling center in Kalamazoo, Michigan. BSA provides treatment services to a six county region for individuals with substance abuse, domestic violence, and sexual behavioral issues. Referrals to the sex offender program come from courts or the Michigan Department of Corrections. All of the clients involved in the program are either on parole, probation, or are awaiting adjudication for criminal sexual behavior. Clients are typically involved in treatment for the duration of their probation or parole, which averages from two to five years. At the time of this study approximately 200 clients were receiving treatment for a criminal sex offense.
The treatment philosophy at BSA Interventions is similar to that of CIT. BSA Interventions also follows the standards of the Association for the Treatment of Sex Abusers (ATSA). Three master’s level therapists provide treatment. An initial intake including a clinical interview is conducted. Polygraph tests are not mandatory, however, they are required if client’s description of their offense does not match the police report. Treatment consists primarily of group therapy, which follows a cognitive-behavioral paradigm. Treatment issues are similar to those at CIT and include participants: learning to take responsibility for their offense, learning their offense cycle, victim empathy and relapse prevention. Individual therapy is utilized to address past abuse issues and deviant sexual arousal issues. Substance abuse treatment at BSA Interventions differs from that at CIT in that it is delivered in a group modality.

Consent and Approval

Permission to collect the self-report data from the juvenile residents and their clinical files was granted by Starr Commonwealth staff including the Director of Evaluation and Planning, the Director of Michigan Programs, the Directors of the Residential Programs, the Program Advisory Council, and the Management Team of Starr Commonwealth. A letter of approval was received on March 31, 1999 (Appendix A). Residents at Starr Commonwealth were informed about the opportunity to participate in the research study in their respective cottage classrooms. Consent forms were read to all residents (Appendix B). Students who volunteered to participate were asked to sign the consent form, after they were informed of the specific types of data.
that were to be collected. No attempt was made to persuade or coerce residents into participating. Permission to collect the self-report data from the clients at CIT was granted by the Director of CIT on behalf of the Board of Directors. A letter of approval was received on August 12, 2001 (Appendix C). Clients at the Counseling Institute of Texas were informed about the opportunity to participate in the research study at the end of group therapy sessions. Consent forms were read to all the clients (Appendix D). Clients who volunteered to participate were asked to sign consent forms; after, they were informed of the specific kind of data that were to be collected. No attempt was made to persuade or coerce clients into participating in this study.

Permission to collect the self-report data from the clients at BSA was granted by the Board of Directors of BSA. A letter of approval was received on August 27, 2001 (Appendix E). Clients at BSA Interventions were informed about the opportunity to participate in the research study at the end of group therapy sessions. Consent forms were read to all the clients (Appendix F). Clients who volunteered to participate were asked to sign the consent form, after they were informed of the specific kinds of data that were to be collected. No attempt was made to persuade or coerce clients into participating in this study.

This study involved human subjects; therefore the Human Subjects Institutional Review Board (HSIRB) at Western Michigan University reviewed the study. A Full Board Review was necessary due to some of the juvenile subjects being minors and the adult subjects being mandated by the Department of Corrections for treatment. This study was approved by the HSIRB on October 23, 2001 (Appendix G).
Procedures

Survey packets were administered to the juvenile residents at Starr Commonwealth in their respective cottage group classrooms. The consent form was read to all residents. After consents had been given, questionnaires were administered to all participating residents. Nonparticipating residents were asked to sit quietly during data collection. The instructions and survey packet were read aloud to each group by the researcher. Self-assessment data collection took one hour per classroom. Of the 48 sex offender clients, 47 (98%) chose to participate. Data collection was completed at Starr Commonwealth in July of 1999.

A Starr Commonwealth research assistant assigned codes to each resident: (a) codes were placed on each resident's self-report questionnaire, and (b) codes were placed on each resident's demographic form. Residents were informed of the information to be collected on their demographic form. The Starr Commonwealth research assistant completed demographic forms in August of 1999. The master list matching names to codes was destroyed once data collection was complete.

The procedure for data collection at the Counseling Institute of Texas and BSA Interventions were similar to each other. Survey packets were administered to clients at the end of a group therapy session. The consent form was read to all clients. After consent had been given, questionnaires were administered to all clients who chose to participate. The instructions were read aloud to each group by the researcher. Of the 50 clients at CIT who were invited to participate in the study, 33 (66%) choose to participate. Of the 50 clients at BSA who were invited to participate
in the study 29 (58%) chose to participate. Self-assessment data collection took 50 minutes for each group. Data collection was completed at the Counseling Institute of Texas on July 26, 2002 and at BSA Interventions on August 9, 2002.

A research assistant assigned codes to each client at the Counseling Institute of Texas and BSA Interventions: (a) codes were placed on each client’s self-report questionnaire, and (b) codes were placed on each client’s demographic form. Clients were informed of the information to be collected on their demographic form. The Counseling Institute research assistant completed demographic forms on August 4, 2002. The BSA Interventions research assistant completed demographic forms on August 12, 2002. The master list matching names to codes was destroyed once data collection was complete.

Throughout the entire process, all participants were informed that their participation was voluntary, and that they could cease their participation at any time without penalty. All residents and clients responses were recorded on coded survey packets. No names were listed on demographic forms or survey packets.

Instruments

The instruments utilized in this study consisted of six self-report, personal-social-emotional assessment instruments (i.e., emotion and behavior) and one demographic form. The participant’s emotional expressiveness was examined by comparing their scores on the Twenty-Item Toronto Alexithymia Scale (TAS-20; Bagby et al., 1992) and the Affective Orientation Scale (AOS; Booth-Butterfield & Booth-
Behaviors were assessed by participants' scores on the following scales: the Self-Defeating Personality Scale (SDPS) by Schill (1990), the Adolescent Risk Taking Scale (ARTS) by Alexander et al. (1990), the Reckless Behavior Questionnaire (RBQ) by Arnett (1989), and the Relationship Scales Questionnaire (RSQ) by Griffin and Bartholomew (1994). Demographic and offense history data were gathered from clients' treatment records. All the instruments and the demographic form are described below.

The Twenty-Item Toronto Alexithymia Scale (TAS-20)

The TAS-20 (Bagby et al., 1992) consists of 20 items designed to assess a person's ability to express emotions. The scale has a three-factor structure: (1) Difficulty Identifying Feelings, (2) Difficulty Describing Feelings, and (3) Externally Orientated Thinking (Parker, Bagby, Taylor, Endlers, & Schmitz, 1993; Taylor et al., 1997). All three factors are combined to produce a total score for alexithymia. The total score was the only score used in this study because it was the intent to have a comprehensive overview of participants' emotional expressiveness rather than analyze each factor independently. The 20 items are answered on a 5-point Likert scale from: (1) Strongly Disagree, (2) Moderately Agree, (3) Neither Disagree nor Agree, (4) Moderately Agree, or (5) Strongly Agree. Total scores can range from 20 to 100. A high score indicates a person with alexithymic tendencies. Taylor et al. (1997) has indicated that individuals who are considered alexithymic have scores of 61 or higher, and those who score 51 or less are considered nonalexithymic.
The TAS-20 has demonstrated good internal consistency for various samples of subjects, including college students, psychiatric outpatient adults, and male adult inmates, with coefficient alphas of .81 (Bagby, Taylor, & Parker, 1994a; Kroner & Forth, 1995; Taylor, 1994) and .82 (Yelsma, Hovestadt, Nilsson, & Paul, 1998). Bagby et al. (1994a) indicated that the TAS-20 also had good test-retest reliability over a 3-week interval \( (r = .77) \).

Bagby, Taylor, and Parker (1994b) examined concurrent validity by comparing the level of agreement on alexithymia ratings between external observers and adult patient scores on the TAS-20 \( (r = .53; p < .01) \). These authors also evaluated convergent validity by correlating scores on the TAS-20 with self-report measures of traits related to alexithymia; for example, in a sample of college students, the TAS-20 negatively correlated with measures of need for cognition \( (r = -.55; p < .01) \) and psychological mindedness \( (r = -.68; p < .01) \). Discriminant validity was examined by correlating scores on self-report measures of traits unrelated to alexithymia with the TAS-20; traits of conscientiousness and agreeableness were found to not be significantly correlated to the TAS-20 in college students (Bagby et al.).

The Affective Orientation Scale (AOS)

The AOS (Booth-Butterfield & Booth-Butterfield, 1990) is a 20-item scale that assesses the extent to which individuals are aware of and use their emotions to guide their interactions with others. It is scored by responding to items as follows (1) Strongly Disagree, (2) Moderately Agree, (3) Neither Disagree nor Agree, (4)
Moderately Agree, or (5) Strongly Agree. The total score ranges from 20 to 100. The higher the score on the AOS, the more a person is aware of their emotions. Individuals with scores above 75 are considered to have high affective orientation (AO), below 65 are considered to have low AO, and between 65 and 75 a moderate degree of AO (Frymier, Klopf, & Ishii, 1990).

Originally, the AOS was designed to be a one-factor scale including the dimensions of “affect awareness” and “use of affect” (Booth-Butterfield & Booth-Butterfield, 1990). After further study, these same authors (1992) determined that the AOS was a four-factor scale including the following components: (1) Affect Awareness, (2) Use of Affect, (3) Affect Intensity, and (4) Implementation of Affect. Therefore, it is suggested these four factors together provide a comprehensive overview of the emotion assessment process and the total score is used and not the individual factor scores when using the AOS (Booth-Butterfield & Booth-Butterfield, 1992).

The AOS has been found to be an internally reliable instrument with a split-half reliability (Spearman-Brown correction) of .92 for college students (Booth-Butterfield & Booth-Butterfield, 1990). Another study by Booth-Butterfield and Booth-Butterfield (1992) demonstrated good test-retest reliability for the AOS over a 4-week interval (Spearman Brown = .91; Spearman Brown = .90) when the instrument was administered to a group of college students. The AOS has also been shown to have adequate internal consistency (alpha = 0.85) for college students (Booth-Butterfield & Booth-Butterfield).

Booth-Butterfield and Booth-Butterfield (1990) also demonstrated some
evidence of convergent and divergent validity by correlating scores on the AOS with conceptually related scales of communication with a sample of college students. These authors found the AOS to be moderately correlated to femininity ($r = .31; p < .05$) and conversational sensitivity ($r = .28; p < .01$) and independent of other constructs including masculinity, need for cognition, communication apprehension, and self-monitoring. Dolin and Booth-Butterfield (1993) determined the AOS to be negatively correlated to emotional distancing ($r = -.21; p < .025$).

The Self-Defeating Personality Scale (SDPS; Schill, 1990)

The SDPS consists of 24 items (short form) and measures an individual's behavior toward himself. Items are based on the criteria for Self-defeating Personality Disorder, which was proposed in the Diagnostic and Statistical Manual, Third Revision (DSM-III-R; American Psychiatric Association, 1987). The 24 items of the SDPS are answered by an Agree or Disagree response (1 = Agree, 2 = Disagree). The summation of the 24 items results in a total score, which can range from 0 to 24. The higher the total score, the more self-defeating personality characteristics a person exhibits.

Studies have found the SDPS to be a precise test with internal consistencies ranging from a Cronbach alpha of .68 for college students (Schill, 1990) to a Cronbach alpha of .81 for a nonclinical sample of adults (McCutcheon, 1995). Schill also demonstrated good test-retest reliability of the SDPS over a 3-week interval ($r = .75$ for female college students and $r = .71$ for male college students).
Schill and Kramer (1991) indicated some evidence of convergent validity for the SDPS with a sample of male college students. They found the SDPS to be negatively correlated with self-reinforcement ($r = -0.46; p < 0.01$) and positively correlated with depression ($r = 0.44; p < 0.01$). Furthermore, Schill and Kramer (1991) found a significant negative correlation between the SDPS and family environment cohesiveness for both male and female college students ($r = -0.42$ and $r = -0.33$, respectively; $p < 0.05$). Men had negative correlations between the SDPS and the family environment moral-religious emphasis ($r = -0.45; p < 0.05$), expressiveness ($r = -0.28, p < 0.05$) and achievement orientation ($r = -0.35; p < 0.05$; Schill & Kramer).

The Reckless Behavior Questionnaire (RBQ; Arnett, 1989)

The RBQ is a 10-item questionnaire measuring a person's reckless behavior. Items are answered using a 5-point format: (1) Never, (2) Once, (3) 2–5 times, (4) 6–10 times, and (5) More than 10 times. The items on the questionnaire were chosen based on "the potential for immediate and/or dire negative consequences" (Shaw et al., 1992, p. 308). An individual's score can range from 10 to 50. The higher the score, the more a person has been involved in several reckless behaviors.

The RBQ indicated good internal consistency for a sample of high school students ($\alpha = 0.80$) and for a sample of college students ($\alpha = 0.83$) (Shaw et al., 1992). In addition, good test-retest reliability was demonstrated by the college sample at a 3-month interval ($r = 0.80$).

Shaw et al. (1992) demonstrated construct validity for the RBQ by correlating
the instrument with the Zuckerman Sensation Seeking Scale-Form V (Zuckerman, 1976), the Aggression subscale of the Personality Research Form (Jackson, 1967), and the MacAndrew scale of the Minnesota Multiphasic Personality Inventory (MacAndrew, 1965). Furthermore, discriminate validity was established when scores on the RBQ were found to be significantly different compared to scores on the Rosenberg Self-Esteem Scale (Rosenberg, 1965).

Shaw et al. (1992) further explored the construct validity of the RBQ by performing discriminant function analyses on a two-factor model of the RBQ. These authors labeled “Drivevandal” as one factor and “Drugsex” as the other factor. Labels were chosen to reflect the dominance of two types of behavior; for instance, driving fast and vandalism for factor one, and substance use and sexual activity for the other factor.

The Adolescent Risk Taking Scale (ARTS)

The ARTS was designed by Alexander et al. (1990), who developed the scale by having teenagers describe things they do for “excitement and thrills” (p. 562). Student answers were then collapsed into a six-item scale measuring adolescents’ risk-taking behaviors. Items were answered using a 3-point format: (1) Never, (2) Once or Twice, or (3) Several Times. For this study, items were answered using a 5-point format: (1) Never, (2) Once, (3) 2–5 times, (4) 6–10 times, and (5) More than 10 times. In the present study, the response format was edited to allow for more specific categories and consistency with the RBQ. A high score indicates an adolescent who
is involved in several risk-taking behaviors.

Psychometric evaluation of the original ARTS indicated good internal consistency with alpha coefficients of .78 (as eighth graders) and .80 (as ninth graders) (Alexander et al., 1990). Alexander et al. invited only male and female eighth graders to complete the ARTS and then 1 year later asked them to complete the ARTS again as ninth graders. Fifty-three to 73% of the students gave the same answers a year later for individual items, which was supportive of test-retest reliability.

Preliminary analyses showed the ARTS meets criteria for construct validity (Alexander et al., 1990). The six items on the ARTS were factors analyzed with a five-item anger scale. Results confirmed that the ARTS was a distinct scale from a hostile behavior scale. Predictive validity was also demonstrated with the ARTS by examining eighth grade scores as predictors of ninth grade risk-taking behavior. Alexander et al. found high eighth grade scores to be predictive of substance use and sexual activity in the ninth grade.

The Relationship Scales Questionnaire (RSQ)

Griffin and Bartholomew (1994) designed the RSQ as a measure of an individual’s attachment style. The scale is based on Bartholomew and her colleagues’ (Bartholomew, 1990; Bartholomew & Horowitz, 1991; Griffen & Bartholomew, 1994) theory of attachment. This theory conceptualizes Bowlby’s (1988) internal working models by defining individual differences in adult attachment in terms of the intersection of two dimensions: (1) view of self and (2) view of others. These two
dimensions are then dichotomized as positive or negative, which leads to four Attachment Styles: (1) Secure, (2) Preoccupied, (3) Fearful, and (4) Dismissive. Hazen and Shaver (1987) initially developed the Relationship Questionnaire (RQ) to measure these four attachment styles. The RQ consists of four paragraphs which individuals read and respond to, indicating which paragraph most closely describes their attachment style. Griffin and Bartholomew developed the RSQ by taking statements from the paragraphs in the RQ. The RSQ has 30 statements which participants respond to by rating their experience in relationships on a 5-point scale including: (1) Not At All Like Me, (2) Not Like Me, (3) Uncertain, (4) Like Me, and (5) Very Like Me. The statements can be phrased to reflect current or past relationships. In the current study statements were phrased to assess current relationships. Individual scores classify subjects into one of the four attachment styles: (1) secure, (2) preoccupied, (3) fearful, and (4) dismissive.

Griffin and Bartholomew (1994) report internal consistencies ranging from alpha = .41 for the Secure pattern to alpha = .70 for the Dismissing pattern. While these internal consistencies are low, Griffin and Bartholomew (1994) suggest this is the function of the nature of the two-dimensional model, due to the two dimensions being combined on one scale. The RSQ has been shown to have adequate convergent validity. The RSQ has been compared with the RQ as well as clinical interviews and has convergent validity coefficients ranging from .22 to .50 (Griffin & Bartholomew).
Demographic Form

A research assistant at Starr Commonwealth completed a demographic form for the residents (Appendix H). The form includes the following information: age, ethnicity, family system status (i.e., residing with parents, stepparents, relatives), length of stay at Starr Commonwealth (measured by months of treatment), abuse history (including past physical, emotional, or sexual abuse), and offense history (the specific offense the subject committed). The research assistant retrieved all information from resident files and an existing computer database.

A research assistant for the adult offenders at CIT and BSA (Appendix I) also completed a demographic form for participants. In addition to the variables gathered for the adolescent offenders (age, ethnicity, family system status, length of treatment, abuse history, and offense history), the age and victim of the offender was also recorded for the adult offenders.

Planned Data Analysis

Descriptive statistics were provided for the juveniles and adult groups. To test the first five research questions, a series of t-tests for independent samples were conducted between the two groups on the five dependent variables (TAS-20, AOS, SDPS, RBQ, and ARTS). The statistical significance level was set at the .05 level. A qualitative analysis utilizing descriptive statistics was conducted to answer the sixth research question.
CHAPTER IV

DATA ANALYSIS

The 47 juvenile subjects were generally homogenous in terms of age and type of offense. The 62 adult subjects fell into three broad ranges based on their offense: fondling, digital penetration, or penal penetration. One of the adult subject's offense involved exhibitionism and that subject was eliminated from the data set due to the difference in offense type, resulting in 61 adult subjects.

The first five research questions were examined through a series of t-tests for independent samples conducted between the two groups, juvenile and adult sex offenders, on the five dependent measures: (1) the Twenty-Item Toronto Alexithymia Scale (TAS-20), (2) the Affective Orientation Scale (AOS), (3) the Adolescent Risk Taking Scale (ARTS), (4) the Reckless Behavior Questionnaire (RBQ), and (5) the Self-Defeating Personality Scale (SDPS). The two groups had significantly different scores on the ARTS, with juveniles reporting a higher degree of risk taking behaviors, $t(106) = -19.051, p < .05$. There was also a statistically significant difference between scores for the two groups on the RBQ, with the juveniles reporting a higher degree of reckless behavior, $t(106) = -7.118, p < .05$. There were no significant differences between the two groups on the remaining three measures; the TAS-20, AOS, and the SDBS.

The sixth research question explored the differences between the attachment
styles of adult subjects based on their offense behavior. The subjects' offense behaviors were determined by their reported offense and classified as one of three types of sexual behavior: (1) fondling, (2) digital penetration, or (3) penal penetration. The distribution of the 61 adult subjects into these offense groups was as follows: (1) the fondling group was composed of 30 subjects, (2) the digital penetration group consisted of 11 subjects, and (3) the penal penetration group consisted of 20 subjects.

Attachment style was measured by the subjects’ responses on the Relationship Scales Questionnaire (RSQ). Subjects were classified into one of four attachment styles (Secure, Preoccupied, Fearful, or Dismissive) based on their highest mean subscale score on the RSQ as described by Griffin and Bartholomew (1994). Five of the subjects scored the same on two subscales, therefore their scores were distributed evenly between the subscales. An analysis utilizing descriptive statistics was conducted.

The percentage of subjects that were classified into each attachment style, based on offense behavior, is displayed in Table 1.

<table>
<thead>
<tr>
<th>Attachment Style</th>
<th>Group</th>
<th>N</th>
<th>Secure</th>
<th>Preoccupied</th>
<th>Fearful</th>
<th>Dismissive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondling</td>
<td>30</td>
<td></td>
<td>50.2 %</td>
<td>16.6 %</td>
<td>16.6 %</td>
<td>16.6 %</td>
</tr>
<tr>
<td>Digital Penetration</td>
<td>11</td>
<td></td>
<td>54 %</td>
<td>18 %</td>
<td>10 %</td>
<td>18 %</td>
</tr>
<tr>
<td>Penal Penetration</td>
<td>20</td>
<td></td>
<td>20 %</td>
<td>10 %</td>
<td>45 %</td>
<td>25 %</td>
</tr>
</tbody>
</table>

Table 1

Percentage of Subjects by Attachment Style
An additional analysis was conducted examining the differences among the three groups of adult sex offenders based on their scores on the three subscales of the TAS-20, Difficulty Identifying Feelings, Difficulty Describing Feelings, and Externally Oriented Thinking. A one-way Analysis of Variance (ANOVA) was conducted to determine if there were any overall differences among the three groups of offenders based on their offense level. There was a statistically significant difference among the three groups on the subscale of Difficulty Identifying Feelings: F (2, 58) = 3.954, p < .05. While there was a difference among group scores on the subscale of Difficulty Describing Feelings, it was not substantial enough to reach statistical significance. There were also no statistically significant differences among the three groups on the Externally Oriented Thinking subscale. Post-hoc analyses were performed using Levene's test for quality of difference to identify exactly where significant differences existed. The analyses revealed that the more severe offense group, penal penetrators, scores differed significantly from the least severe group, fondlers, scores, t (49) = 2.62, p < .05. There were no significant differences between the penal penetrators and digital penetrators scores nor between the digital penetrators and fondlers scores on the Difficulty Identifying Feelings subscale. Descriptive data regarding the other two subscales is also provided in Table 2.
Table 2

Group Means on the TAS-20 Subscales

<table>
<thead>
<tr>
<th>Adult Group</th>
<th>N</th>
<th>Difficulty Identifying Feelings</th>
<th>Difficulty Describing Feelings</th>
<th>Externally Oriented Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondlers</td>
<td>30</td>
<td>13.73 (5.75)</td>
<td>13.53 (4.53)</td>
<td>20.10 (4.46)</td>
</tr>
<tr>
<td>Digital Penetrators</td>
<td>1</td>
<td>16.20 (4.77)</td>
<td>16.70 (4.27)</td>
<td>21.70 (3.43)</td>
</tr>
<tr>
<td>Penal Penetrators</td>
<td>20</td>
<td>18.57 (6.96)</td>
<td>15.66 (4.28)</td>
<td>21.76 (5.33)</td>
</tr>
</tbody>
</table>

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
CHAPTER V

DISCUSSION

This chapter is divided into four sections. In the first section the findings of the study are discussed in the context of the current literature. The discussion is followed by a summary of the current finding's implications for treatment. In the third section the limitations of the study are presented. Finally, recommendations for future research are suggested.

Discussion of Findings

While it is generally accepted that there are differences between juvenile and adult sex offenders (Barbaree et al., 1993; Rubinstein et al., 1993), few studies have compared these two groups. The current study is the only known study that has compared juvenile and adult sex offenders on the variables of emotional expressiveness as well as problematic behaviors. This study did not find any statistically significant differences between juvenile and adult sex offenders in emotional expressiveness as measured by the variables, Alexithymia and Affective Orientation. In addition, this study did not find a statistically significant difference on the variable of self-defeating behavior. However, statistically significant differences were found on the variables of risk taking and reckless behaviors with juvenile sex offenders reporting a higher degree of these behaviors than adult sex offenders.
There are several possible reasons why this research did not find any significant differences between juvenile and adult sex offenders on the emotional expressiveness measures. One possible reason is that emotional expressiveness is established in childhood and does not change over the course of latter development. Taylor (1994) describes Alexithymia as a general personality trait involving difficulty understanding one's feelings and regulating one's emotions. It is believed that Alexithymia is formed in early childhood and remains stable over the course of an individual's life (Taylor et al., 1997). Considering the early development of Alexithymia, it is possible that the degree of an individual's emotional expressiveness is well established by adolescence. Therefore, adult and juvenile sex offenders may have similar degrees of alexithymia despite their difference in age.

Another reason why there were no differences on the emotional expressiveness variables could be that lack of emotional expressiveness may be unrelated to the development of sexually aggressive behavior. A previous study that utilized a standardized measure of alexithymia (the TAS-20) found adult sex offenders and general criminal offenders were no more alexithymic than a "normal" group with no known history of criminal behavior (Kroner & Forth, 1995). Ness (2000) also found no significant differences in alexithymia scores (the TAS-20) between juvenile sex offenders, juvenile non-sexual criminal offenders, and juveniles without known histories of criminal behavior. However, the results of Kroner and Forth's as well as Ness's study conflicted with earlier research (Hudson et al., 1993; Keltikangas-Jarvinen, 1982) that indicated sex offenders had higher alexithymia scores compared to a non-criminal
group. Given these inconsistent findings, it remains unclear as to whether sex offenders are more alexithymic than non-offenders.

A third reason why no differences between the two groups of sex offenders on emotional expressiveness were identified could be due to the measures that were used. Insignificant findings may be due to sex offenders' abilities to determine socially appropriate responses on the TAS-20 as well as the AOS, and their reluctance to be candid. Both of these emotional expressiveness measures, the TAS-20 and the AOS, are self-report instruments. Subjects may have been able to discern socially appropriate responses on these measures and responded in what they believed was the appropriate or normative fashion. As previously stated, earlier studies have found sex offenders to be high in alexithymia (Hudson et al., 1993; Keltikangas-Jarvinen, 1982). However, these earlier studies used non-standardized measures (Rorschach inkblots and photographs) to assess alexithymia. These non-standardized measures are of a more ambiguous nature and may be harder to feign socially appropriate responses.

There also were no statistically significant differences between the juvenile and adult sex offenders on the Self Defeating Personality Scale (SDPS). A possible reason for this finding could be due to the same developmental factor that may have led to the similar finding in emotional expressiveness. The self-defeating personality trait may be established by early adolescence. If that were the case it would be unlikely that two similar groups, juvenile and adult sex offenders, would be different regardless of their difference in age.

There were statistically significant differences on two of the three behavioral
measures. Juvenile sex offenders reported a higher degree of risk taking behaviors on the Adolescent Risk Taking Scale (ARTS) compared to the adult sex offender group. Juvenile sex offenders were also found to report a higher degree of reckless behavior on the Reckless Behavior Questionnaire (RBQ). The finding that juvenile sex offenders reported a greater degree of risk taking behavior is consistent with past research. Arnett (1992) found that juveniles scored higher on risk taking (as measured by the ARTS) compared to adults offenders. Ness (2000) also found that juvenile sex offenders and juvenile general offenders reported a higher degree of risk taking behavior than a non-criminal juvenile comparison group. Therefore the current results and previous research support the hypothesis that juvenile sex offenders have a higher degree of risk taking behavior compared to non-criminally offending juveniles as well as adult sex offenders. A high degree of risk taking behavior appears to be a unique factor that distinguishes juvenile sex offenders from an adult offender group.

It is unclear as to why a high degree of risk taking is a unique factor to juvenile sex offenders. One possible explanation is that engaging in criminal sexual behavior is more of a risk for juveniles than adults. When viewed in a social context this theory appears to have merit. Adults typically have more control over other persons and their social environment. Therefore they are less likely to be caught engaging in sexually inappropriate behavior and thereby incur less risk than a juvenile would. A possible explanation is that juveniles who engage in criminal sexual behavior are more willing or comfortable engaging in risk taking behaviors.

A post-hoc analysis of the data from adult subjects found that there was a
significant difference among adult subjects on the subscale Difficulty Identifying Feelings of the TAS-20 when the severity of the offense was considered. Adult sex offenders whose offenses were more violent, involving penal penetration, reported more difficulty identifying feelings than those whose offense involved digital penetration or fondling. As previously mentioned, past research has provided conflicting results in reference to sex offenders’ difficulty identifying feelings and managing emotions. The findings of this study suggest that the severity of the offender’s offense is correlated with their difficulty identifying feelings. This may provide an explanation as to why past studies have had conflicting findings. It is possible emotional expressiveness is more related to the degree of violence that an individual commits. Therefore a group of sex offenders whose offense was not overtly violent (i.e., fondling) may not report having difficulty identifying feelings.

The present study also examined adult sex offenders’ self-reported attachment style in current relationships. Forty-one percent of the adult sex offenders reported secure attachment styles in intimate relationships. A small number of studies have examined attachment style among sex offenders. One study that has examined sex offenders’ attachment style in current relationships found that 22% of an incarcerated sex offender population had secure attachment styles (Ward et al., 1996). This finding was markedly lower than what is typically reported in a non-sex offender population. Bartholomew and Horwitz (1991) reported that 55% to 65% of the general (non-criminal) population have secure attachments. The present study’s finding of 41% of offenders having secure attachments, in comparison to Ward et al.’s report of 22%,
may be due to their use of incarcerated subjects. While it is not possible to know if the current study’s subjects, who were not incarcerated, committed less severe offenses, than Ward et al.’s group, it is a plausible explanation. Subjects who are treated in the community typically have committed less heinous offenses than those who are incarcerated.

When the adult subjects in the present study were classified by the severity of their offense, a noticeable attachment style pattern emerged. Only 20% of the adult subjects who offended by penal penetration had a secure attachment style. However, 50% of adult subjects in each of the less severe offense categories (fondling and digital penetration) reported having secure attachment styles. One possible explanation of this finding is that the severity of the sex offense is related to attachment style. Individuals who have an insecure attachment style may be more prone to engage in more violent sexual behavior. Seidman et al. (1994) found that individuals with insecure attachment styles have increased difficulty establishing interpersonal relationships. This finding also is consistent with the finding that adult sex offenders in the current study, who had committed more violent offenses, had more difficulty identifying their feelings.

Implications for Treatment

As previously stated, the cause of sexually aggressive behavior is most likely the result of a complex inter-related system involving biological, cognitive, affective, and developmental components. Effective treatment methods will need to address a
broad range of individual variables. The findings of the present study provide some tentative support that juvenile sex offenders may be more prone to engage in risk taking behaviors compared to adult sex offenders or peers of their own age. Assuming that risk taking behaviors predisposes adolescents to engage in sexually inappropriate behavior, it would be beneficial for treatment programs to assess individuals for risk taking behaviors and provide appropriate treatment. However, it is important for treatment providers to view risk taking behavior within a developmental model. Lightfoot (1997) has described risk-taking behavior to be a natural developmental process during adolescence. Therefore it is unlikely that risk-taking behaviors can or should be completely eliminated; however, they may be channeled into more socially appropriate activities.

The present study also provides some support for the conclusion that adult sex offenders appear to be prone to having difficulty identifying their feelings. Treatment approaches often acknowledge that feelings are a "trigger" (i.e., initial cause for individuals to proceed to committing sex offenses). However, treatment frequently remains focused on behavior and cognition. While a focus on behavior and cognition may be helpful, it could result in taking the focus off an equally important element of treatment, offenders' understanding of their feelings. Treatment may benefit by integrating a component focusing on increasing affect awareness and emotion regulation.

The finding that adult sex offenders frequently report an insecure attachment style also has potential implications for treatment. Griffin and Bartholomew (1994) suggest that individuals with insecure attachment styles have a negative view of
themselves as well as others. Consistent with this theory are findings that sex offenders have low self-esteem and negative attitudes towards women (Scott & Tetreault, 1987; Seidman et al., 1994). Marshall (1989a) has suggested that for treatment to be effective it has to not only decrease deviant interests but also increase more socially appropriate behaviors. In order to foster increased self-esteem and more positive attitudes towards others, offenders may first need to resolve childhood attachment issues. Treatment programs may want to incorporate a component that addresses offenders past and current relationships with parental figures. With improvement in those relationships offenders may have subsequent increases in self-esteem and develop more favorable attitudes towards women.

Limitations

This study had a number of limitations. This study relied on self-report instruments, which are susceptible to dishonest responding. While participation was voluntary and subjects were guaranteed anonymity, there remains a possibility that subjects may have distorted their answers because all were involved in treatment mandated by the courts.

There was a significant difference in the percentages of juvenile subjects who volunteered to participate compared to the adult subjects. The vast majority of the juveniles, 47 out of 48, chose to participate, while a smaller percentage of the adult group, 62 out of 100, participated. This difference may be due to a number of reasons. Requests to participate in research studies are fairly common experiences for
the residents in the juvenile treatment center that was used in this study. By compari-
son, both adult treatment programs have rarely had researchers solicit subjects to par-
ticipate in research. Regardless of the contributing cause, the effect of partial partici-
pation among the adult subjects may have impacted this study's findings. It is possi-
ble that the 62 adult subjects who chose to participate were distinctly different than
the 38 subjects who chose not to participate. For example the 62 subjects that partici-
pated may have been a more cooperative and well-adjusted sub-sample of the adult
group.

A third limitation was that adult and juvenile subjects were selected from dif-
frent treatment settings. Adult subjects were in community-based treatment pro-
grams and the juveniles were in a residential treatment program. While the severity
of the groups offenses were similar, different treatment settings may have led to
unforeseen differences. The juvenile offenders received a greater intensity or fre-
quency of treatment. Juveniles were in treatment five days per week, while adults
were in treatment only once a week. These differences in treatment environments
may have had unforeseen effects on the subjects and their responses on the research
instruments. It is possible that the juveniles' greater intensity of treatment had a more
favorable effect on their emotional health and positively impacted their scores on this
study's research instruments.

Finally, the subjects that participated in this study limit the population to
which the findings can be generalized. As the subjects in the current study were
involved in community or residential-based treatment, the present findings can only
be generalized to subjects in those types of treatment settings.

Recommendations for Future Research

Given that subjects may present themselves in an overly positive fashion on self-report instruments, future studies should include measures to assess socially desirable responding. While none of the instruments used in the present study had validity scales incorporated into their questions, a number of independent scales, which measure socially desirable responding, have been developed. Future studies should incorporate such scales into their self-report instruments. In addition, it is recommended that data about the subject's emotional expressiveness and attachment style be gathered from family members, friends, and treatment providers. This information could be compared to the subject's self-report data and used as a further indication of the validity of the subject's responses.

Another factor that should be taken into account is the length of treatment that subjects have received. Subjects in the present study had variable amounts of treatment at the time they participated. Treatment could have affected the subject's response on the research instruments. Future studies could be improved by soliciting subjects at the onset of treatment. Furthermore, subjects could be evaluated both at the onset and conclusion of treatment to assess for treatment effects.

A third factor that should be examined is how the degree of violence impacts offenders' scores on emotional expressiveness and attachment. While the specific type of sexual offense should be considered, so too should other factors that indicate
increased violence. Data on whether the offender injured the victim or used a weapon should be obtained and used as well as the type of sex offense to determine the degree of violence that was used.
Appendix A

Starr Commonwealth Approval Letter
March 31, 1999

Ms. Carin Ness
2028 Colgrove Avenue #313
Kalamazoo, MI 49001

Dear Carin,

Your persistence and dedication to this research study seems to be paying off. I have received your dissertation proposal and reviewed it with our Vice President of Programs and the Director of Michigan Programs. We are very anxious to move forward with this project. Certainly, studying the differences in emotional expressiveness and risk-taking behavior among our sex offenders and non-sex offenders is an important project that has great potential for our treatment staff.

As we have discussed over the past year, Starr Commonwealth has the permission of its constituents to use the data obtained from our clients for research purposes. We participate in applied research studies to learn more about the clients we serve and to advance the quality of service we provide. Starr Commonwealth has the authority to allow external researchers access to this client data, as long as client confidentiality is strictly enforced.

The use of our own internal evaluation technician to code the client information before giving you access to this data is an effective way of protecting the identity of our clients. We appreciate your efforts in support of this.

You, and Peter Rausch, have met the requirements for approval by Starr Commonwealth to proceed with your research study.

Sincerely,

Randall K. Davis, MA, LPC
Director of Research and Evaluation

James Longhurst, Ed.D
Director of Michigan Programs

Martin L. Mitchell, Ed.D
Vice President of Programs

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Appendix B

Consent Form for Starr Commonwealth
I have been asked to participate in a research project that is in fulfillment of dissertation requirements for Ms. Carin Ness and Mr. Peter Rausch. The differences in emotional expressiveness and behavior among groups of male students will be compared. The purpose of the study is to explore young people's expression of emotions and their risk-taking behaviors. This study is being conducted with the support of the research staff at Starr Commonwealth.

The information I provide will help in the prevention and treatment of young people like myself who are struggling with some of the same issues that brought me to Starr Commonwealth. In addition, this information will help researchers and helping professionals to better understand some of the struggles young people are facing today.

I will be given five questionnaires during two, one hour, time periods in June or July. I will not get any extra credit, and if I don't wish to participate, there will be no effect on my school grades. Even if I agree today to participate by signing this form, I can change my mind at any time. The researchers would like to compare my answers on the questionnaires with my personal history and listing of legal charges in my case file. If I sign below, I am agreeing that a Starr Commonwealth staff member may provide information from my case file to the researchers.

My name will not be on any of the forms. The researchers will use a code number instead. The Starr Commonwealth staff member will keep a list of names and code numbers that will be destroyed once the researchers have collected all of their information. None of my forms will be seen by staff at Starr Commonwealth other than the research assistant. The only risk anticipated are minor discomforts typically experienced by young people when they are given questionnaires (e.g., boredom). As in all research, there may be unforeseen risks. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or treatment will be made available to me except as otherwise specified in this permission form.

If I have any questions or concerns about this study, I may contact my cottage counselor or Dr. James Loughurst, Psychologist, at any time. I may also ask my cottage counselor to help me contact either Dr. Alan Hovestadt, Ms. Carin Ness, Mr. Peter Rausch, or Western Michigan University's Human Subjects Institutional Review Board and/or Vice President of Research, if I have further questions.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature.

My signature below indicates that I agree to be given the five questionnaires and I agree that the Starr Commonwealth staff member can provide information from my case file to the researchers.

Print name here

Sign name here

Date

Permission obtained by:

Initials of researcher

Date
Appendix C

The Counseling Institute of Texas
Approval Letter
August 12, 2001

Mr. Peter Rausch
Department of Counselor Education
and Counseling Psychology
Western Michigan, 49008

Dear Peter:

The Counseling Institute of Texas, Inc. is honored to assist you in your research project aimed at examining the differences that may exist between adult male and juvenile male sex offenders on variables of emotional expressiveness and behavior.

The Board of Directors is in support of research particularly in the area of sex offender treatment.

I look forward to working with you on this project.

Sincerely,

Maria T. Molett, M.A., L.P.C., RSOTP
Executive Director
Appendix D

Consent Form for the Counseling Institute of Texas
CONSENT FORM – The Counseling Institute of Texas

Principle Investigator: Dr. Alan Hovestadt
Student Investigator: Peter Rausch

I have been invited to participate in a research project entitled, Affective Expression and Behavior In Sex Offenders. The purpose of this study is to study the expression of emotion and behavior in individuals who have been convicted of a sex offense. This study is Peter Rausch’s dissertation project.

If I choose to participate I will fill out a questionnaire consisting of questions that ask about how I express my feelings and behavior. Some examples are: “I worry about being alone,” “people I find exciting are often abusive or insensitive,” or “I am very aware of my feelings.” You are free to skip any question that you do not want to respond to or to stop your participation in the study at any time without any penalty. It will take about one hour to fill out. In addition the researchers would like to compare my answers with my personal history in my case file.

My participation in this study will not affect my treatment status in any way. My name will not be on the questionnaire or personal history forms. The researcher will use a code number instead. Staff at The Counseling Institute of Texas will not see the results of my questionnaire. The information from my case file will be identified with a number so the researcher will not know my name.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form. Some of the questions may be emotionally upsetting to you or bring up other thoughts that are upsetting. If you find that you become upset or have any questions you can contact researcher Rausch who is a counselor or any of your treatment team at CIT.

There is no direct benefit to me from participating in this study. However, the results may contribute to the body of knowledge on individuals who have sex offender issues and may be helpful to treatment provides.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Due to the use of a research code, the information you provide, if you choose to participate will be confidential. The only connection of your name to your code is the master list which will be destroyed immediately after you are given the research packet and before you choose to participate or not. Your choice to participate or not will not effect your probation or parole in any way. Your probation/parole officer and treatment staff here will not know if you participated or not.

If I have any questions or concerns about this study, I may contact my therapist, the director of The Counseling Institute of Texas, Maria Molett at (972) 494-0160, or the researchers, Dr. Alan Hovestadt at (616) 387-5117 or Peter Rausch at (616) 387-5100. I may also contact the Chair of the Human Subjects Institutional Review Board at (616) 387-8293 or the vice president for research at (616) 387-8298.

The Human Subjects Institutional Review Board as indicated has approved this consent document for one year by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature.

My signature below indicates that I have read and/or had explained to me the purpose and requirements of the study and that I agree to participate.

Participant’s Signature       Date

Initials of researcher       Date
Appendix E

BSA Interventions Approval Letter
August 27, 2001

Mr. Peter Rausch
Department of Counselor Education
and Counseling Psychology
Western Michigan University
Kalamazoo, MI 49008

Dear Mr. Rausch:

We have reviewed your proposal for your dissertation research project on emotional expressiveness in sex offenders. We are agreeable to your collecting data at BSA Interventions. If you have any questions feel free to call us.

Charles Wilkens, MSW, CSW
Director

Dave Wingard, MSW, CSW
Director

B.S.A. INTERVENTIONS, P.C.
GROUP, INDIVIDUAL AND FAMILY COUNSELING
Appendix F

Consent Form for BSA Interventions
CONSENT FORM – BSA Interventions

Principle Investigator: Dr. Alan Hovestadt
Student Investigator: Peter Rausch

I have been invited to participate in a research project entitled, Affective Expression and Behavior in Sex Offenders. The purpose of this study is to study the expression of emotion and behavior in individuals who have been convicted of a sex offense. This study is Peter Rausch’s dissertation project.

If I choose to participate I will fill out a questionnaire consisting of questions that ask about how I express my feelings and behavior. Some examples are: “I worry about being alone,” “people I find exciting are often abusive or insensitive,” or “I am very aware of my feelings.” You are free to skip any question that you do not want to respond to or to stop your participation in the study at any time without any penalty. It will take about one hour to fill out. In addition the researchers would like to compare my answers with my personal history in my case file. A research assistant at BSA has filled out a form with some history about my offense. My name will not appear on that form, instead a research code will be used.

My participation in this study will not affect my treatment status in any way. My name will not be on the questionnaire or personal history forms. The researcher will use a code number instead. Staff at BSA Interventions will not see the results of my questionnaire. The information from my case file will be identified with a number so the researcher will not know my name.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or additional treatment will be made available to the subject except as otherwise stated in this consent form. Some of the questions may be emotionally upsetting to you or bring up other thoughts that are upsetting. If you find that you become upset or have any questions you can contact researcher Rausch who is a counselor or any of your treatment team at BSA.

There is no direct benefit to me from participating in this study. However, the results may contribute to the body of knowledge on individuals who have sex offender issues and may be helpful to treatment provides.
Due to the use of a research code, the information you provide, if you choose to participate will be confidential. The only connection of your name to your code is the master list which will be destroyed immediately after you are given the research packet and before you choose to participate or not. Your choice to participate or not will not effect your probation or parole in any way. Your probation/parole officer and treatment staff here will not know if you participated or not.

If I have any questions or concerns about this study, I may contact my therapist, the directors of BSA Interventions, Charles Wilkens or David Wingard at (616) 345-3617 or the researchers, Dr. Alan Hovestadt at (616) 387-5117 or Peter Rausch at (616) 387-5100. I may also contact the Chair of the Human Subjects Institutional Review Board at (616) 387-8293 or the vice president for research at (616) 387-8298.

The Human Subjects Institutional Review Board as indicated has approved this consent document for one year by the stamped date and signature of the board chair in the upper right corner. Subjects should not sign this document if the corner does not have a stamped date and signature.

My signature below indicates that I have read and/or had explained to me the purpose and requirements of the study and that I agree to participate.

Participant’s Signature  Date

Initials of researcher  Date
Appendix G

Human Subjects Institutional Review
Board Letters of Approval
Date: October 23, 2001

To: Alan Hovestadt, Principal Investigator
    Peter Rausch, Student Investigator for dissertation

From: Mary Lagerwey, Chair

Re: HSIRB Project Number 01-08-03

This letter will serve as confirmation that your research project entitled “Affective Expression and Behavior in Sex Offenders” has been approved under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: August 15, 2002
Date: 16 June 1999

To: Alan Hoevestadt, Principal Investigator
   Carin Ness, Student Investigator for dissertation
   Peter Rausch, Student Investigator for dissertation

From: Sylvia Culp, Chair

Re: HSIRB Project Number 99-04-07

This letter will serve as confirmation that your research project entitled “The Differences in Emotional Expressiveness and Behavior Among Male Juvenile Sexual Offenders, General Offenders, and Nonoffenders” has been approved under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: 16 June 2000
Appendix H

Demographic Form for
Starr Commonwealth
STUDENT DEMOGRAPHIC QUESTIONNAIRE

[To be filled out by Starr Commonwealth Research Assistant from database and files]

CODE:_____

1. Age:_______

2. Length of time at Starr:
   a) 0 to 3 months
   b) 4 to 6 months
   c) 7 to 9 months
   d) 10 to 12 months
   e) 13 to 16 months
   f) over 16 months

3. Ethnicity: (self-identified)
   a) African American
   b) Alaskan Native
   c) American Indian
   d) Asian-American
   e) Caucasian
   f) Hispanic
   g) Multiracial
   h) Pacific Islander
   i) Other:____________________

4. Family System Status:
   a) both biological parents present
   b) single biological parent
   c) blended family (step parents or LTP)
   d) extended family:________________________
   e) non-familial custodial arrangement

5. Presenting Problem (including abuse history):________________________
   (see Listing for Presenting Problems)

6. Committing Offenses:________________________________
   (see Listing for Committing Offenses and Adjudications)

7. Previous Adjudication(s) Other than Committing Offenses(s):
   (see Listing for Committing Offenses and Adjudications)

8. Age of 1st offense, if known:______ (for JSOs only)

9. Total Number of Treatment Services prior to Starr placement:_______
Appendix I

Demographic Form for the Counseling Institute of Texas and BSA Interventions
SUBJECT DEMOGRAPHIC QUESTIONNAIRE

1. Age: __________

2. Length of time in current program: ___ years ___ months

3. Ethnicity: (self-identified)
   a) African American    b) Alaskan Native    i) Other: __________
   c) American Indian    d) Asian-American
   e) Caucasian          f) Hispanic
   g) Multiracial        h) Pacific Islander

4. Family System Status:
   a) single and not involved in a dating relationship
   b) single and currently dating/in a relationship
   c) engaged
   d) living with a sexual partner
   e) married
   f) separated
   g) divorced
   h) widowed

5. Committing Offense(s) [offense that client was believed to have committed regardless of what they plead guilty to]
   {check all that apply}:
   a) rape [forced penetration]
   b) non-familial child molestation [molesting a child that was not a blood relative]
   c) incest [molesting a child who was a relative]
   d) exhibitionism [showing someone their genitals]
   e) other i.e. froterism

6. Actual criminal charge, i.e. 1st. degree CSC, etc.: ________________________________

6. Age(s) of victim(s) __________

7. Age of client at the time of their first offense __________

8. Age of client at the time of their last offense __________

9. Total number of treatment services for sex offenses prior to current treatment
   (prior treatment can include; any treatment which the focus was for a sex offense
   include treatment in prison, or outpatient __________

10. Did the client experience any physical abuse during their childhood? Yes / No

11. Did the client experience any emotional abuse during their childhood? Yes / No

12. Did the client experience any sexual abuse during their childhood? Yes / No
BIBLIOGRAPHY


Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.


