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The Effects of a Therapy Review Board Procedure on Denial and Self-Disclosure of Incarcerated Sex Offenders

Richard Martin Happel
Western Michigan University

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THE EFFECTS OF A THERAPY REVIEW BOARD PROCEDURE ON DENIAL AND SELF-DISCLOSURE OF INCARCERATED SEX OFFENDERS

by

Richard Martin Happel

A Dissertation
Submitted to the
Faculty of The Graduate College
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and Counseling Psychology

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THE EFFECTS OF A THERAPY REVIEW BOARD PROCEDURE ON DENIAL AND SELF-DISCLOSURE OF INCARCERATED SEX OFFENDERS

Richard Martin Happel, Ed.D.
Western Michigan University, 1994

The clinical practice of assessing sex offenders was the focus of this study. Using a pretest-posttest, non-randomized control-group design, the research compared two groups of incarcerated sex offenders. The study investigated whether or not a one-hour assessment interview, conducted by prison psychologists, reduced denial and increased self-disclosure. Also the study investigated whether both groups differed on the basis of the sex deviance patterns of rape, pedophilia, and exhibitionism.

The study's independent variable was the one-hour interview. The dependent variable was the Multiphasic Sex Inventory (MSI): a 300-item true/false inventory administered to sex offenders after discovery (Nichols and Molinder, 1984). To check for group nonequivalence, subjects filled out a life history questionnaire.

Seventy-three experimental and 63 control group subjects were compared on the MSI using a one-way analysis of covariance. The MSI Lie Scales and Sex Deviance Pattern Scales revealed 79 subjects dishonest about their

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sexual deviance and 26 suppressing their deviant sexual interests.

Only the MSI Rape Lie Scale produced a statistically significant result at the .025 confidence level. However with just a 1.55 difference in adjusted posttest means, no treatment effect was claimed. Therefore, the hypothesis that the Therapy Review Board interview would reduce denial and increase disclosure was not sustained.

Also, no change was found in subject willingness to admit atypical sexual behaviors or sexual dysfunction. Fifty-nine subjects did acknowledge a need for accurate information about sex. Information on the MSI Sex History reconfirmed data on the life history questionnaire.

The study also reviewed interview strategies when evaluating sex offenders. The creation of a true/false inventory that assesses eight forms of sex offender denial is also proposed.
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The effects of a therapy review board procedure on denial and self-disclosure of incarcerated sex offenders

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Western Michigan University, 1994
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Also, I am appreciative of Warden Joseph Abramajtys,
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Richard Martin Happel
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INTRODUCTION

Over the last several years deviant sexual behavior has become a national tragedy. Across the country people have demanded not only protection but reassurance: reassurance that dangerous perpetrators will remain incarcerated and not recommit deviant acts once released.

Consequently, in many states and for many reasons, prison psychologists and officials have been asked to comprehensively screen and treat sex offenders, to assess dangerousness and determine risk. Therefore, they face a difficult and complex task.

Background of the Problem

Nowhere has this task been more challenging than in the State of Michigan. In the Spring of 1992 the Michigan Department of Corrections (MDOC) and the Michigan Parole Board came under attack for paroling a previously assessed (and treated) rapist, Leslie Allen Williams. Early in 1990 Williams was paroled from the Muskegon Correctional Facility (MCF) after completing 14 months of group psychotherapy, several educational programs, several work assignments, and 7 years of incarceration. His institutional record was excellent despite
his subsequent rape and murder of four young women.

After Williams' rearrest, several state officials and MDOC administrators were asked to re-examine (and revise) Michigan's parole system. In addition, the MDOC's provision of psychological services was scrutinized: especially the department's assessment and treatment of sex offenders (or lack thereof). Questions were raised as to how well MDOC psychologists and officials assess and treat rapists, exhibitionists and pedophiles.

Interestingly, Michigan's penal system has seen tremendous growth in the last 18 years. In 1975 Michigan prisons housed 10,855 men and women. According to the department's Annual Report of Statistics for 1991 (published in August, 1993), by the end of 1991 this figure had changed to 36,448 men and women (the 36,448 being housed in 33 facilities across the State). At that time there were 5,022 sex offenders in the MDOC, 4,975 males and 47 females.

In other words, over the last 18 years Michigan's penal system has become a "growth industry." Numerous prisons have been built and more and more sex offenders incarcerated. For instance, there are now three MDOC prisons in Muskegon that house 3,488 men (1,356 at the Muskegon Correctional Facility opened in 1975, 965 at the Muskegon Temporary Facility opened in 1987, and 1,167 at the Brooks Regional Facility opened in 1989).
3,488 housed at Muskegon complex, 959 are sex offenders with the largest number being at the Muskegon Temporary Facility - 523.

Moreover, growth has occurred in the area of psychological services. Before 1970, only four psychologists were employed by the MDOC to deal with suicidal and mentally ill inmates. Therapeutic services were minimal and crisis oriented. However, after 1975 more psychologists were hired to start therapy programs throughout the State. The psychologists were thinly spread across the entire MDOC. These programs were loosely structured and rarely evaluated. With the exception of very general guidelines, the content and organization of psychological treatment was left to each practitioner at his or her facility. Clinicians were expected to function independently with little or no clinical supervision.

Also, throughout the 1970’s and 80’s the MDOC experienced a high turnover rate among institutional psychologists. Several established positions went unfilled. Many applicants viewed the work as unrewarding and the environment as difficult. Of the psychologists hired, most were not familiar with correctional clients. They had little or no experience working with sex offenders.

The organization and delivery of MDOC psychological services improved in 1984 with the appointment of a Chief of Psychology in the department’s Bureau of Health Care...
Services. As a result, specific policies and procedures were adopted, expanded, and revised.

Nonetheless, two areas still need attention: (1) staff procurement and distribution, and (2) sex offender assessment and therapy. For example, there are currently 86 psychologist positions in the MDOC. A disproportionate number of them (29) are allocated to the Jackson complex. Moreover, turnover is still a problem. As of January 1, 1994, there were 11 vacancies, or a vacancy rate of 12.7%.

With regard to sex offender treatment, the MDOC has no formal program or treatment regimen. Simply put: MDOC clinicians must fend for themselves! For instance, when this investigator joined the MDOC in 1989, he was told that, because of turnover, vacancies, and insufficient staff, a well-defined program had not been developed to treat sex offenders. Instead, this investigator was told that when all offenders enter the system (at MDOC’s Reception and Guidance Center), they are assessed via the Minnesota Multiphasic Personality Inventory, Rotter Incomplete Sentences Blank, Draw-A-Person and Bender-Gestalt instruments. Next, offenders are interviewed individually for 10 minutes by a psychologist who makes a recommendation for sex offender group psychotherapy, if the offender has a sex offense in his background (not necessarily his current offense).
Consequently, at present the MDOC has no formal assessment regimen unique to sex offenders. For example, none of the following instruments (recognized and used by sex offender treatment programs across the country) are used by the MDOC — with any degree of regularity — to assess sexual perpetrators and their amenability to treatment: Abel and Becker Cognitions Scale, Abel and Becker Sexual Interest Card Sort, Attitudes Toward Women Scale, Burt Rape Myth Acceptance Scale, Buss-Durkee Hostility Inventory, Family Adaptability and Cohesion Scale, Fear of Negative Evaluation Scale, Interpersonal Reactivity Index, Multiphasic Sex Inventory, Millon Clinical Multiaxial Inventory, Nowicki-Strickland Internal/External Scale, Penile Plethysmograph, Social Avoidance and Distress Scale, Sone Sexual History Background Form, Thorne Sex Inventory, Clarke Sexual History Questionnaire, and the Wilson Sexual Fantasy Questionnaire.

In March, 1992 three institutional psychologists at the Western Clinical Complex in Muskegon decided to create a program to treat and assess the 523 sex offenders at the Muskegon Temporary Facility (MTF). Although still in development, this program now has three distinct components.

Part one is sex offender assessment. It consists of each offender completing a battery of nine psychological instruments. At present these instruments are: Abel and
Becker Cognitions Scale, Attitudes Toward Women Scale, Burt Rape Myth Acceptance Scale, Carnes Abuse Checklist, Steele Sexual Assault Inventory, MTF Life History Questionnaire, Michigan Alcoholism Screening Test, Sone Sexual History Background Form, and the Wilson Sexual Fantasy Questionnaire.

Next, having completed the aforementioned battery, the offender is scheduled to meet the Western Clinical Complex Therapy Review Board for one hour. This board is composed of three psychologists who meet every Friday to assess five prisoners for sex offender treatment. Prior to each interview, board members review the offender’s institutional record. Special attention is paid to the offender’s pre-sentence investigation report, his Reception and Guidance Center report, and his record of institutional adjustment. If available, police reports, court documents, and victim impact statements are reviewed as well. The results of the aforementioned battery are also discussed.

During the interview all three psychologists interact with the offender and take notes. In addition, because the interview is structured to gather as much information as possible about the inmate and his case, each psychologist assumes a predetermined role. The following are assessed: age and type of victim(s); relationship to victim(s); number of victims; nature and frequency of
sexual acts; associated justifications and cognitive distortions; related plans and fantasies; eye contact, voice tone, and posture; overall affect and hygiene; willingness to self-disclose; levels of anger and denial; level of force or coercion used; grooming or stalking processes; masturbation practices; sexual and physical abuse as a child or young adult; history of chemical use; marital and family discord.

Only sex offenders who are willing to discuss their crime(s) in detail, accept personal responsibility and admit the seriousness of their deviance, are accepted for MTF's treatment program. Inmates who adamantly profess their innocence, who express disinterest in treatment, who continually project blame, who demonstrate a lifelong history of antisocial acts, who show sadistic aggression and/or mutilation in their crimes, or who are severely retarded, psychotic, and/or impaired by a psychiatric disorder, are screened from participation.

In addition, offenders who have difficulty recalling offense and before offense activity may be screened from participation because of their inability to assimilate, retrieve, and/or use information offered in treatment. In a similar fashion, the board may reject very intelligent, accommodating inmates who, because of their ability to learn professional jargon and appropriate theories, say what they think clinicians want to hear. Typically these
inmates talk about psychotherapy as a "prerequisite" for parole. Their primary motive is to gain release as soon as possible - not to do the rigorous self-work of treatment.

Part two of MTF's program involves the offender in a psycho-educational counseling group. The group is comprised of 15 members who meet for a total of 26 sessions. Each session is 2 hours long. The group interweaves didactic material, group discussion and supportive counseling. Each offender is expected to read books and articles, complete specific homework assignments, speak about his sexual deviance, delineate his antecedent behavior and sexual assault cycle, master particular relapse prevention concepts and learn what it means to be a productive group member.

In essence, this component meets the MDOC's minimum requirement for group treatment. It offers each offender an opportunity to change through self-work and increased knowledge. It also offers the group's therapist a more detailed picture of the offender's ability to handle (and benefit from) participation in a small, more intense confrontational group.

Once this component is finished, the offender is reassessed by the Therapy Review Board. His therapist is present during the interview, and a report is written afterward recommending program continuation or termina-
Part three of MTF's program is confrontational. Sex offenders are placed in a small group with no more than 10 members. Offenders are expected to do the following: write extensive autobiographies, engage in peer confrontation, keep therapy journals, analyze their deviant sexual fantasies, cultivate greater victim empathy, develop specific relapse prevention strategies, write a personal maintenance contract, work on different issues associated with survival in the free-world.

Statement of the Problem

Denial is a major problem when sex offenders are referred to MTF psychologists for assessment and treatment. Frequently sex offenders offer limited self-disclose. They will say nothing happened, that they committed only some of their crime and not all of it, that their victims lied or that their behavior was misinterpreted.

Denial can be defined as any attempt by the offender to remove disagreeable realities from his life by refusing to acknowledge them. It is any form of self-protection that the offender chooses so as to avoid culpability and the unpleasantness of his deviance. It is a very simple and primitive form of ego-defense. Consequently, it is one of the most profound issues that clinicians face when assessing treatment amenability.
In a recent review of 5,000 sex offenders treated over a 17 year period at the Sexual Abuse Clinic of Portland, Oregon, Maletzky (1991) found that over 87% denied all or part of their crime when first assessed. Consequently, Maletzky concluded that when sex offenders are referred for treatment, i.e., most of the time by the criminal justice system, they are typically "in denial." Maletzky noted that frequently sex offenders give "lip service" to accepting responsibility but are unable to comprehend the depth of their own deviance and the damage they have done to their victims and families.

Subsequently, Maletzsky stated that, because denial is so prevalent with sex offenders, working with them is very difficult — especially when treatment is mandatory. He echoes Herman (1981) who wrote 10 years earlier, "denial has always been the incestuous father's first line of defense" (p. 22).

Additionally, Salter (1988) observed that to date there has been little theorizing about the subject of denial in sex offender literature, i.e., its many forms and how to handle it when assessing or treating sexual perpetrators. Instead, Salter noted that denial is unfortunately viewed as a "...binary phenomenon in which an offender either is or is not in a state of denial" (p. 96).

To address the problem of denial, staff psycholo-
gists at MTF created the Western Clinical Complex Therapy Review Board in May, 1992. As already noted, its primary purpose is to assess sex offenders prior to treatment. However, its secondary purpose is to impact sex offender denial and increase self-disclosure. To accomplish this task the board interweaves positive regard and offender confrontation (see Chapter III for explication of the format).

Finally, although abundant references exist about the problem of denial, as well as the need to assess offenders "in denial," to date this investigator has been unable to find any study of sex offenders that uses, and evaluates, a review board concept to assess, confront, and reduce sex offender denial and increase sex offender self-disclosure.

Rationale and Purpose for the Study

After creating the Therapy Review Board in May, 1992, MTF psychologists observed that sex offenders seen by the Board exhibited less denial when starting treatment: that they self-disclosed and bonded more quickly once in treatment. Also, it was discovered that offenders refused treatment by the Board maintained denial for a shorter period of time, that is to say than before the Board's creation.

In fact, MTF psychologists found that offenders who
were refused treatment often claimed a "change-of-heart." They requested reconsideration as soon as possible to "tell the truth." When reassessed by the Review Board, they would incriminate themselves by giving detail far in excess of the written record of their crime.

Therefore, the main purpose of this study was to investigate whether or not the one-hour Therapy Review Board interview reduces denial and increases self-disclosure prior to sex offenders starting the MTF Sex Offender Treatment Program.

Design of the Study

The study compared two groups of sex offenders at the Muskegon Temporary Facility in Muskegon, Michigan. One group was considered the experimental group, the other the control. Specifically, the study employed a pretest-posttest, nonrandomized control-group design. The independent variable was the one-hour structured interview with MTF's Therapy Review Board.

The dependent variable was a 300-item true/false test, the Multiphasic Sex Inventory (MSI), developed by Nichols and Molinder (1984). This instrument was constructed after a decade of inpatient work with sex offenders at the Western Washington State Hospital, Fort Steilacoom, Washington. In the current study, scores on the MSI were compared to determine whether or not the
one-hour Therapy Review Board interview reduced offender denial and increased disclosure prior to treatment. In other words, the MSI was used to measure denial and self-disclosure before and after sex offenders were interviewed for one hour.

Of the MSI's 20 scales, particular attention was paid to scores on the Lie Scales because they measure sex offender dishonesty and denial (especially when correlated with the Social Sexual Desirability Scale). Also, special attention was given to scores on the Justification Scale and the Treatment Attitudes Scale because they measure accountability and openness (the offender's willingness to self-disclose, accept responsibility, and seek help).

Research Questions and Hypotheses

Research Questions

The primary question behind the study was: Does the structured interview of the Therapy Review Board lower denial and increase self-disclosure, as measured by the MSI, before sex offenders start MTF's treatment program?

A group of secondary questions were examined as well. Using the pretest-posttest, nonrandomized control group design, it was be possible to ask the following 14 questions.
1. Would there be any significant group differences in denial and self-disclosure, as measured by the Lie Scales, the Social Sexual Desirability Scale, the Justification Scale, and the Treatment Attitudes Scale, when comparing experimental and control groups on the MSI (the primary emphasis of this study)? Would there be any significant group differences in denial and self-disclosure when comparing the groups on the basis of deviance type (e.g., rapists, child molesters, and exhibitionists)?

2. Would there be any significant group differences in denial and self-disclosure when comparing just experimental group members on the basis of deviance type? When comparing just only control group members on the basis of type?

3. Would there be any significant group differences in fetishism, voyeurism, sado-masochism, bondage and discipline, and obscene calls (the atypical sexual behavior subset) when comparing experimental and control groups? Would there be any significant group differences on the same subset when comparing the groups on the basis of deviance type?

4. Would there be any significant group differences on the atypical sexual behavior subset when comparing just experimental group members on the basis of deviance type? When comparing just control group members?
5. Would there be any significant group differences in sexual inadequacy, premature ejaculation, impotence and physical disabilities (the sexual dysfunction subset) when comparing experimental and control groups? Would there be any significant group differences on the same subset when comparing the groups on the basis of deviance type?

6. Would there be any significant group differences in sexual dysfunction when comparing just experimental group members on the basis of deviance type? When comparing just control group members on the basis of type?

7. Would there be any significant group differences in sexual obsessions, cognitive distortions and immaturity, social sexual desireability, and offense justifications (the validity subset of the MSI) when comparing experimental and control groups? Would there be any significant group differences on the same subset when comparing the groups on the basis of deviance type?

8. Would there be any significant group differences in sexual obsessions, cognitive distortions and immaturity, social sexual desireability, and offense justifications when comparing just experimental group members on the basis of deviance type? When comparing just control group members on the basis of type?

9. Would there be any significant group differences in sexual knowledge (Sexual Knowledge and Beliefs Scale)
when comparing experimental and control groups? Would there be any significant group differences on the same subtest when comparing the groups on the basis of deviance type?

10. Would there be significant group differences in sexual knowledge when comparing just experimental group members on the basis of deviance type? When comparing just control group members on the basis of type?

11. Would there be significant group differences in attitude toward treatment (the Treatment Attitudes Scale) when comparing experimental and control groups? Would there be any significant group differences on the same subtest when comparing the groups on the basis of deviance type?

12. Would there be significant group differences in attitude toward treatment when comparing just experimental group members on the basis of deviance type? When comparing just control group members on the basis of type?

13. Would there be significant group differences in sexual history (the five-part MSI 50 item Sexual History) when comparing experimental and control groups? Would there be any significant group differences in sexual history when comparing the groups on the basis of deviance type?

14. Would there be significant group differences in
sexual history when comparing just experimental group members on the basis of deviance type? When comparing just control group members on the basis of type?

Hypotheses

Overall it was hypothesized that the one-hour structured interview with the Therapy Review Board would decrease denial and increase offender willingness to self-disclose before starting treatment. Next, it was hypothesized that this decrease could be measured via a pretest-posttest, nonrandomized control-group design when comparing group means for similarity on scales of the MSI. Thirdly, it was hypothesized that the one-hour interview would be therapeutic because it would reduce denial and increase a willingness to self-disclose: that it would increase offender openness to treatment. Lastly, it was hypothesized that, if effective in addressing the problem of denial, the Therapy Review Board concept (procedure) could have relevance for the entire MDOC.

Significance of the Study

Historically speaking, the assessment of sexual deviance has developed in six directions.

Pomeroy, Martin and Gebhard, 1953).

2. The identification of (or diagnosis of) sex offenders subsequent to their arrest for particular crimes (Barnard, Fuller, and Shaw, 1989; Greer and Stuart, 1983; Groth, 1979; Laws, 1984b; Pithers, Cumming, Beal, Young, and Turner 1988).


6. The evaluation of therapeutic outcomes (Hanson, Cox, and Woszczyna, 1991; Tracy, Morgenbesser, and MacDonald, 1983).

At present, three basic assumptions guide the field
of sex offender assessment (Dougher, 1988). Abbreviated they are:

1. Sex offenders comprise an extremely heterogeneous group which cannot be characterized by a single motivation or etiological factor. Therefore, the task of the assessment clinician is to not only evaluate the offender’s psychological make-up but to collect as much pertinent information as possible about the individual’s offense(s). Although clinicians are normally taught to focus on why a behavior occurred, with sex offenders it is extremely important to focus on what occurred.

2. Some but not all sex offenders can be treated effectively with existing techniques. Therefore, the task of the assessment clinician is to determine who is amenable to treatment and who is not. Not all sex offenders are good candidates for treatment. For example, the promise to never reoffend cannot be accepted as a reliable indicator (predictor variable) of sincerity, honesty, and a willingness to work in treatment.

3. Each sex offender requires a comprehensive, individually tailored treatment plan with measurable goals and objectives. Therefore, the task of the assessment clinician is to identify those high-risk factors, early antecedents, and seemingly unimportant decisions that constitute the offender’s pre-assault syndrome and sexual assault cycle. It is also the responsibility of the in-
take clinician to carefully evaluate fetishes, fantasies, obsessive thoughts, deviant arousal patterns and other variables that measure treatment progress.

To implement these assumptions, psychologists across the country have used a variety of techniques. These have been multidimensional in character. Psychological inventories, rating scales, questionnaires, plethysmography and polygraphology have been used with regularity. Each is discussed in Chapter II.

Nonetheless, the clinical interview still remains the principal diagnostic tool used to obtain complex data: data that reveal the assets, deficits, and excesses of the offender (Barnard, Fuller, and Shaw, 1989). Without such data, no clinician can develop or implement a viable treatment plan consistent with the offender's individual needs.

As already noted, sex offenders typically fail to accept responsibility for their sexual deviance during the interview process. Frequently they deny culpability and minimize their behavior. Simply put: they fail to understand the traumatic impact of their sexually aberrant behavior.

For example, pedophiles can blame their victims for being too seductive and interested in sex while claiming that their own deviance is beneficial and educational in nature - that it is in the best interest of the child.
Rapists can also be heard to blame their victims - to blame their attacks on the sexual provocativeness of their victims and/or the old adage, "Every woman has the secret desire to be raped."

In addition, sex offenders are often quite sensitive about their deviance. Even when not intentionally deceitful, the offender can deny his deviance in an unconscious effort to rationalize his behavior: the offender wanting others to believe that there is nothing wrong with his sexuality. The fact that he is a sex offender is so frightening and distressing to him that he is incapable of admitting it. Moreover, if he is aware that he is a sex offender, then he typically expects rejection and/or disapproval whenever the matter is discussed.

Therefore, whether the offender is totally aware of his denial or unconsciously rationalizing his offense(s), the assessment clinician is faced with two things: (1) reluctant self-disclosure and (2) deceptive, unreliable self-presentation. When trying to secure adequate information for treatment planning and outcome evaluation, the assessment clinician needs an effective strategy, method, or technique to help defuse denial and facilitate disclosure.

The significance of this study was that it investigated whether or not a one-hour clinical interview with three psychologists impacted the interwoven problems of
reluctant self-disclosure and deceptive self-presentation. It investigated whether or not using a panel of three psychologists to assess incarcerated sex offenders would decrease denial and increase disclosure as measured by the MSI. If so, then it could be argued that MTF's review board procedure could have significance for the entire Michigan Department of Corrections and how it screens offenders for treatment amenability. Furthermore, if proven effective, then the Therapy Review Board concept could have significance for other systems, institutions, and agencies engaged in sex offender treatment and programming.

Finally, this study was viewed as having financial significance for the MDOC. In other words, if proven effective, MTF's Therapy Review Board procedure could result in less time and money being spent on (a) offenders who are unwilling to admit their deviance and work in group therapy, (b) offenders who prompt others to feel uncomfortable, suspicious, and less willing to self-disclose in group therapy, and (c) offenders who threaten group confidentiality through their own denial, intimidation of others, and personal voyeurism in group therapy (their voyeurism regarding the deviance and lives of others).
Limitations of the Study

The purpose of this study was to investigate whether or not a structured interview with MTF’s Therapy Review Board did, in fact, reduce denial and increase self-disclosure, as measured by the MSI, before sex offenders entered MTF’s sex offender treatment program. To reach this goal, the study proposed to compare two groups of incarcerated sex offenders, as similar as availability permitted, using a pretest-posttest, nonrandomized control-group design. For legal reasons explained in Chapter III, this investigator chose a design that embodied limitations affecting statistical validity. The limitations and their management are detailed in the method section of Chapter III.

Second, in addition to limitations on validity associated with the pretest-posttest, nonrandomized control-group design, this study had other limitations. Briefly, this study did not focus on areas typically associated with sexual deviance and the treatment of sex offenders (the historical attitudes toward rape, pedophilia, and other sexual acts; twentieth century theories about sexual deviance and/or the nature of sexual assault; specific physiological, psychopharmaceutical, psycho-educational, interpersonal, behavioral, and/or social learning approaches to sex offender treatment; victim-offender
communication/confrontation; aftercare planning and the reunification of families; treatment outcomes within the MDOC; sex offender recidivism within the State of Michigan; the physiology of sexual arousal, genetics, and/or anomalies of the brain in relation to sexual deviance and assault; the impact of pornography and/or other social practices, values, myths, or beliefs on the presence of sexual assault in America; the legal issues associated with sexual deviance, its assessment, treatment, and control within society today).

In other words, this study was specific. It focused on one area – the area of sex offender assessment and the interwoven problems of limited disclosure and offender denial as encountered by prison psychologists when they evaluate offenders for treatment amenability. Its main focus was the effectiveness of one approach or technique (procedure) used by prison psychologists in Muskegon, Michigan to reduce denial and increase self-disclosure.

Summary

This study investigated whether or not the one-hour structured interview, used by the Muskegon Correctional Complex Therapy Review Board to assess treatment amenability, decreased denial and increased self-disclosure among sex offenders screened for treatment at MTF in Muskegon, Michigan. To answer this question, the study
employed a pretest-posttest, nonrandomized control-group design involving two groups of sex offenders. The independent or stimulus variable was the one-hour structured review board interview. The dependent or outcome variable was the 300-item, true/false Multiphasic Sex Inventory, its 20 scales and 50-item Sexual History (Nichols and Molinder, 1984).

Special attention was paid to scores on the MSI Lie Scales, as well as to scores on the Social Sexual Desirability Scale, because these scales assess offender defensiveness, deception, and denial. Also, special attention was paid to scores on the Treatment Attitudes Scale and the Justification Scale because they measure an offender's willingness to self-disclose, accept responsibility, and seek help.

Second, although treatment programs have multiplied over the last 22 years, and although articles and books have been published about sex offender assessment and treatment, to date no article or book has used a review board procedure to reduce denial and increase self-disclosure. In fact, little exists in sex offender literature about denial (or typologies of denial) and how to best handle it (them) when working with sexual perpetrators (Salter, 1988).

Chapter II of this study reviews relevant literature on the assessment of sex offenders. Also attention is
paid to the subject of denial and the typology Salter proposed in 1988.

Chapter III addresses research methodology, design limitations, the selection of groups, the definition of variables, the collection of data, and the use of statistical techniques. Special attention is paid to the Multiphasic Sex Inventory, its design, scales, validity, construction and interpretation.

Chapter IV of this study describes the analysis of data and summarizes significant effects.

Chapter V of this study discusses the implications of the data and suggests research possibilities for the future.
CHAPTER II

REVIEW OF THE LITERATURE

Assessment is the first basic step to sex offender rehabilitation and change. Because sex offenders vary in motivation, psychological make-up, and the kinds of acts they commit, in-depth assessment is absolutely necessary for comprehensive, individually tailored treatment plans and the measurement of overall therapeutic effectiveness. Decisions about treatment amenability, target areas for intervention, and the selection of specific treatment techniques can only be reached once an adequate information base has been acquired. As Groth (1979) stated:

Assessment refers to the procedure of clinically evaluating the offender in order to identify the factors that are related to the commission of his offense - the characterological features or traits of the offender, the emotional or psychological issues lived out or expressed in the offense, and the situational events or conditions that activated or supported such acts - as well as the degree to which these same factors continue to operate both in the offender and in the environment in which he functions. Through such evaluations, the offender-client's need for, interest in, amenability to, and potential performance in treatment can be assessed (p. 61).

As a precondition to treatment, sex offender assessment is a time-consuming process that requires considerable effort. The procedure itself involves a number of participants, an extended period of study, diverse clini-
cal, behavioral and social data, and a variety of evaluation techniques. As Maletzky (1991) said, "A rushed and careless assessment can be more misleading than no assessment at all" (p. 64).

Typically, the clinical assessment of sexual perpetrators is a task assigned to mental health professionals who are trained and experienced in conducting such evaluations. The assessment itself consists of as full and complete a psychological investigation as possible. It is characterized by both objectivity and thoroughness (O'Connell, Leberg and Donaldson, 1990).

Objectivity means the assessment specifies data relevant to the offender without the clinician becoming unduly influenced by the offender's behavior, by the offender being overly solicitous, penitent, and/or compliant. Because offenders frequently view clinicians as having power to influence others on their behalf (e.g., various courts, social agencies, probation/parole personnel, etc.), sex offenders commonly make every effort possible to please and impress their evaluators when being assessed. Consequently, psychologists, psychiatrists, and others who assess sexual perpetrators must be able to skillfully collect data without being blatantly manipulated.

Second, thoroughness means the ability of the evaluator to cover important topics in-depth. It also means
gathering and checking information from many different sources. In addition, it means retrieving both objective data (fact and events) and subjective data (the prominent attitudes and feelings that accompany factual information). Hence, if thoroughness is not practiced, and if significant data are not retrieved (omitted), then appropriate questions are less apt to be raised during the initial phase of treatment: the offender having learned indirectly from his assessor that honestly and openness are not that important. As Abel (1976) stated:

The therapist may himself harbor severe sanctions against such behaviors as rape, bestiality, or pedophilia. A thorough assessment, however, demands a complete understanding of exactly what deviant behaviors occurred and what internal cues were associated with that behavior. The therapist should thus convey, in a concerned manner, his desire to assist the client in identifying antecedents and concomitants of the deviant acts. If the therapist, due to his belief system, is unable to maintain objectivity, he should identify this to the client and refer him to a therapist whose personal attitudes will allow a more accurate assessment (p. 438).

Finally, while there are many uses to which a thorough evaluation can be put, five general goals appear over and over again in the literature on sex offender assessment (Abel, Blanchard, Becker, and Djenderedjian, 1978; Barlow, 1977; Groth, 1979; Herman, 1976; Hindman, 1987; Laws and Osborn, 1983; Laws, 1988). The five are:

1. To identify the offender's deviant behaviors and any associated patterns of thought, feeling, and action
which can serve as benchmarks to measure progress in treatment.

2. To clearly determine the offender’s amenability to specialized treatment. To discover if he is an adequate candidate for therapy, willing and motivated to change aberrant thoughts, attitudes, emotional reactions and behaviors.

3. To answer the question of whether or not the offender’s crime was a transitory event, the result of a combination of situational factors which the offender did not initially appreciate but whose subsequent realization can lead to self-corrective and restitutive behavior.

4. To answer the question of whether or not the offender’s offense, for the most part, stemmed from inner psychological determinants which reflect deep-seated unresolved issues in his biological and psycho-social development.

5. To answer the question of risk, of whether or not the offender can be treated in a manner that provides for community safety once paroled/released.

The Multidimensional Assessment of Sex Offenders

Over the last several years two schools of thought have dominated the fields of psychiatry and clinical psychology, the psychodynamic and the behavioral. The psychodynamic perspective evolved with Freud and his associ-
ates. Meanwhile, the behavioral perspective was influenced more by conditioning theorists, either classical or operant. Moreover, although there have been recent efforts to integrate these approaches under the rubric of social learning theory (Bandura, 1977; Dollard and Miller, 1950; Millon, 1981), many mental health practitioners are still primarily trained in one modality to the exclusion of the other.

Fidelity to a given model can influence the approach clinicians take when assessing sex offenders. Clinicians from the psychodynamic school tend to use traditional assessment methods (e.g., psychological tests and diagnostic interviews), whereas those from the behavioral perspective tend to use the techniques of behavioral analysis and psycho-physiological assessment (e.g., polygraph and plethysmography). Nevertheless, as pointed out by Barnard, Fuller, Robbins and Shaw (1989), a multidimensional, comprehensive model has greater value when assessing sex offenders: that a strict adherence to either position is too limiting.

Nonetheless, there has been a decline in the use of traditional psychological tests when assessing sex offenders (e.g., the Minnesota Multiphasic Inventory (MMPI), the Thematic Apperception Test (TAT), the Wechsler Adult Intelligence Scale (WAIS), and the Rorschach). This trend seems to be related to two factors. Perhaps the

In other words, because behavioral techniques like verbal satiation, masturbatory satiation, and olfactory aversion are more closely related to specific behaviors identified as in need of change, behavioral assessments have become a routine precursor to sex offender treatment in many parts of the country. In essence, clinicians can more easily use the results of a behavioral assessment (the form, duration, magnitude, and frequency of specific behaviors; the antecedents and consequences of those behaviors) to write offender treatment plans (Knopp, 1984).

The second factor is the failure of traditional psychological tests to distinguish sex offenders from other types of perpetrators. Most relevant studies have serious methodological problems (Levin and Stava, 1987). For example, the MMPI has shown little ability to differentiate pedophiles and rapists from men who have committed non-sexual crimes (Armentrout and Hauer, 1978; Hall,

Also, the MMPI has shown little ability to differentiate rapists from pedophiles (Anderson, Kunce, and Rich, 1979; Langevin, Paitich, Freeman, Mann, and Handy, 1978). Projective procedures such as the Rorschach, TAT and Draw-A-Person have not done any better (Pascal and Herzberg, 1952; Scott, 1982; Wysocki, and Wysocki, 1977).

Although fairly convincing, the above research must be considered tentative at best, especially given: (a) the limitations noted by Levin and Stava (1987) regarding the MMPI and (b) the research of Kalichman (1990) distinguishing subtypes of incarcerated rapists on the MMPI. Basically it is important to keep in mind that the MMPI is a measure of psychopathology rather than personality; therefore, it may not be the most appropriate test for assessing sexual perpetrators.

At present, interest is focused on the California Psychological Inventory (Gough, 1956) and the Millon Clinical Multiaxial Inventory (MCMI) (Millon, Green, and Meagher, 1982). Both measure personality traits and, when used in combination, may prove to be more effective in assessing sex offenders. For example, it has been observed that on the MCMI child molesters often score
high on subscales 1, 2, and/or 3 (schizoid, avoidant, and dependent) and low on scales 5 and 6 (narcissistic and antisocial). In contrast, rapists frequently score high on scales 5 and/or 6 and low on scales 1, 2, and/or 3 (Hall, 1989).

There is another reason, however, to exercise caution when considering the ability of traditional tests to differentiate types of sex offenders. Frequently distinctions are made between clinical and criminal entities. A clinical entity or syndrome is a group of symptoms that occur together and constitute a recognizable condition. A criminal or legal entity is an act that is forbidden by law.

Criminal entities are defined more in terms of social deviancy. Hence, many acts considered morally deviant are also considered criminal solely on the basis of the rule of law (Schwartz, 1988). On the other hand, clinical entities are less tied to social deviancy and morality. They are defined more in terms of covarying symptoms.

Subsequently, although the criminal entity of incest may exist simultaneously with a clinical entity of pedophilia, the two entities are treated as independent. In other words, although the illegal act of incest may or may not be part of the clinical entity pedophilia, it can never be considered synonymous with the clinical syn-
drome. Therefore, statements like the following are in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R), i.e., "Isolated sexual acts with children do not necessarily warrant the diagnosis of Pedophilia" (p. 285).

Consequently, it is important to point out that terms like sex offender, incest offender, child molester, rapist, or mentally disordered sex offender are considered legal terms rather than clinical diagnoses (Weiner, 1985). They are assigned solely on the basis of someone committing an act prohibited by law. Therefore, for test and research purposes these terms do not represent true clinical entities.

Therefore, as Levin and Stava (1987) have pointed out, many of the studies using traditional psychological tests used samples not reflective of true clinical syndromes. Consequently, it is possible that the apparent failure of various tests to differentiate categories of sexual offenders says more about the legitimacy of the groups used than it does about the legitimacy of the instruments used. Similarly, Hall, Maiuro, Vitaliano, and Proctor (1986) concluded that the failure of the MMPI to differentiate sex offenders on the basis of offense variables may be a result of the variables being more criminal in nature and not clinical in character.
Lastly, the current trend of relying heavily on behavioral techniques requires a word of caution. There are several reasons. One, with their emphasis on the analysis of specific cognitive behaviors and the measurement of tumescence, behavioral evaluations encourage a very narrow focus: the assessor primarily focused on deviant arousal, preference, fantasies and acts.

Because other non-sexual conditions can be overlooked, e.g., mental retardation, organic brain syndrome, personality disorders, mood disorders, and psycho-active substance-induced disorders, relying on behavioral techniques can be problematic (Murphy, Coleman and Haynes, 1983). In other words, it is important to identify these conditions because they can take precedence in treatment regardless of whether they relate to the offender's sexual deviance (Gebhard, Gagnon, Pomeroy, and Christenson 1965b; Matson, 1980).

Moreover, in some cases traditional assessment procedures may be preferable (or at least complementary) to behavioral techniques. For instance, consider the sex offender who is very shy, embarrassed and/or anxious when interviewed, but who may provide relevant information directly by means of a projective test. As Meichenbaum (1977), a well-known advocate of the cognitive-behavioral approach, has pointed out, the Thematic Apperception Test (TAT) can be useful in just such a case to more accurate-
ly assess the offender's cognitive state.

Finally, when assessing sexual perpetrators it seems prudent to use a multidimensional, comprehensive approach that includes traditional and behavioral components (Groth, 1979; Maletzky, 1991). Both approaches yield helpful information when determining treatment amenability, therapy interventions and risk to the community. Moreover, data gathered through one approach can complement data gathered through the other - thereby enhancing the clinician's understanding of the offender.

For example, a behavioral assessment may identify the parameters of a homosexual, incestuous arousal pattern: the antecedents and consequences that help sustain its existence. On the other hand, a traditional test like the MMPI may identify specific characteristics associated with the offender's deviance, e.g., depression, schizophrenia and etc. Subsequently, when used together both meet the definition of evaluation or assessment suggested by DSM-III-R. Combined they identify specific behavioral problems, mental conditions and the contexts in which they occur.

Thus, although certain procedures are associated with each approach, both sample offender behavior. The essential difference between them lies in the purpose to which the assessor directs his or her evaluation.
Assessment Procedures and Content Areas

In the literature on sex offender assessment, a variety of techniques have been used to collect data and evaluate perpetrators. These techniques include psychological tests, physiological measures and clinical interviews. Each is presented as part of a multi-dimensional, comprehensive approach to sex offender assessment. It is not, however, the intention of this investigator to suggest a rigid framework for this task. Instead each component is reviewed as to its role in identifying the psychological assets, deficits and behavioral excesses of sexual perpetrators.

The Clinical Interview

By far the most commonly used diagnostic tool for the acquisition of complex data is the clinical interview. However, when assessing sex offenders it is not used with the same degree of confidence that clinicians normally assign to it.

For example, a client entering therapy for family, marital, or vocational difficulties is expected to be open and relatively honest with his or her therapist. The individual is experiencing distress and is seeking help to alleviate it. It would be foolish for this person to lie extensively regarding his or her problem (the
same as it would be foolish, when injured, to show a physician the wrong part of the body). Obviously, not all clients know exactly what troubles them, nor do they trust their therapist sufficiently to initially share in-depth knowledge. Of course there is the client's tendency to present himself or herself in a positive light to elicit sympathy and concern. However, there is no systematic reason for the client to lie. As a result, the clinical interview can be used to obtain a reasonable sample of information and history.

By contrast, even a cursory reading of the literature on sexual perpetrators reveals that sex offenders are notoriously unreliable and deceptive in their verbal self-report. For instance, in a study conducted by Abel, Mittleman and Becker (1985), interview and self-report data only coincided with the objective measure of sexual arousal (plethysmography) in 30% of the study's sample - even when complete confidentiality was assured. When the remaining 70% were confronted with the discrepancy, only 12 cases out of the remaining 17 admitted additional deviant sexual activity. Thus, only 49% of Abel's sample revised their verbal self-report after phallometric assessment and confrontation. This was especially striking because all of the subjects were volunteers and additional admissions would not have been reported to authorities.
Therefore, when the clinical interview is used to assess sex offenders, it is used as a check on offender denial, minimization and rationalization (as much as it is used to gather information and construct a longitudinal view of the offender). All information is viewed with a good degree of skepticism.

Furthermore, there are other considerations for the clinician to keep in mind when interviewing sex offenders. Even when not intentionally deceitful, sex offenders can deny the existence of deviant sexual behavior in an unconscious effort to convince others that there is no problem with their sexuality. Sex offenders are often highly sensitive about their deviance and are afraid to admit the truth even to themselves. The thought of being a "sexual deviant" is so frightening to them that for years they hide from themselves and their own sexual proclivities.

In addition, the sex offender is typically afraid of disapproval and rejection because at some level he believes all sex offenders are the "scum of the earth." Therefore, any self-disclosure would mean the collapse of his world. In other words, he catastrophizes himself into denial. He tells himself that he would be scorned, lose his family, friends and job, go to jail and never be cared for again. As McGovern (1991) stated, "Some offenders falsify or distort relevant information. These in-
individuals may exclude pertinent bits of information or distort past sexual history. Obviously, most sexual offenders recognize that these clinical evaluations will have a major impact on their future freedom and financial stability" (p. 63).

Meanwhile, even if offenders could be convinced that no catastrophies would occur, Salter (1988) remains convinced that many sex offenders would lie.

Magical thinking may be at work here whereby if they say it isn't so, it isn't so. For many sexual deviancy does not occur when they commit the act, it occurs when they admit it. A sex offender is not a sex offender until he tells you he is. He really is, in some sense, a wrongly accused innocent until he says the words, "Yes I did do it" (p. 186).

When interviewing sexual perpetrators, clinicians may encounter a number of other procedural problems. For example, sex offenders may simply refuse to answer specific questions or complete certain tests. They may understate their own psychopathology and complain that the assessment process is too time consuming and too costly (especially, if they are out on bond and still employed). They may also create a smoke screen by providing information that is interesting but irrelevant, thereby keeping the clinician focused on areas not directly related to deviant thoughts, urges, or experiences (O'Connell, Leberg and Donaldson, 1990).

Generally, the main goal of the clinical interview
is to gain as much information as possible - with as much
detail as possible. In light of the aforementioned prob­lems, the clinician may have to probe, challenge, and
confront the sex offender to get essential information.
To paraphrase Pithers, Martin, and Cumming (1989), some­
times there is little choice and strong confrontation be­
comes a necessity. However, because bold confrontation
can destroy rapport, care must be taken.

Because clinical interviews are time consuming, and
because sex offenders frequently minimize and distort
their deviance, obtaining collateral information is con­
sidered an absolute necessity by every expert in the
field. Thus, after obtaining informed consent, securing
documents pertaining to the offender’s instant offense -
and especially the victim’s version of the offense - is
considered essential. Depositions, arrest reports, trial
transcripts, pre-sentence investigation reports, medical
reports, prior psychological evaluations, child welfare
reports and etc. are natural requisites for determining
the relevance, reliability and validity of offender self­
report. They are needed to assess offender veracity.

Nonetheless, these should never be used as a substi­
tute for the interview. Too much additional information
is obtained through personal interaction with the offen­
der. For example, evidence from the victim which con­
tradicts the offender’s story should be presented frank­
ly, along with any information found in reports prepared by other professionals. In the process, specific questions can be asked, discrepancies pursued, and observations made. For as Groth (1979) noted:

Not only are life history data retrieved through interviewing the offender, but impressions are also gained in regard to his attitudes, values, feelings, and thought processes. The clinician is able to note the behavior of the offender during the interview, his relationship (rapport) with the examiner, his engagement in the task, his emotional tone and its intensity, his manner of dealing with the questions posed, the quality of his verbalization, and the like, as well as any physical reactions such as trembling, stuttering, retarded speech, etc. (p. 204).

Needless to say, when sources of data are in conflict (which is often the case), objectivity becomes extremely important.

Finally, there is no standardized way to conduct a clinical interview when assessing sexual perpetrators. However, in the field of sex offender assessment, many well known practitioners suggest that the interview be sufficiently structured to ensure that relevant issues and themes are explored (Bancroft, 1977; Barlow, 1977; Davis, Granowitz and Levi, 1990; Dougher, 1988; Earls, 1985; Freund, 1981; Groth, 1978a, 1979; Laws, 1984b; Malatzky, 1991; Marshall, 1983; McGovern, 1988, 1991; O'Connell, Leberg and Donaldson, 1990; Pithers, Beal, Armstrong and Petty, 1989; Quinsey, 1977; Salter, 1988).

Second, as previously mentioned the interview should
be comprehensive in scope. It is important to obtain critical information in a variety of areas. Beginning with the reason for referral, all of the following areas should be pursued: current offense and criminal history, family of origin and childhood, educational history, social-developmental history, sexual history, marital history, military history, employment history, financial and chemical use history, religious beliefs, psychiatric and medical history.

Although no one assessment can conceivably cover all aspects of any one person, when interviewing the offender the above variables are considered essential to form as complete a picture as possible of the offender's psychological makeup, deviance, current level of functioning, background and development as possible. Therefore, each variable will be reviewed in concise form: this investigator synthesizing and summarizing the ubiquitous ideas of numerous clinicians in the field of sex offender assessment and therapy (Abel, 1976; Abel, Becker, Blanchard and Flanagan, 1981; Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan and Reich, 1984; Abel, Blanchard and Becker, 1978; Abel, Mittleman and Becker, 1983, 1985; Adams, Tollison, and Carson, 1981; Bancroft, 1977; Barbaree and Marshall, 1988; Barlow and Abel, 1981; Barlow, 1977; Blader and Marshall, 1989; Clements, 1986; Cox and Daitzman, 1980; Davis, Granowitz and Levi, 1970;

**Instant Offense**

Defining the offender's instant (governing) offense is central to determining treatment amenability and intervention. The instant offense refers not only to the physical acts that occurred but also to those behaviors leading up to and immediately following the assault. Hence, understanding the offender's offense(s) requires more than a simple recapitulation of the crime. An explanation of how the offense was conceived and carried out is "just as important" as describing who was involved directly or indirectly.

In only the rarest of cases is the sexual offense a single event occurring spontaneously without some initial preparation. Instead many non-sexual behaviors (discussed below) are relevant for evaluation and treatment. Therefore, to simplify the discussion to come, five categories are used regarding the offender's crime(s): offense committed, victim characteristics, offender's account, antecedent behaviors, significant circumstances.
Offense Committed. A thorough, candid, and anatomical discussion of the offense is imperative. This includes the people involved, the acts performed, the degree of coercion or force used, and how the offender achieved compliance or overcame resistance. Did the crime involve fondling, exhibitionism, digital penetration, masturbation, oral contact, rape, beating, bondage, sadism, murder, et cetera? Did the sexual activity involve any bizarre or ritualistic interpersonal acts?

The acts that occurred are to be described in sufficient detail so that there is no doubt about what took place. If there is doubt, the ambiguity should be discussed explicitly, e.g., whether fondling took place over or under the victim's clothing, whether the victim was undressed by the offender or undressed him/herself, whether the victim was made to touch the offender's body or genitals, whether the offender penetrated the victim's mouth, anus, or vagina, and if so, what was used to effect the same - finger, tongue, penis, or object.

All significant aspects of the assault are typically addressed, especially those pertaining to the amount of force used. Seduction, coercion and physical force fall along a continuum and need to be explored. For instance, at one end of the continuum the offender may have used persuasion to gain compliance, e.g., offering gifts, privileges, and promises. Meanwhile punching, slapping,
and cutting would fall at the other end of the continuum. Included at this end would be the use of weapons - weapons ranging from simple household objects (like belts, ropes, and extension cords) to firearms and hunting knives. It is one thing for the offender to hold his victim down with his hands and body during an attack, and it is quite another for him to bind, stab or torture his victim with a rope and/or a knife.

Another way in which offenders induce compliance is through psychological coercion. It is every bit as damaging as physical force. For example, the pedophile who threatens to kill a child's pet(s) may evoke far greater long-term trauma than the offender who threatens to spank the child with a belt.

Secondly, the location of the offense needs to be particularized. Was it in the victim's home, the offender's home, a car, a store, a park, a school, the woods, or elsewhere? Along with the time of day, this information can be instrumental in developing an effective relapse prevention plan once the offender enters treatment.

Moreover, there is a second reason the environment-location needs to be clarified. For example, if the offender molested his victim while others were in the immediate vicinity, this could mean that those present would not (or could not) protect the victim. Also it could mean that the offender was willing to take great
risks. This kind of information has direct relevance when deciding under what conditions (restrictions) the offender can remain free or be released (paroled) back into the community.

Lastly, what follows the offense is significant. The offender's behavior after the assault may reveal how he tries to conceal his deviance and project blame onto others — including his victim(s). Such projections often exacerbate the trauma to the victim(s) and reveal the offender's impoverished sense of empathy.

Additionally, the offender might tell his victim not to tell, not to share their secret. He may threaten the victim if he or she tells. Another offender may express guilt and remorse and promise never to do it again — a promise seldom kept. A third offender may tell the victim to stop him from committing any future assaults, he implying that the offense was the victim's fault (he inferring that the victim was not clear about his or her intent). For example, children are often punished by sex offenders for allowing the assault to take place in the first place.

**Victim Characteristics.** A complete assessment of the sex offender includes some discussion of the victim. This assessment is important for several reasons. For example, it can help clarify the offender's level of psy-
chopathology and his selection and grooming patterns. Moreover, a discussion of the victim can communicate to the offender the harm he has done.

Identification of the offender's victim(s) is to be clearly stated. The clinician is to review basic demographic factors such as age, sex, physical characteristics, family position and relationship to the offender. Additional data is to be obtained as well.

For example, it is important to know whether the victim was especially vulnerable due to age, mental disability or social isolation. Some victims are doubly vulnerable by virtue of separation from (or loss of) a parent. Thus, a 13-year-old victim could run away from her physically abusive mother only to be preyed upon by an unscrupulous uncle.

In other words, the life circumstances of the victim more fully clarify the impact of the assault. Moreover, offenders typically use the problems of their victims to rationalize their deviance. Also, afterwards they use them again to excuse their behavior and blame their victims. It is not uncommon to hear offenders say, "The girl looked like she was 14 (11-year-old victim). And anyway, her mother was alcoholic and beat her. And her mother's past boyfriends, well you know what they did. She knew what she was doing, if you know what I mean, and was no virgin."
Practitioners in the field of sex offender assessment (and treatment) do know what is meant. However, they are not persuaded by offenders who imply (argue) that their victims provoked their crimes. Instead sex offenders are held fully accountable for their deviance. Discussions of provocativeness (adult or child) are believed to be just one manifestation of how offenders minimize and mask the seriousness of their own behavior, that is to say their exploitation of victims with particular vulnerabilities.

Besides evaluating the offender's attitude toward the victim(s), clinicians usually ask about any problems the victim(s) may be experiencing. Academic difficulties, social isolation, sexual acting out and recurring nightmares can all demonstrate the traumatic impact of the offender's deviance. However, the real underlying questions are: How sensitive is the offender to the harm he has inflicted? and How well does he understand the impact of his own behavior? Initially offenders like to express concern about their victims, yet their superficiality is quickly exposed when they are simply asked: And what else?

**Offender's Account.** This section is one of the most crucial aspects of the interview process. It allows the clinician to perceive how the offender sees the events
that led up to his arrest and conviction. These observa-
tions are critical to understanding the offender and to
making clinical judgments about risk and treatment
amenability.

Clinicians frequently begin by having the offender
give a chronological description of his activities the
day of the offense. In this manner, the clinician can
ascertain the offender’s perceptions, thinking, and
behavior. The clinician seeks to find out who initiated
the events that transpired between the offender and the
victim, what kinds of sexual acts were manifested, and
whether there were threats issued or force used. Since
many offenders use alcohol and/or illicit drugs, the
clinician asks whether both (as well as any prescribed
medications) were used on the day of the crime, and if
so, explores whether the effect of these substances may
have influenced the offender’s awareness of what occurr-
ed.

Corroboration of the sex offender’s account through
police reports, court documents and the victim’s own
statement is essential. If the offender freely acknow-
ledges the extent of his deviance, his account may yield
very important information clinically. He may reveal his
willingness to talk openly, to work on deviant arousal
patterns and learn methods of control regarding his aber-
rance. In other words, he may demonstrate amenability to
If he denies, distorts, or minimizes his responsi-
bility, the offender may represent a poor treatment risk
(unless the clinician can bring him to an attitude of
more candor). For example, the offender who completely
denies his crime, alleges that his victim conspired
against him (often for retaliatory purposes) or claims he
has no problem with deviant sexual arousal, is not likely
to invest himself in therapy. In other words, the quan-
tity of relevant detail provided by the offender is a
good indicator of treatment amenability.

Next, after hearing the offender's version of the
offense, the clinician needs to highlight any discrepan-
cies between the victim's version, the offender's ver-
sion, and other accounts of the crime. For instance, sex
offenders often admit to fondling a child's vagina but
deny any digital penetration when penetration is known
(by other means) to have occurred. Rather than dismiss
the discrepancy, the clinician needs to confront it.
Possible reasons for the discrepancy need to be explored
in-depth.

No one has stated the value of comparing the differ-
et versions of the crime better than Groth (1979).

An examination of the correspondence between
the offender's and the victim's versions of the
sexual assault has important implications for
the diagnostic assessment and treatment of the
offender. It is impossible to evaluate the of-
fender without knowledge of the victim's perception of the offense. If the offender is interviewed without the evaluator's knowing the victim's version of the offense, a number of significant details may not be retrieved because of distortions in the offender's perception or because of deliberate falsification. With both versions, the clinician can then determine what the offender can acknowledge, when he minimizes or distorts, and what he evades or denies. The closer the correspondence between the victim's and the offender's versions, the fewer the questions raised as to distortion, evasion, or projection of responsibility on the part of the assailant. Qualifications may have implications regarding areas of conflict; for example, an offender may be comfortable with aggression but not sexuality. The nature and the quality of his defenses likewise have important diagnostic implications. For example, denial is fairly primitive, whereas repression suggests a higher-level conflict over impulse behavior. Prognostic issues are also raised: to what extent can the offender explore his feelings and observe his behavior, or to what extent must he avoid this approach and externalize the responsibility for his actions? How much does he experience himself as a victim, as being helpless and adrift in a hostile world? How much does he have access to his feelings? And what is the nature and the quality of his self-image and his empathic perceptions of others, both men and women?

The obtaining of information in regard to the offender's and the victim's versions of the offense is only one of the sources of data necessary for an assessment of the offender's dangerousness and the prediction of repetition, but it is indispensable and perhaps the single most important factor in our clinical evaluation (p. 205).

Lack of truthfulness by the offender is a serious problem. Therefore, clinicians contend they are never absolutely certain of all aspects of the offender's deviance. Moreover, what a clinician believes about each
offender has a direct bearing on the offender's treatment. If, after hearing the offender's account of the crime, the clinician believes that the victim was indeed seductive and seeking sex, then the offender's treatment will more likely focus on issues of personal judgment and self-restraint in the face of temptation.

If, on the other hand, the clinician believes the offense was predatory in nature, that coercion and force were used, then the offender's treatment is likely to be very different. Typically, clinicians keep one thing in mind: nondefensive candor by the offender, about the details and extent of the crime, may actually mean the offender is so asocial that he lacks all capacity to understand or care about the impact of his own sex deviance.

Antecedent Behaviors. Understanding the precursors to the offender's crime permits better decision-making and clinical recommendations regarding treatment and the possibility of relapse. For example, there is the question of risk. How did the offender manage risk at the time of the offense?

The clinician assessing sex offenders has to be sensitive to the amount of preparation the offender made. Did the offender take a great deal of risk in committing the offense, or did he minimize his chances of getting caught? Taking a great risk describes the offender who
is so compulsive in his deviance that he is of great risk to the community. On the other hand, the offender who is very cautious is equally dangerous by virtue of his calculating approach.

The offender manages risk in various ways. For instance, the offender can minimize risk by selecting victims who are unable, or at least not likely, to reveal the offense. He can find victims previously assaulted: victims who are not likely to respond in the same way (self-protective) as a person who is being abused for the first time. Also, he can select victims over whom he exercises authority or control.

Besides the management of risk, antecedent behaviors include the use of material resources. The types of materials used are limited only by the creativity of the offender. Practically anything can be used for a sexual assault. Consequently, assessing how the offender used money, pornography, clothing, vehicles, drugs and alcohol (as well as a variety of other materials) plays an important part in understanding the offender's overall pattern of deviance.

Typically, material resources are used in two ways: (1) to set the victim up to be assaulted and (2) to assist the offender in preparation to commit the crime. While one offender may use his vehicle to "cruise" and search for potential victims and locations, a second may
use his vehicle for enticement, e.g., exchanging driving lessons for sexual favors from a pubescent girl. Alcohol and drugs are often used to trap victims, to lure them into situations or to keep them silent via leverage, e.g., "If your mother knew you were smoking dope, she'd kill you. And if you tell her about what we did, I will tell her you started it all when you were high on drugs." Also, the use of mood-altering substances, to reduce inhibition or establish a defense, is very common, e.g., "I was too drunk; I didn't know what I was doing."

Gaining proximity to the victim is another antecedent behavior assessed when screening sex offenders. The sex offender can cruise schools, parks, playgrounds and roads nearby. He can choose nearby homes or other places where children congregate. He can befriend single and married women with children in his target age-range. Frequently he will choose girlfriends with children the age of his sexual preference. He will select jobs which bring him closer to potential victims. He will choose a work schedule that increases his ability to offend.

Next, grooming is the most important antecedent behavior (Erickson, Walbek and Seely, 1988). Broadly defined, grooming is any activity the offender engages in that desensitizes the victim(s) (and/or any significant others) for the purpose of committing the sexual assault. Victims, neighbors, acquaintances and family members can
all be groomed.

Recently, Christiansen and Blake (1990) reviewed three types of grooming common to sex offenders. A short summary of each is given below.

Physical grooming starts with contact that adults and children typically consider appropriate. The contact becomes grooming when it is used to accustom the victim to touching — touching that leads to sexual involvement.

For example, a sex offender can use back rubs to desensitize a child progressively to more intrusive physical contact. With a child on his lap, the offender can give a massage: he holding the child there while becoming erect. Initially the offender makes no comment or movement. If the child fails to notice the erection, the offender may joke about it. If the child shows interest, the offender may offer to educate the child visually. Typically, this leads to self-exposure and the offender asking to see the child's genitals — to touch them as he has allowed the child to see and touch him. Naturally, all of this is presented as innocent activity, normal and nonthreatening.

Next, gaining the victim's acceptance and confidence, the offender breaks down the child's resistance. Eventually the offender confuses the child, for the contact that felt appropriate and safe now feels less so. Hence, physical grooming becomes a reach-and-retract ac-
tivity during which the offender tests the child's level of resistance, comfort and vulnerability. If ever confronted, this approach gives the offender an easy escape (or excuse) from any accusation of deviance. It is another way to manage risk.

Psychological grooming also occurs in various ways. The promise of material gifts, or the granting of special privileges, are two common techniques. By creating indebtedness, the offender skillfully manipulates the victim. For instance, the offender can permit a victim to stay up past his or her regular bedtime. He can promise not to tell the victim's mother (his girlfriend or wife). For the incestuous parent, this works well when a son or daughter knows staying up late is against the mother's wishes. The strategy is even more effective when the offender is able to convince the child that, if the secret is revealed, he or she will be punished by the other parent or relationship partner. Manipulations of this kind create a compact between the offender and the victim(s). It establishes a barrier between the victim and the nonoffending caretaker. Hence, when the offending begins, the victim fears revealing the problem because it will lead to disclosure of the victim's "bad behavior."

Creating a state of fear and uncertainty in the victim's mind is another technique. For example, one incestuous sex offender could read a newspaper article
about another sex offender and say, "That poor guy was treated unfairly, and cruel Judge Jones is sending him to prison for the rest of his life, just for playing with his kids." Needless to say, the incestuous offender is using the newspaper article to manipulate his victim(s) into not telling. Other threats are also possible as psychological grooming, e.g., children who do not obey their parents should be beaten, or children should not ask questions and only do as they are told.

Some victims are vulnerable by virtue of isolation, prior abuse or similar factors. Presenting a demeanor that is pleasing and rewarding, the offender can groom his victim(s). He can spend time playing with a child who feels neglected, abused and/or alone. He can travel with, entertain or comfort the child to create a that "special bond." Listening to the child's problems, he talks and gives advice. Offering advice, the offender encourages a sense of importance and wisdom.

Often the offender will introduce his own problems and elicit advice. For example, when the offender begins talking about problems between the child's mother and himself, the grooming continues. Subtly or directly the offender introjects the idea that the child gives him comfort and support when his partner cannot (or will not) because of her own problems. Hence, the offender lays the psychological groundwork for sexual exploitation at a
later date. In effect he creates a special relationship with his victim because they "understand each other." At this point he typically continues to reduce any victim resistance by flattering the child.

This form of psychological grooming is traumatic. Frequently the victim believes the deceits laid down by the offender; therefore, what the victim believes is often reinforced by memories of shared warmth and tenderness. Initially, the victim's sense of importance and maturity grows; however, both are undercut when the abuse is finally exposed. Also undercut are the victim's sense of self-esteem and adequacy. Hence, guilt, self-doubt, hurt, anger and despair are natural victim outcomes arising from offender psychological grooming.

Environmental grooming occurs when the offender manipulates people outside the victim's home to increase access. For example, the offender may work with children in a school or community youth group, he performing many worthwhile services. He may also take advantage of his position in the community to arrange times to be alone with potential victims.

By establishing the image of a community benefactor, the offender engenders a special trust. The mere suggestion that he may have offended is met with disbelief. Moreover, once charges are filed, those having regular contact with the offender (and who frequently rely on
him) will have to grapple with what his loss will mean if he is convicted. The community will lose his reliability, organization skills and committee work. Consequently, if the offender groomed everyone effectively, community members will proclaim (with certitude) that the offender is a caring individual who just loves children; they will assert the improbability of the charges filed.

Finally, to cut through the facade of denial that sex offenders can erect, a candid discussion of grooming is essential when assessing them. If the allowed to stand, the facade would impede both the criminal justice system and treatment. The criminal justice system would be unable to deal with sex offenders in the same objective manner it deals with other less evasive clients. And, allowing the facade to remain clinically would undermine honesty in treatment. Consequently, the assessment of grooming behavior helps to do two things: (1) counteract denial and (2) establish a therapeutic frame (context) for treatment.

The clinician who allows the facade to persist is not assessing (or challenging) the extensiveness of the offender’s denial. Failing to break down the facade allows the offender to continue the pretense that he has a host of redeeming characteristics, which are in reality a solid base for his deviance. In other words, by maintaining a false image of virtuosity, the offender is
likely to forget (a) the psychological trauma inflicted on the victim(s) and (b) the toll his behavior has taken on the community.

Also, if allowed to continue, the offender will not examine the darker, manipulative aspects of his good deeds to see how they served as a safe base from which to initiate assaultive behavior. Therefore, a clear discussion of grooming is essential. It helps everyone, including the victim and other family members who may still be involved with the offender, to see how skillfully they were manipulated and how carefully the offender structured his efforts to breakdown their will and sense of self-protection. Subsequently, the identification of grooming behaviors is beneficial to the victim and other family members. It helps them to break through their own confusion about the offense, to more constructively deal with their feelings about the offender.

Significant Circumstances. There may be special circumstances which need exploration relating to the offender’s case. For example, the offender may assault a victim who recently experienced another traumatic life-event, e.g., the loss of a parent. Other special circumstances might be: the brutal use of a dangerous weapon, raping an infant, killing a victim, body dismemberment, exploiting authority as a caretaker in a home for de-
velopmentally impaired adults. Special circumstances should always be assessed in situations where sadistic and ritualistic behaviors are displayed and callous insensitivity is apparent.

**Criminal History**

In addition to investigating the offender's instant offense, it is important to assess his criminal background as a juvenile and adult. For example, Dreiblatt (1982) and Tracy (1983) found that the number of previous crimes was the best predictor of future illicit behavior. Also, Abel, Mittleman and Becker (1983) found that only a few offenders had one form of criminal behavior on file. Therefore, when assessing sex offenders it is necessary to construct a chronological history of previous illegal activity. Moreover, it is beneficial to know what other forms of deviance may set the stage for future crime.

To complete this task there are several sources of information. The principal source is the offender himself. Nonetheless, because offenders distort and lie, minimize and deny, other sources of information need to be checked. For example, one additional source is the offender's pre-sentence investigation report. The court officer preparing this report has the legal capacity to request and receive information from nearly all criminal agencies across the country. A third source of informa-
tion is the offender's family. A fourth source is significant others: the offender's employer, doctor, clergy-person, attorney, etc.

Generally, the offender's criminal history is considered symptomatic of his dangerousness and failure to lead a responsible, adaptive life. In particular, clinicians look for repetitive episodes of violence, ritualistic behavior, arson, murder, prostitution, sexual assault, and/or cruelty to animals and children. Also, clinicians look for escalation in the severity of violence exhibited by the offender. The compulsive, violent sex offender (with a well-developed modus operandi) has different treatment needs than the first-time offender who has no well-established offense pattern.

Sexual History

The offender's sexual history is always covered in great detail because it bears so heavily on the offense itself, the issue of offender placement, and the issue of whether the offender can be successfully treated. Also, it is essential because it provides data regarding the longevity and severity of the offender's deviance, and because it suggests the amount of supervision the offender may need.

From the time of his first recollection of sex up to the present, all relevant aspects of the offender's
sexual functioning are to be included. The assessment is to focus on the quality, quantity and nature of his sex life. Hence the following factors are typically included: his childhood sexual behavior, his own sexual victimization as a child or young adult, his age at the onset of puberty, his first sexual contact, his age when sexual intercourse began to occur on a regular basis, his fantasies and sexual fears, his record of sexual dysfunction, his sexual preference, his use of pornography, his sex education, his masturbatory behavior, his experience watching others behave sexually and what he thought about it.

Developing a catalog of the offender's sexual behaviors is helpful. This catalog should include all homosexual and heterosexual activities as well as those activities involving animals and inanimate objects. Also included should be activities such as marital sex, infidelity, acquaintance rape, bar hopping, prostitute use and being sexual with relatives.

In the process, particular attention is paid to situations and locations that promote arousal. Moreover, special attention is paid to fantasies that reinforce sexual deviance. If a relationship is found between coerciveness and arousal, it needs to be investigated to determine what idiosyncratic and stereotypic behaviors exist on the part of the offender.
Unless the clinician determines frequency, this catalog is of limited value. Knowing the prevalence of sexual activity, and the offender's attitude about it, is helpful because it explains how often intervention will be needed to interrupt the offender's pattern of deviant arousal and activity.

Finally, the way the offender conducted his sexual life is important because it is prototypical of how he deals with the world. Does he achieve sexual relationships through negotiation and consent? Pressure and exploitation? Force and assault? Moreover, what nonsexual motivations underlie his sexual behavior?

In other words, the offender's sexual history reflects his self-image, his mode of relating, and his level of comfort or discomfort with emotional intimacy. Hence, when obtaining the offender's sexual history, it is important to ascertain what meaning(s) sexuality has for him.

Family of Origin and Development

A good assessment obtains data regarding the offender's family of origin and personal development. It includes the offender's basic family constellation, and it highlights significant problems during his formative and developmental years. Typically data are collected on the following: date, place, and order of birth; number of
siblings and stepsiblings; parental divorces, remarriages, new marriages, and common-law relationships; any history of parental abandonment, physical or sexual abuse, emotional or physical neglect, substance abuse, chronic illness, mental health problems, institutionalization, and/or criminal activity; the family's socioeconomic status and financial stability; methods of parental discipline and various behavior problems such as rebelliousness, temper tantrums, sibling rivalry, or individuals running away from home.

In other words, knowing (a) how the offender was raised, (b) whether his parents were adequate role models, (c) what personal problems the offender faced, and (d) what family crises, disruptions, enmeshments, and hardships occurred, are beneficial to understanding the offender's attitudes, values and behaviors as an adult. Moreover, the lack of any extended family is significant. It helps illuminate the offender's offense-pattern via feelings of disconnectedness and a general lack of community. Finally, family norms and experiences can serve as guideposts when assessing the offender's response to (and progress in) therapy.

**Educational History**

This characteristic varies tremendously among offenders. Subsequently, a review of the offender's educa-
tional history provides an indication of his early social adjustment and ability to perform. It can signal early psychological tensions and problems that interfered with concentration, the handling of responsibilities and the mastering of tasks. His educational history can offer information about the development of peer relationships and the offender's ability to relate to authority figures in a productive manner. In addition, the offender's record of academic achievement and adjustment can give some information about his esteem, self-discipline, and ability to persist at long-term goals.

Furthermore, this area is helpful in assessing the offender's ability to persist in treatment. If the offender's record of adjustment in school is marked by hyperactivity and/or antisocial behavior, then the offender's capacity to do the required self-work of therapy is suspect. Therefore, the following areas need to be assessed accurately: his ability to read and write, his intelligence, his learning disabilities, his history of classroom behavior, his history of suspensions and expulsions, his highest grade level, and his involvement in special education classes.

Social History

A thorough assessment includes reviewing the character and quality of the offender's social relationships.
Keeping in mind that the offense is an interpersonal act, it is important to know what type of friendships the offender formed with peers, with males and females, and with persons older or younger than himself. The relative age and number of his friendships, as well as their duration and stability, are just as important. Also, to understand the basis for his friendships, clinicians to pay attention to the offender's social interests, activities, and memberships.

Secondly, the careful analysis of the offender's personal relationships can reveal deficits needing therapeutic intervention. For example, friendships based on passivity and compliance, relationships built on power and control, episodes of social isolation (few or no friends), stereotypic perceptions of men and women, and associations which lack warmth, tenderness, trust and affection, all can offer insight into the offender's self-image and value system.

If the offender lacks certain social skills, then a social skills training modual is in order. If, for example, a debilitating anxiety is present around women, then desensitization is a good strategy. If extreme isolation exists, then a blend of individual and group psychotherapy may be needed to treat severe psychopathology and/or a personality disorder.
Military Record

The offender's history of military service is valuable information. Often it is a reflection of the offender's initial functioning (as an adult) outside the parental home. Issues normally assessed are whether the offender completed his tour of duty, had disciplinary problems or received anything less than an honorable discharge. Also, special attention is paid to the branch of service chosen, to the receiving of commendations and medals, and to the experience of combat and any trauma associated with it.

Assessing the offender's military record also allows the clinician to evaluate the following: the offender's self-image, his military friendships, his ability to take instructions and follow orders, his relationships with authority figures and the like. Also, the branch of service entered, and the offender's reason for choosing it, can reflect his aspirations and understanding of manhood as applied to his self-image.

Finally, these data have implications regarding the offender's feelings of competency, responsibility, and self-worth. Because military service is often the offender's first time away from home (with access to alcohol, drugs, prostitutes and other similar activities), success or failure in the military can reflect the aforementioned
qualities. It can be a good indicator of the ability (or lack thereof) to respond to treatment — to the structure of therapy, and to the authority of those who conduct it.

**Marital History**

Marital history plays an important role in assessing the sex offender. The number of marriages, separations, reconciliations, children, common-law marriages and adoptions make a statement about the offender’s personal history. Patterns in one marriage are more than likely repeated in another. In taking a thorough history of each marriage, the careful clinician makes as few assumptions as possible. The clinician does not let vague statements like "we grew apart" stand by themselves. Instead he probes to discover what the offender means by such a response. For example, the statement "we grew apart sexually" can have widely divergent meanings, depending on the offender who uses it.

Confronting the offender who says "we put sex on the back burner" helps the clinician understand the sexual attitudes of both partners. Failure to explore such a statement allows the offender to conceal a host of potential deviances — to therein maintain denial. Also, the neglect of vague comments about past marriages, divorces and infidelities contributes to offender denial and the offender’s successful manipulation of the assessment.
Third, sex offenders can deflect the assessment process by flooding clinicians with irrelevant detail and happenings. Therefore, when conducting a thorough evaluation, the therapist needs to avoid superfluous detail while not neglecting significant events in the marital life of the offender.

Lastly, the character of the offender’s marital history has implications regarding his impulse control, need for affiliation, success in handling adult responsibilities, and ability to communicate. Data about his marriage(s) can indicate underlying dependency needs, needs for power and control, unresolved psychological issues, etc. Multiple failures can point to problems with intimacy, commitment and relationship formation. Also, many failures can typify the inability to self-correct; they can represent the living-out of some unresolved need. The offender’s interest in his children - how much time he spends with them and in what ways - also reflects his capacities and his needs. To marry is to take on the responsibilities of adulthood, thus this area of the offender’s life is a test of his ability to handle the demands of adulthood in a mature and responsible fashion.

**Vocational and Financial History**

Like his marital history, the offender’s employment history can serve as a valuable indicator of how well the
offender has adjusted to adult life. Typical areas assessed are: type of positions held; job performance and work habits; relationships with co-workers; longevity, seniority and periods of unemployment; levels of responsibility, advancements and awards received; work-related disabilities; specific vocational skills; reasons for termination (dismissal, quitting, suspension, disability, layoff, chemical use, etc.).

Generally the offender's vocational history can give the clinician an indication of the value the offender places on working, his sense of competency and pride in doing a good job. Secondly, the offender's employment record is often a good indicator of the offender's ability to apply himself in treatment. For instance, job stability can indicate good frustration tolerance and the ability to cooperate with others, especially authority figures. On the other hand, brief serial employment can indicate a lack of persistence: a pattern that may repeat itself in therapy. Therefore, the offender's overall job history reflects his self-image and his ability to pursue long-term, goal-oriented activity.

The same is also true of his financial history. Although often forgotten when assessing the offender, how the offender manages his money can be revealing. Special note should be given to any history of high indebtedness, failure to make loan or mortgage payments, bankruptcies
and/or dishonest/illegal business transactions. This data can suggest the degree of responsibility and honesty with which the offender is likely to approach on-going evaluation and treatment. It is also indicative of his ability to cope and manage personal resources.

Also, the offender's financial record can indicate personal stability, especially in terms of impulse control. It can reflect his integration into society. In addition, it can indicate whether the offender will remain in treatment or use financial excuses to terminate when confronted with difficult and painful issues he wants to avoid.

**Substance Abuse History**

Assessing the role of drugs, both legal and illegal in the life of the offender and his crime(s), is essential. Often drugs are disinhibitors. Their use can release latent urges that provide the offender an excuse to act out. Also, afterwards the offense the offender can use them to explain away the sexual nature of his crime. In addition, they contribute to relapse by impairing the offender's ability to learn new behavior and thinking patterns while in treatment.

Hence, if there is a history of drug or alcohol use, it is important to evaluate at what age and where the offender began to abuse these substances. Also, it is im-
important to know what the offender's historic use-pattern is, both over an extended period of time and during the months, weeks, and days prior to his arrest and conviction. It is important to assess whether the offender has ever been treated for chemical dependence and what symptoms may be characteristic (blackouts, the shakes, delirium tremens, substance-related arrests, etc.).

Putting the blame for one's sex offense on chemicals is a form of denial. Many offenders state that "I would have never committed my crime, if it weren't for my being high and drinking at the time. In part, they are correct. However, offenders tend to err by saying that the drugs or alcohol made them do something totally against their nature.

The premise that alcohol or drugs released a latent characteristic "controlled when sober" is simply an attempt to minimize the complexity of sexual offending. Generally, clinicians in the field of sex offender treatment and evaluation do not believe the bottle or the drug contained the idea to molest. They do not believe that simple abstinence is a sufficient response to control deviance and eliminate risk to the community.

Finally, the offender's history of chemical use relates to more than his deviance. It has implications for how he deals with stress. It can reveal to what extent he relies on impersonal, nonhuman sources for tension re-
lief when dealing with life's problems. In addition, it can indicate problems with impulsivity, low self-esteem, feelings of anger, chronic depression, and etc.

**Medical and Psychiatric History**

Because the offender's physical health can play an important role in his offense and treatment, most clinicians do a quick review of the offender's medical history when assessing him for therapy. Chronic illnesses and prescribed medications can have a bearing on the offender's sexual functioning, especially his ability to have an erection. Moreover, this review is vital if the offender is going to be assessed via plethysmography or a polygraph.

Secondly, it is not uncommon for older offenders to claim impotence (and/or heart problems) to avoid phalometric measures. While such complaints are often manipulative, clinicians do not take them lightly. Here the clinician is concerned not only about legitimate health problems, that may handicap the offender temporarily or permanently, he or she is also concerned about how these problems may affect the offender's perceptual set (e.g, the offender seeing the world as anxiety-producing and feeling vulnerable).

For example, not only can the conditions of diabetes, epilepsy, and/or acquired-immune-deficiency-syndrome...
(AIDS) create real obstacles (in terms of job opportunities, social friendships, etc.), they can also impact the offender's self-worth, self-confidence and overall feelings of competence. Hence, the following areas are of particular note when assessing the offender's physical health: chronic illnesses, seizures, venereal diseases, hospitalizations, surgeries, recovery periods, physical handicaps, accidents, losses of consciousness and self-inflicted injuries.

Third, the offender's record of mental health functioning is important. It can provide additional clues regarding self-image, impulse control, and feelings of adequacy and worth. Thus, periods of chronic depression, hallucinations, delusions and paranoia, along with suicidal ideation and gestures, are to be assessed.

Whenever it exists, prior psychiatric treatment is carefully explored because of the role it can play in affecting therapeutic expectations. Other therapy experiences are important as well. For example, having learned the "talk" of therapy, the offender can use his experience in treatment to anticipate questions. By steering his therapist astray, the offender can use his experience to sustain denial and avoid his deviance. Consequently, by not exploring the extent and nature of the offender's therapeutic past, the assessor can unintentionally reinforce misconceptions articulated by the treatment-wise
Religious Beliefs

Frequently, sex offenders come from religious backgrounds that instill repressive sexual attitudes, a fear of adult sexuality and a lack of accurate/adequate sexual knowledge. Therefore, the religious background and beliefs of the offender should be assessed.

Moreover, it is not uncommon to find sex offenders who try to escape guilt and responsibility by suddenly becoming religious. Often they state they do not need treatment because they have been forgiven all their sins. They also object to certain types of behavioral assessments or treatment techniques. They can resist procedures such as masturbatory reconditioning, satiation or olfactory conditioning (via plethysmography) because they have to view/hear sexually explicit material and fantasy.

Psychological Testing and Related Measures

The use of psychological tests with sex offenders has a long history. Although primarily used to identify personality characteristics, these attempts were not very successful. One reason for this lack of success was that traditional tests like the MMPI, WAIS, Bender-Gestalt, and others were not specifically constructed for sex of-
fenders. Another reason was the high degree of inference which reduced reliability.

Nevertheless, according to Knopp's (1984) survey of treatment programs across the country, psychometric testing is generally considered a necessity when assessing sexual perpetrators. Numerous clinicians argue that a broad-based, multidimensional approach to client assessment should include psychological testing for at least six reasons (Abel, Mittleman, Becker, Cunningham-Rathner, and Rouleau, 1988; Baxter, Marshall, Barbaree, Davidson, and Malcolm, 1984; Bonheur, 1982; Cox and Daitzman, 1980; Earls and Quinsey, 1985; Fehlow, 1973; Freund, 1981; Groth, 1978a, 1979, 1983; Hillbrand, Foster and Hirt, 1990; Laws, 1983, 1984a, 1984b; Malamuth, 1988; Maletzky, 1991; Marques, 1988; Marshall, Abel and Quinsey, 1983; McGovern, 1988, 1991; Overholser and Beck, 1986; Quinsey, 1977; Rosen, 1964; Salter, 1988; Wincze, 1982). In condensed form these reasons are:

1. The use of multiple psychological measures helps the clinician to develop a more comprehensive picture of the offender's functioning. For instance, the suspicion of intellectual retardation can be confirmed through the use of a dependable IQ test.

2. By the offender marking specific "critical items," the clinician can discover specific problems that the well-defended offender will not admit openly. For
example, a self-administered personality inventory can reveal a deep-seated feeling of inadequacy that makes it difficult for the offender to relate to authority figures or a therapist.

3. The early stages of some clinical syndromes can be identified. Whereas depression or psychosis can be masked during the clinical interview, the MMPI (for example) can pick up the early stages of both.

4. Psychological measures can serve as a consistency-check when compared with other sources of information. They can be used to further evaluate, confirm, clarify or contradict impressions gained from other collateral sources, e.g., self-report, significant others, court documents and et cetera.

5. Clinicians can have more confidence in their own observations and conclusions to the extent that similar findings are obtained through a battery of psychological measures. In other words, the battery of tests can be helpful as a supplement when (a) identifying target areas for therapeutic intervention, (b) analyzing psychological factors operative in the offender's crime, (c) assessing the offender's risk to others, and (d) estimating the offender's potential for recidivism.

6. Psychological tests provide a relatively objective standard of comparison by producing results that are quantifiable and therefore useful for research purposes.
Finally, there is no one test, or battery of psychometric instruments that will suffice to evaluate, diagnose or classify offenders. Instead psychological tests are to be used as part of a comprehensive assessment procedure. Therefore, discussed below are those that are used most frequently to assess sex offenders.

**Traditional Objective Measures**

The Minnesota Multiphasic Personality Inventory (MMPI) is the most widely known and frequently used instrument with sex offenders. Since its initial use, over 5,000 research studies have been conducted using the MMPI. Also it is the best researched instrument with sex offenders. Consisting of 566 true/false items, the MMPI produces four validity scales and 10 clinical scales.

Early efforts to develop scales comprised of selected items which would discriminate sex offenders from other populations (Marsh, Hilliard, and Liechite, 1955; Toobert, Bartleme, and Jones, 1959) and to identify profiles characteristic of sex offenders (McCreary, 1975) did not produce reliable results. Meanwhile, more recent studies have found the 4-8 MMPI code to be the predominant mean profile for some types of child molesters.

For example, when comparing child rapists to incest offenders, Armentrout and Hauer (1978) found the rapists to have a 4-8 profile whereas the incest offenders did.

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not. Likewise, Panton (1978) found child rapists to have a 4-8 profile but not nonviolent child molesters. Moreover, in subsequent research Panton (1979) found incest offenders to have a 4-2 mean profile.

Other researchers have found no differences in mean profiles when comparing sex offenders with other types of offenders (Langevin, Paitich, Freeman, Mann and Handy, 1978; Quinsey, Arnold and Pruesse, 1980). A 1986 study of 406 jailed sex offenders by Hall, Mauiro, Vitaliano and Proctor (1986) found the highest mean elevations were on scales 4 and 8. This was true despite the fact that only 7.1% of the offenders had a 4-8 or 8-4 profile. Most of the offenders had multiple-scale elevations, with 67% having three or more. Even though scales 4, 8, and 2 had the highest mean ratings, no subject had these three scales elevated exclusively. Seven percent had no scale elevations at all. Consequently, Hall found his population to be more heterogeneous than he had initially proposed (Hall et. al, 1986).

The aforementioned research does not suggest the MMPI is useless when assessing sexual perpetrators. Recently, the MMPI was used to differentiate subgroups of incarcerated rapists (Kalichman, Szymanowski, McKee, Taylor and Craig, 1989). The MMPI, however, did not adequately describe the heterogeneity of sex offenders in the sense of a broader taxonomy of sexual perpetrators.
Meanwhile, the MMPI is a valuable tool when used to identify personality characteristics and severe pathology (Kirkland and Bauer, 1982; McIvor, and Duthie, 1986; Lanyon and Lutz, 1984; Raider, 1977). Obviously the MMPI provides valuable information regarding the presence of depression, anxiety, cognitive distortions, antisocial tendencies, psychotic processes, chronic impulsivity, sexual identity conflicts, and a host of other psychological characteristics relevant to sexual perpetrators.

Moreover, the MMPI is useful when all scale scores are within normal limits. Even when all scale scores are 70 or less, Graham (1977) and Green (1980) offer useful interpretations of the scales and highpoint pairs. For example, if a sex offender produces a profile with a highpoint pair on Scales 4 (psychopathic deviance) and 3 (hysteria), or on Scales 4 and 10 (social isolation), this information has clinical significance. With the former pair one might be concerned with the offender’s level of repressed hostility or unrecognized stress; with the latter issues of social withdrawal and social anxiety might be present.

The MMPI’s validity scales can be of value as well. These scores can indicate whether the offender is purposely portraying himself in an overly positive or overly negative light. Hence, the extent to which the offender
is being dishonest, defensive or malingering has obvious implications for treatment amenability and prognosis.

Unlike the MMPI, the Wechsler Adult Intelligence Scale (WAIS) is not extensively used to assess sex offenders (Maletzky, 1991). Unless a specific offender has a history of organic impairment, academic failure, a learning disorder or developmental handicap, the WAIS is not given. Nonetheless, it is often used as a control variable in sex offender research (Perdue and Lester, 1972; Ruff, Templer and Ayers, 1976).

Existing studies that emphasize IQ report mixed results. For example, three early studies of incestuous fathers found average intelligence in each sample of offenders (Cavallin, 1966; Maisch, 1972; Meiselman, 1978). A more recent study by Langevin, Handy, Hock, Day and Russon (1985) found incestuous fathers to be (a) less intelligent than a group of nonfamilial child molesters and (b) less intelligent than a group of community controls. Moreover, Lee (1982) found no statistical difference in average IQ when comparing incest offenders to fathers who physically abused their daughters. Yet Lee did find one interesting difference: none of the physically abusive fathers had an IQ of 69 or less, while 10% of the incestuous fathers scored 69 or below.

In a study conducted by Bonheur (1982), two groups of sex offenders, each composed of rapists and child
molesters, were compared on the WAIS. The only difference between the two groups was, one group was charged with just sex crimes while the other group was charged with sex crimes and larceny. While most of the 62 subjects obtained a wide discrepancy between their verbal and nonverbal intelligence, the full scale IQ scores for each group fell well within the normal range. However, the groups did differ on their choice of "action versus words" as a coping strategy. The group accused of sex crimes and larceny favored action over words.

Interestingly, it was only one year earlier that Bonheur and Rosner (1981) conducted a similar study using 60 sex offenders referred to a forensic clinic for psychiatric treatment. In this study it was found that only a small segment of their sample, 13 subjects, obtained full scale IQ scores in the borderline to lower range on the WAIS.

Overall, what the aforementioned studies suggest is that intelligence is not correlated with sexual deviance when assessing child molesters. However, numerous studies do suggest that rapists are more likely to have below average IQ's (Allen, 1969; Gebhard, Gagnon, Pomeroy and Christenson, 1965c; Karacan, Williams, Guerrero, Salis, Thornby and Hursch, 1974; Randell, 1973; Vera, Bernard and Holzwer, 1979).

Lastly, except in situations where a borderline of-
fender is pretending to understand for fear of being embarassed, the WAIS appears to be of little value when assessing sex offenders. Instead, a test like the Wide Range Achievement Test (Jastak and Witkinson, 1984) is more helpful. It can be used to determine the offender's reading ability and to assess his need for help in processing written materials used in treatment. Also, if the offender appears to have perceptual motor difficulties, the Silverstein (1982) two- and four-subtest short form of the WAIS can be used to assess intellectual impairment, as can the Bender-Gestalt (Pascal and Suttell, 1951).

**Traditional Projective Measures**

In the 1950's the Rorschach (Rorschach, 1921) and the Thematic Apperception Test (TAT) (Bellak, 1954) were used to identify the underlying dynamics of sex offenders and to determine whether there were signs (or responses) that would differentiate sex offenders from other populations (Hammer, 1954, 1968; Hammer and Glueck, 1957; Hammer, 1954; Hammer and Jacks, 1955; Pascal and Herzburg, 1952). As Laws (1984b) pointed out, not much came of this work because reliability and validity were questionable.

Subsequently, these techniques are rarely used to assess sex offenders. When they are employed, these in-
struments are used to identify distorted thinking, depression, anxiety, impulsivity, somatic concerns psychotic thought processes and a preoccupation with sexual themes. As McGovern (1991) pointed out:

In some cases, a sexual offender may be able to camouflage his current psychological deficits during the clinical interview and while responding to the standardized psychological tests. However, during the administration of these projective tests, he may reveal a number of aberrant psychological characteristics. As he reacts to these materials, the sexual offender may become less confident and begin to reveal a number of deficits and disturbances (p. 50).

Consequently, clinicians often use the Rorschach or TAT as a backup measure when sex offenders are unable to complete (read) objective instruments, or when offenders yield inconsistent results on other tests (Barnard, Fuller, Robbins, and Shaw, 1989).

The Rotter Incomplete Sentences Blank (ISB) (Rotter, 1950) is yet another projective technique used by some treatment programs across the country (Knopp, 1984). Consisting of 49 open-ended items, the sex offender is instructed to fill in each incomplete sentence with whatever response seems appropriate. In reviewing the sex offender's answers, the clinician can discover defensiveness, anxiety, fears, internal concerns and troublesome emotions. To date no meaningful research has been found using the ISB with sex offenders. Instead, Mann (1992) has developed the Sex Offender Incomplete Sentence Blank
(SO-ISB). It is currently being field tested for reliability and validity.

Finally, because traditional objective and projective measures do not adequately address many of the issues specific to sex offenders (Barnard, Fuller, Robbins and Shaw, 1989; Dougher, 1988; McGovern, 1991; Salter, 1988), a variety of supplemental measures have been used to assess sex offenders. Most have not been researched to determine if sexual perpetrators differ from published norms. Nonetheless, these instruments are briefly reviewed in the following section.

Other Scales, Measures, and Questionnaires

The Jackson Personality Inventory (JPI) is a recent personality test used by clinicians to assess sexual perpetrators (Jackson, 1976). It is a 320-item true-false test consisting of 16 scales, each scale having 20 statements. The 16 scales are as follows: anxiety, complexity, energy level, interpersonal affect, responsibility, self-esteem, social participation, value orthodoxy, conformity, breadth of interest, organization, innovation, risk-taking, social adroitness, tolerance, and infrequency. A number of these scales are relevant to assessing sexual perpetrators. The last scale, infrequency, is the validity scale.

The JPI's primary disadvantage is its norms. They
are based on a population of normal college students (Jackson, 1977). To date working-class norms are not available. As a result, it is difficult to determine if an offender's profile differs from middle-class student norms because of sexual deviance or because of social class. Nonetheless, it is believed that the JPI is usable because many sex offenders function well in nonsexual areas of society, and because many sex offenders are not psychiatrically disturbed.

The Peters and McGoven Rating Scale (P-M Rating Scale) is another tool that is used to assess sexual perpetrators (McGoven and Peters, 1988). The P-M Rating Scale is a multi-page form containing 45 items. The scale is designed to be used in conjunction with police reports, victim statements, prior criminal records, and psychological and/or psychiatric reports.

On each of the 45 items the offender is assigned a separate score. A high score implies multiple psychological problems and deficits. A low score suggests the offender is unhampered by serious psychological or sexual problems. Essentially the P-M Rating Scale helps the clinician (a) assess risk and (b) make decisions regarding incarceration, outpatient therapy and victim-offender contact (Groth, 1979).

Besides the JPI and P-M Rating Scale, several other scales are used by clinicians to assess a variety of
issues related to sex offender treatment. For example, the Subjective Anxiety and Distress Scale (SADS) is a 28-item true/false scale designed to evaluate an individual's desire to avoid social interactions (Watson and Friend, 1969). It also detects personal distress in social interactions. High scorers avoid social situations and are anxious in them. Thus, because sex offenders are often deficient in social skills (Arkowitz, Lichtenstein, McGovern and Hines, 1975; Barlow, Abel, Blanchard, Bristow, and Young, 1977; Hayes, Brownell and Barlow, 1983; Howells, 1981; Segal and Marshall, 1985), the SADS is used to assess their uneasiness in (and retreat from) social situations.

For example, child molesters typically avoid social situations for fear of negative evaluation. In a study by Overholser and Beck (1986), incarcerated child molesters, rapists and three non-sex-offender groups were assessed on measures of hetero-social skill and social anxiety, hostility, impulsivity and specific attitude variables. At a given point, all subjects were observed interacting with a female confederate in a naturalistic situation and in several role-play scenes. Overall, the child molesters displayed greater fear of negative evaluation than did the rapists or the three groups of non-sex-offenders.

One instrument used by Overholser and Beck was the...
Fear of Negative Evaluation Scale. Consisting of 30 true/false items, this questionnaire was designed by Watson and Friend (1969) to measure the following: anxiety over evaluation by others, expectations of negative evaluations, discomfort over evaluations and avoidance of them. It is useable with sex offenders because it evaluates their sensitivity to criticism. It also evaluates their tendency to avoid social situations because of deficient social skills (Howells, 1981) or because of inadequate assertiveness skills (Abel, Mittelman and Becker, 1985).

Empathy for others is the mechanism that is thought to help control negative impulses (Truax and Carkhuff, 1969). As a group, sex offenders typically lack empathy for a variety of reasons (Becker, Abel, Blanchard, Murphy and Coleman, 1978). As a result, the Interpersonal Reactivity Index by Davis (1980) is used to assess offender empathy. Containing 28 items, this instrument measures four dimensions of empathy: perspective taking, empathic concern, personal distress and fantasy. Perspective-taking measures the ability to cognitively assume the role of the other. Empathic-concern measures feelings of warmth, compassion and concern for another. Personal-distress addresses the anxiety and negative emotions felt from the distress of others. Fantasy addresses the ability of the respondent to identify with characters in
movies, novels and plays.

The value of this index lies in its ability to divide the generic term empathy into cognitive and emotional components. Correlations have been demonstrated between the two components and measures of social competence, self-esteem, emotionality and sensitivity to others (Davis, 1983a, 1983b). Hence, when assessing sex offenders, special attention is paid to scores on the Perspective-taking scale and the Empathic-concern scale. If a poor correlation exists between them, then the offender may lack warmth, compassion and concern but be able to assume (cognitively speaking) the perspective of his victim for manipulative purposes. To date however, research has not been done comparing child molesters, rapists and non-sex-offender control groups on the index.

Another instrument used with sex offenders is the Nowicki-Strickland Internal-External Scale. It is a locus-of-control measure that consists of 40 statements. Depending on whether they believe each item applies to them, offenders respond "yes" or "no." Low scorers tend to think they are responsible for what happens to them. High scorers tend to believe they have little control over their fate (Nowicki and Duke, 1974).

Given the degree to which sex offenders externalize responsibility for their crimes, this instrument is useful. At present, however, it is not clear whether the
externalization of blame is specific to sexual deviance or to a larger, more general pattern of personal denial. Because the Nowicki-Strickland is not focused on sexual issues and simply measures locus-of-control, research is needed to determine if a specific sex-item scale is necessary to measure locus-of-control regarding sexual deviance.

Anger and hostility are two variables common to sex offenders and their crimes (Burgess and Holmstrom, 1974; Gebhard, Gagnon, Pomeroy and Christenson, 1965b). Groth (1979) notes that, although present in both child molesters and rapists, anger and hostility are more closely associated with rapists. Finkelhor (1984) reiterated this point when he reviewed the research on child sexual abuse and sexual perpetrators. In addition, Pithers, Cumming, Beal, and Buell (1988) make the same point when they discussed their approach to relapse prevention.

Similar conclusions have been drawn by others in the field. For example, in a study of paraphilias, Abel, Mittleman and Becker (1985) found that 71% of rapists used unnecessary force in the commission of their offense as compared to 58% of child molesters. In a study of children who were victims of sexual assault, Peter (1976) found that 46% of the children had excessive physical force used against them; 37% of them being subject to forcible rape. Likewise, Abel, Becker, Blanchard and
Flanagan (1981) found that 50.6% of their rapists had raped children, whereas only 16.8% of their child molesters had raped children.

With significant numbers of rapists and child molesters using unnecessary force, clinicians often use the Buss-Durkee Hostility Inventory to measure offender aggressiveness. This scale is composed of 66 true/false items that measure the following aspects of hostility: negativism, resentment, indirect hostility, suspicion, irritability, verbal hostility and assault (Buss and Durkee, 1957). Along with subscale scores, a comprehensive hostility index is obtained for the offender.

Repeatedly, alcoholism has been correlated with deviant arousal and sexual aggression. Virkkunen (1974) reviewed the literature and found alcoholism rates of 50% to 80% in sex offenders. Peters (1976) and Rada (1975a, 1975b, 1976, 1979) reported that approximately half of their samples of sex offenders were drinking at the time of the offense. Abel, Mittleman and Becker (1985) found that 30% of child molesters said drinking alcohol increased their attraction to children, and that 45% of rapists said alcohol increased their desire to rape. Additionally, others report the same relationship between alcohol and sexual assault, i.e., for both child molesters and rapists (Amir 1967; Briddell, Rim, Caddy, Krawitz, Sholis and Wunderlin, 1978; Barbarree, Marshall,

Consequently, given the strong correlation between sexual assault and alcohol (as well as the disinhibiting power of alcohol), an inventory of problems associated with drinking is often used to assess sex offenders prior to treatment. The Michigan Alcoholism Screening Test (MAST) is a 25-item true/false questionnaire growing in nationwide popularity (Selzer, 1971; Skinner and Sheu, 1982). The MAST does not ask questions regarding the quantity of alcohol consumed. Instead questions are asked in three general areas: (1) interpersonal problems pertinent to drinking; (2) social, physical and/or job-related consequences of drinking; and (3) attempts to control drinking.

Two additional scales used to assess sex offenders are the Attitudes Toward Women Scale (ATW) (Spence and Helmrich, 1972, 1978) and the Burt Rape Myth Acceptance Scale (Burt, 1980, 1983; Burt and Albin, 1981). Interestingly, the ATW focuses on the rights and roles of women. It measures the offender's response to 25 items via a four point scale ranging from "agree strongly" to "disagree strongly." Included are vocational, educational, intellectual and interpersonal items regarding the female role. The interpersonal items cover dating, sex-
ual behavior and marital obligations.

To date ATW research has concentrated on non-offending populations. All of Spence and Helmrich's data suggest that the ATW successfully measures traditional versus more egalitarian attitudes towards women. Spence and Helmrich (1972, 1978) report that (a) women are more egalitarian than men, (b) college students are more egalitarian than parents of the same sex and (c) undergraduate psychology students are more egalitarian than engineering students; etc.

Using the ATW, Koss, Leonard, Beezley, and Oros (1985) conducted a study that divided male college students into four categories: (1) sexually assaultive males who obtained intercourse through threatening violence, (2) sexually abusive males who applied force to fondle and attempt intercourse but did not complete the act, (3) sexually coercive males who employed only verbal manipulation to achieve sexual contact and (4) sexually nonaggressive males who only admitted to consenting sex. Overall, Koss et al. (1985) found that those who threatened violence, and/or used force subscribed to more conservative, less egalitarian attitudes about women.

The Burt Rape Myth Acceptance Scale is a 19-item questionnaire designed to measure the acceptance of myths about adult rape. The items are scored on a 7-point scale ranging from "strongly agree" to "strongly dis-
agree". Research indicates that the greater the amount of sex role stereotyping, adversarial sexual beliefs and tolerance of interpersonal violence, the higher subjects' agreement with rape myths (Burt, 1980; Segal and Stermac, 1984).

In a study of the general population, Burt and Albin (1981) found that, the more male subject subscribed to rape myths, the less likely they were to define a sexually coercive situation as rape. Later Burt (1983) found that the higher rapists scored on the scale, the more they would justify observed violence in clinical descriptions of rape.

A similar finding was reached by Check and Malamuth (1985). They gave a group of college males a pornographic rape portrayal and later a newspaper account of an actual rape. They correlated Burt Scale scores with individual self-reports measuring subject likelihood of rape. Subjects who scored higher on the Burt Scale were more likely to (a) believe the victim's experience in the pornographic depiction was positive, (b) believe that the victim in the newspaper account was responsible for the rape, (c) believe that women secretly wished to be raped, and (d) believe that the behavior of women, as well as a natural tendency in men, was responsible for rape. In addition, the subjects were more willing to self-report a higher likelihood of raping women. Similarly, using an
earlier version of the Burt Scale, Koss, Leonard, Beezley and Oros (1985) found that sexually assaultive college males score higher than sexually non-aggressive college males.

Unlike the Burt Rape Myth Acceptance Scale, the Abel and Becker Cognitions Scale measures the cognitive distortions of child molesters (Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan and Reich, 1984). It measures many of the thinking errors used by child molesters to rationalize their behavior. Using statements offenders have actually make in treatment, the scale consists of 29 items. Because offenders are often unaware of their distorted thinking when assessed, this scale is very effective. The scale is used clinically and is not formally scored.

When assessing sex offenders, one area of concern is sexual fantasies. One instrument growing in popularity is the Wilson Sexual Fantasy Questionnaire (Wilson, 1978). It consists of 40 items, each describing a sexual fantasy. The questionnaire covers a spectrum of sexual activity from sado-masochism to object fetishes. Offenders are asked to respond in four ways: (1) how often they fantasize about various sexual activities during the daytime, (2) how often they fantasize about these activities during intercourse or masturbation, (3) how often they dream about these activities, and (4) whether they
would like to act them out in reality.

Another technique used to assess offender fantasy and arousal is the Abel-Becker Card Sort (Abel, 1976; Abel and Becker, 1985). This self-report instrument contains 75 items that measure sexual arousal in 15 categories: adult male, adult female, heterosexual pedophile, homosexual pedophile, rape, sadism, frottage and etc. Arousal is measured on a scale ranging from "extremely sexually repulsive" to "extremely sexually arousing." Because the response categories are diverse and well-conceived, this instrument can help assess offender honesty; especially when its results on the card sort are compared with the more objective findings of plethysmography.

Other clinicians have used a more informal card sort technique (Brownell and Barlow, 1976). For example, Laws (1984) described a card sort procedure where offenders were requested to read descriptions of normal and aberrant sex scenes written on index cards. Instructed to use the rating scale of -3 to +3, the offenders were asked to sort the cards into seven different piles. Minus 3 indicated no arousal while plus 3 indicated high arousal. Once completed, the piles were checked for patterns of sexual interest, preference, and deviance.

Finally, the offender's knowledge about sex, sexual interests and attitudes, sexual experiences and behav-
iors are of importance when evaluating treatment amen-
ability and the potential to reoffend (Zuckerman, 1973).
Although the aforementioned tests, scales and question-
naires are helpful in clarifying cognitive deficiencies,
personality deficits and other psychological problems,
they do not provide sufficient information about the of-
fender's sexual beliefs and/or behaviors. As a result,
clinicians often use additional instruments designed to
obtain such data. Given below are six short illustra-
tions.

For example, the Sex Knowledge and Attitude Test
(SKAT) (Lief and Reed, 1972), the Thorne Sex Inventory
(Thorne, 1966a, 1966b, 1966c), and the Clarke Sexual
History Questionnaire (Clarke SHQ) (Paitich, Langevin,
Freeman, Mann, and Handy, 1977; Langevin, 1983) are three
such instruments. The SKAT measures the offender's know-
ledge of, and attitudes about, human sexuality. Often it
is used to determine if a sex education module needs to
be included in a offender's treatment plan (Cotten-

The second inventory, the Thorne Sex Inventory meas-
ures the following: sexual conflicts, fixations, repres-
sions, control, confidence and promiscuity. It is long
and involved, and it has been used to classify sex offen-
ders by type (Allen and Haupt, 1966; Cowden and Pacht,
The third instrument, the Clarke Sexual History Questionnaire measures the frequency of specific sexual behaviors. It also measures the offender's disgust for specific sexual acts (Russon, 1985). Moreover, like the Thorne Sex Inventory, the Clarke has been used to differentiate categories of sex offenders, i.e., via the 350 dichotomized items that make up its 26 scales (Langevin, Handy, Paitich and Russon, 1985a).

After Masters and Johnson (1970) finished their initial research, different questionnaires were devised to identify specific sexual concerns and dysfunctions. Therefore, examples four and five are the Sexual Interaction Inventory and the Sexual Background Information Questionnaire, both developed by LoPiccolo and Steger (1978). These instruments collect information regarding level of sexual satisfaction and disappointment. According to Knopp (1984), only a few programs use either instrument to assess sex offenders.

The last example is the Sone Sexual History Background Form (Sone, 1984). The Sone was specifically designed for sexual perpetrators. It consists of 54 questions. Beginning with childhood, the form assesses the sexual development of the offender. Overall, the questionnaire covers the following: fantasies, arousal patterns, masturbatory behaviors, sexual dysfunctions, homosexual and heterosexual experiences. It also requests
the offender to rate his own sexuality. Toward the end of the questionnaire, there are several questions regarding the offender's instant offense and the use of coercive force. At the very end the offender is also asked to write an account of his crime.

Finally, the Sone Sexual History Background Form was designed to supplement pre-sentence investigation reports, victim impact statements, police reports and verbal statements from the offender. Moreover, data on the Sone can be compared with information from a phallometric exam.

**Psychophysiological Assessment**

Assessing clients and determining their treatment needs is an ever-present challenge for the fields of counseling, social work, psychology and psychiatry. Traditionally, therapists have relied on client self-report to evaluate individual need and treatment progress. In many cases this approach is efficient. It provides the therapist extensive data for making clinical decisions. However, when working with sex offenders, it is apparent that self-report can be unreliable because of minimization, rationalization, and denial. Therefore, psycho-physiological techniques are used to comprehensively assess sex offenders.

Within the past 2 decades, five physiological meas-
ures have been used to examine male sexuality: (1) electrodermal responses, (2) cardiovascular responses, (3) respiratory responses, (4) pupillary responses, (5) penile arousal (Tollison and Adams, 1979). The first four are either in development or have been abandoned (Maletzky, 1991). The last, however, is recognized as the most important physiologic measure when assessing sex offenders.

**Plethysmography**

For years plethysmography has been used to assess deviant sexual arousal in relation to five variables: (1) the offender’s history of sexually deviant acts, (2) the offender’s likelihood of using excessive force during a sexual assault, (3) the offender’s likelihood of being sadomasochistic, (4) the offender’s age and gender preference regarding victims, (5) the offender’s treatment needs and response to behavioral interventions.

Barlow (1974), Laws (1984), and Abel et al. (1976, 1978) have all argued that deviant sexual arousal must be assessed if the sexual perpetrator is to be treated effectively. Others have argued that plethysmography is the only reliable, objective way to assess deviant and normal arousal patterns for the development of offender-specific treatment plans (Earls and Marshall, 1983; Geer, 1980; Laws and Osborn, 1983; Laws, 1984; Wincze, 1982;
Moreover, McGuire, Carlisle and Young (1965) have argued that deviant sexual fantasies (coupled with masturbation) play an important role in sustaining deviant sexual behavior. Also, Quinsey (1981) and Quinsey and Marshall (1983) have argued that, when treating sexual perpetrators, the best predictor of long-term success is the reduction of deviant sexual arousal, along with an increase in appropriate arousal, as achieved through plethysmography and the use of behavioral techniques.

To take a phallometric exam, the offender is placed in a room alone. The offender is instructed to sit in a comfortable chair (usually a recliner) with his pants lowered to his knees. Next he is instructed to place a small transducer on his penis. The two most popular forms are the Barlow (1977) Mercury-filled Strain Guage and the Parks Guage (Laws and Osborn, 1983). These transducers are sensitive to subtle changes in penile blood flow and engorgement.

Before starting the evaluation the clinician gives the offender a brief overview of the procedure and asks the offender to give informed consent. In addition, the clinician calibrates the equipment to avoid any undo distraction or mechanical failure (Abel, Blanchard, Becker, and Djenderedjian, 1978).

Lastly, seated in an adjacent room the clinician
watches the offender through a special protection window. Over a two-way intercom the clinician instructs the offender to (a) cover himself with a sheet, (b) place his arms and hands on the arms of the chair (where they can be seen at all times), (c) sit back and relax and (d) listen to (or watch) the stimuli presented.

Being connected to a recording device, the transducer measures tumescence throughout the entire exam. Results are reported in terms of percentage of maximal erection. Offenders are typically instructed to masturbate to 100% erection. A measurement of maximum circumference is then taken. Next, subsequent arousal levels (to various stimuli) are calculated as a percentage of full erection.

Laws and Osborn (1983) offer a guide to interpreting arousal levels. They subdivide arousal levels as follows: 0-20%, no arousal; 20-40%, low arousal; 40-60%, moderate arousal; 60-80%, high arousal; 80-100% very high arousal. They argue that at least moderate arousal is necessary for clear judgments when evaluating offenders for treatment.

A few years earlier Abel (1976) developed his well-known rape index. This index is a ratio: the percentage of the offender's arousal to rape stimuli compared to his percentage of arousal to mutually consenting sex. If an offender's rape index is 1.5 or greater, then Abel,
Barlow, Blanchard and Guild (1977) conclude that the offender is sexually aggressive despite any contrary statements by the offender.

Typically, sex offenders are exposed to one of three stimulus modalities: slides, videotapes and/or audiotapes. Which modality to use, as well as its sexual content, is determined before the examination and is based on data collected from the offender. In advance of the exam, the offender completes a sexual history form that includes descriptions of his deviant sexual activities (Laws and Osborn, 1983; Matetzky, 1991).

At present there is variation among researchers as to which modality elicits the strongest response. Some researchers argue that the most erotic cues are visual (Abel, 1976; Bancroft, 1977; Barlow, 1974; Freund, 1963, 1967, 1971). Distinguishing between the two forms of visual stimuli, Laws and Osborn (1983) conclude that slides are less erotic than videotapes but more arousing than audiotapes. Meanwhile, Salter (1988) concludes that slides are the weakest of all three.

Overall, videotapes and slides are used to portray the widest range of sexual activity. Scenes vary from nudity to explicit hard-core sexual behavior. Themes include rape, incest, sadism, bestiality, bondage, discipline and murder. Included are adults, teenagers and young children of each sex. The degree of force ranges
from consent (manipulated consent in children and genuine consent in adults) to the aggressive, painful rape of children and adults (the application of physical force sufficient to perpetrate the assault), to sadism (the application of physical force far in excess of what is needed to obtain compliance).

Isolating individual erotic cues is the primary difficulty with visual stimuli. Clinicians are unable to determine what particular aspect of the visual stimuli the offender finds arousing. For example, a sex offender with a homosexual arousal pattern can be shown visual stimuli of heterosexual intercourse. When tumescence occurs, the assessor can conclude the offender has considerable heterosexual arousal. However, upon in-depth questioning the clinician may discover that the offender saw himself in the female position: that the offender was actually attending to the male in the scene. Consequently, with visual stimuli the field of erotic cues is global. For the clinician it is difficult to isolate which cues or triggers need therapeutic intervention and change.

By contrast, audiotapes are more attractive because of flexibility and cost. They are easier to produce, and they can be refined continuously to: (a) facilitate maximum levels of arousal and (b) minimize boredom. Both appropriate and deviant sexual activities can be describ-
ed and recorded. Also, descriptions of idiosyncratic and bizarre sexual scenes (or scenes that are technically and ethically impossible to construct visually) can be produced.

The offender's deviant and appropriate fantasies (and sexual experiences) are excellent sources of data for these tapes. Prior to the exam the offender is instructed to write out personal descriptions of deviant behavior. He can be asked to verbalize his favorite deviant fantasies, to masturbate to them and record them on tape in the process.

Later, after analyzing the offender's fantasies, the clinician can monitor arousal by (a) reading the offender's written descriptions, (b) having the offender listen to his own recorded material or to material that is similar and (c) asking the offender to articulate his most vivid deviant sexual fantasies for comparison. If the clinician chooses to reuse the offender's descriptions, the clinician can also determine, by observing concomitant changes in penile erection on the recording device, which cues actually accelerate or decelerate arousal for that offender. Moreover, subsequent trials may refine the same for the purpose of therapy.

Years ago Abel, Blanchard, Barlow and Mavissakalian (1975) clarified the distinct advantages associated with audiotape stimuli. Condensed they are:
1. With audiotape it is possible to overcome three disadvantages associated with visual stimuli: distortion through repression, lack of discrimination and denial associated with verbal report.

2. With audiotape it is possible to capitalize on the major strength of verbal report because audiotape, like verbal report, utilizes the breadth and flexibility of orally described cues — cues which can encompass both internal fantasies and external stimuli.

3. With audiotape it is possible to present cues that would raise legal or ethical objections if produced visually via motion picture, videotape or slide technology.

4. With audiotape it is possible to exert precise control over the cues presented.

5. With audiotape it is possible to present stimuli that are not readily translatable to the visual mode, for example the feeling state of a victim or partner.

6. With audiotape it is possible to lessen voluntary suppression because of more precise control over the cues presented.

Therapists today try all stimulus modalities to determine which is most arousing for a given offender (Maletzky, 1991). An effective and popular combination is the use of slides and videotapes to determine the preferred age and sex of victims, and the use of audiotapes
to determine specific cues and the degree of force unique
to the offender (Barnard, Fuller, Robbins and Shaw,
1989).

Typically, the "stimulus-content" tries to capture,
as closely as possible, the environmental conditions,
people and acts the offender identifies as arousing via
self-report. By doing so, the clinician achieves greater
accuracy when assessing the offender's deviant arousal
pattern, its presence and extent (Abel, 1976).

Regardless of the modality used, deviant stimuli are
usually presented for no longer than two or three
minutes. Care must be taken not to satiate the offender
and thereby diminish responsiveness (Dougher, 1988).
Interestingly, a study by Julien and Over (1984) suggested
that habituation was not a problem when normal males
were presented eight 12-minute depictions of sexual
activity over a 5-day period. Nevertheless, when assessing
sex offenders caution seems appropriate.

Besides the length of stimulus presentation, two
other concerns are present when assessing sex offenders
via plethysmography: faking and suppression. It has
long been known that, like normal males, sex offenders
have some degree of control over their erections during
measurement situations. Sex offenders can influence tu-
mescence by controlling their cognitive processes during
different stimulus presentations. While looking at or
listening to stimuli, they can imagine alternative sen-
arios internally (Abel, 1976; Abel, Blanchard, Becker and 
Djenderedjian, 1978; Henson and Rubin, 1971; Laws and 

In addition, evidence exists that it is the offen-
der's ability to refocus attention in his field-of-view 
(by concentrating on something nearby) that makes sus-
pression possible — and thus the faking of an appropriate 
looking profile (Geer, 1976). Also, three less sophisti-
cated techniques are used: (1) repeated masturbation the 
day of the exam, (2) staying awake the night before the 
exam, (3) ingesting a number of sedatives prior to the 
exam (Barnard, Fuller, Robbins and Shaw, 1989).

While suppression and faking cannot be eliminated 
completely, there are some steps clinicians can take to 
minimize them. They are as follows:

1. It is advisable to observe the offender periodi-
cally while he is undergoing the assessment. Arms and 
hands are to remain stationary on the chair's arms to 
prevent the offender from manipulating himself or the 
strain guage. In addition, the offender's lap-sheet 
should remain undisturbed, the offender sitting calmly in 
the exam chair.

2. To help the offender attend to the stimuli pre-
sented (not to some internal fantasy) the offender can be 
asked to describe the slides, videotapes or audio scenes
used. Also, the offender can be asked factual questions about what he is watching or hearing.

3. The offender can give a subjective rating of his own arousal while attending to the stimuli. This step is frequently used in combination with step two. If discrepancies arise, i.e., between what the offender claims is arousing and what the clinician sees on the monitor, the offender can be confronted about these differences after the exam.

4. The clinician can present stimuli under two different instructional conditions. For example, with one set of stimuli the offender can be told to achieve the highest level of tumescence possible. With the second set, the offender can be told to suppress erection as much as possible. The difference between the two instructional conditions can then be used to indicate the degree to which the offender can cognitively suppress arousal.

After the sex offender has completed the exam, his arousal responses are reviewed. By examining the print-out together, the offender can see which stimulus scenes caused the greatest level of arousal and which did not. In many instances this is the first time anyone has provided the offender objective data regarding his normal and deviant arousal patterns.

Often a significant difference exists between the
offender's pre-exam estimate of arousal (to deviant and normal stimuli) and his actual tumescence as measured by the exam (Greer and Stuart, 1983; Laws, 1988). For example, a man arrested for sexually abusing prepubescent boys only admits to inappropriate "horseplay." He totally denies any sexual interest in boys because it is "unmanly." He states his only sexual interest is his wife and their having consensual sex. Meanwhile, his exam data could indicate a high arousal to young boys, a somewhat lower arousal to preadolescent girls, and almost no arousal to adult heterosexual or homosexual cues.

In this situation the man would be confronted with the results: he would be confronted with his own distorted perception of his arousal. It would be suggested that he is not being truthful about his sexuality; that although he may have consensual sex with his wife, he may be fueling his arousal with fantasy material involving young males.

Next, although phallometric data can be useful when confronting denial, there are several limitations (problems) associated with the entire procedure. They are as follows:

1. Plethysmography is a test of sexual preference. It cannot determine whether an individual has acted (or will act) in a sexually deviant manner. It cannot be used to prove innocence or guilt. It is possible that
individuals exist who have deviant preferences and sufficient inner control to avoid arousal when presented aberrant stimuli (Finkelhor, 1984).

2. No proof exists that all sex offenders have deviant arousal patterns. Subsequently, various terms like opportunistic, situational and regressed have been used to describe offenders who commit sex crimes and who do not demonstrate deviant arousal patterns when tested (Abel, Becker, Murphy and Flanagan, 1981a, 1981b; Groth, 1979; Murphy, Haynes, Stalgaitis and Flanagan, 1986; Quinsey, Chaplin and Carrigan, 1979).

3. Plethysmography can be used indiscriminately because only a few state licensing boards have established reasonable certification procedures and guidelines for conducting phallometric exams (McGovern, 1991).

4. The setting for collecting phallometric data is not like the real world. The two are very different. Consequently, phallometric data should not be used exclusively to diagnose or classify individual offenders. Offender-specific data must be interpreted within the context of available records and the offender’s history, as well as any psychological characteristics assessed through more conventional techniques (Dougher, 1988).

Overall, the research appears to show that phallometric exams are useful in a variety of ways. They have been shown to: (a) diagnose paraphilic arousal patterns
and confirm the validity and reliability of erection in diagnosis (Freund, 1967), (b) differentiate rapists from nonrapists (Abel, Blanchard, and Becker, 1978; Abel, Blanchard, Becker, and Djenderedjian, 1978; Barbaree, Marshall, and Lanthier, 1979), (c) determine an individual's interest in sexual sadism (Abel, Blanchard, Barlow, and Mavissakalian, 1975; Abel, Blanchard, Becker, and Djenderedjian, 1978; Abel, Barlow, Blanchard, and Guild, 1977) (d) identify child molesters with an inclination toward child rape (Abel, Becker, Murphy and Flanagan, 1981), (e) separate recidivists from nonrecidivists (Quinsey, Chaplin, and Carrigan, 1980), (f) evaluate the results of experimental behavioral techniques (Abel, Levis, and Clancy, 1970; Bancroft, 1968; Barlow and Agras, 1973), and (g) measure offender response to traditional forms of psychotherapy (Quinsey, Bergersen and Steinman, 1976). Consequently, among offenders whose self-disclosure is suspect, plethysmography remains the most objective method to assess deviant arousal and to determine sexual preference.

Polygraph

The polygraphy is less widely used to assess sex offenders. It is another source of valuable information. Although the object of considerable controversy (Lykken, 1984; Saxe, Dougherty and Cross, 1985), polygraph testing
generates data comparable to information gathered from other sources. Here the clinician looks for consistency when reviewing all data. As Groth (1979) stated over a decade ago:

The use of instruments such as a polygraph, a voice-stress evaluator, or a penile plethysmograph, to record physiological reactions of the offender can provide additional useful data. The lie detector or stress indicator may serve to confirm or negate the truthfulness of the offender's allegations when these are inconsistent with information acquired from other sources and to differentiate intentional deception on his part from genuine misperception (p. 206).

For example, consider the offender who denies anything close to inappropriate sexual behavior, i.e., the offender who presents himself as a virtuous person with no history of irresponsible behavior. If data gathered from collateral sources revealed a pattern of sexual deviance, dishonesty in business and lies in the offender's personal life, then a distressed polygraph can help to confront the offender's denial.

In other words, a polygraph exam can round out the database used to assess denial, confront it, determine risk and plan treatment. Although it is not an absolute test of truth, the polygraph exam does communicate the need to be honest to the offender - if the sex offender is going to work on his deviance and make progress in treatment. As McGovern (1991) stated: "While controversy exists about the subjectivity, validity and reli
ability of this instrument, this test has often been useful in promoting fuller disclosure during treatment" (p. 65). The same can be said when assessing the offender.

**Diagnosis and the Determination of Risk**

The preceding review indicates that the comprehensive assessment of sex offenders is a multidimensional task. Information is gathered from variety of sources: the process involving a full battery of psychological tests, a thorough clinical interview and, if possible, a phallometric exam to determine arousal patterns to both deviant and nondeviant stimuli.

Once this process is complete, the accumulated data is reviewed and the assessor forms impressions about the offender's deviance, amenability to treatment, risk to recidivate and danger to the community. Not treated as fact, the clinician's impressions are to be seen as opinions open to refinement and change. As Groth (1979) said:

> It is important, therefore, to regard the results of the initial evaluation as a preliminary judgment and to regard the process of assessment as continuing from the point of referral, through all successive stages of involvement (intake, treatment, discharge, and aftercare), to the time of termination. Initial impressions should be refined and revised with increasing study, additional information, and more extensive contact (p. 194).

Secondly, the term diagnosis is often misused when
assessing sex offenders. The term refers to the process of identifying specific psychiatric and psychological disorders and the context in which they occur. Also it refers to the classification system that denotes the outcome of the process, e.g., such as the labels used in the Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised (DSM-III-R) to summarize assessment findings and classify disorders into categories.

However, when assessing sex offenders the term diagnosis is not always appropriate. Although the DSM-III-R classification system is routinely used by clinicians, not every sex offender is diagnosable as having a psychosexual disorder (Berlin, 1983). For example, it is possible to have a child molester with deficient interpersonal skills and specific cognitive distortions who does not meet the full DSM-III-R criteria for pedophilia, even though when drunk he sexually molested his 10-year-old son on two separate occasions.

In other words, offenders and their crimes are not always synonymous with DSM categories. Often this happens in cases of rape (Tirrell and Aldridge, 1983). Consequently, when assessing sex offenders, failure to meet DSM criteria should not preclude the offender from treatment.

Finally, Barnard, Fuller, Robbins and Shaw (1989) point out the advantages and disadvantages of using the
DSM system when assessing sex offenders, especially child molesters. The advantages are:

1. The DSM system attempts to classify disorders the offender can experience rather than the offender himself. This approach results in a more precise and valid system with reference to who the offender is (e.g., chemically dependent, exhibitionistic, schizophrenic, depressed, etc.).

2. Unlike its two predecessors (DSM-I and DSM-II) the DSM-III-R provides fairly explicit criteria for each disorder. This enhances interrater reliability on which validity is so dependent.

3. The DSM system is subject to periodic review and modification. This improves the precision, reliability and distinctiveness of its categories, especially those pertaining to paraphilia.

4. The DSM system is multiaxial. It encourages the clinician to develop a comprehensive clinical picture when assessing sex offenders. It encourages the clinician to take into account the social and environmental factors that may affect the offender.

The disadvantages are:

1. Information is inevitably lost when labels are attached to sexual perpetrators. Frequently sex offenders show characteristics that are not associated with the diagnostic labels assigned to them. At best, the
label ensures that the offender possesses only some of the characteristics associated with that label.

2. A label such as pedophilia is descriptive. It simply names a condition or disorder; it does not explain the condition or disorder. The label does not automatically imply specific etiological factors, e.g., the offender having been sexually victimized as a child.

3. The paraphilias in the DSM-III-R are not entirely distinct. Overlap exists; thus differential diagnosis may be difficult in some cases.

Finally, there are two approaches to assessing risk and making predictions about dangerousness and/or the likelihood of sexual aggression. The first, individual evaluation, emphasizes interpersonal, psychometric, and psychophysiological methods of assessment (Hall, 1990a). The second approach, called the actuarial method, emphasizes a set of factors which have been determined, by way of common sense or research, to be useful as predictors of risk. The actuarial method seeks to differentiate levels of dangerousness within a given population, e.g., sex offenders (Gottfredson and Tonry, 1987).

Both approaches have differing strengths and weaknesses. The first is staff intensive. It requires a significant investment of time. Objectivity is difficult to verify and demonstrate.

The second is more objective and efficient. It sup-
ports the rank ordering of large numbers of offenders on "perceived risk to re-offend." It misses unique personal facts regarding the individual offender.

In general mental health clinicians tend to rely on the former. Criminal justice officials tend to rely on the latter, especially state parole boards. When working with sex offenders, clinical decision-making interweaves both (Quinsey, 1981).

For example, on the subject of predicting risk, the research suggests several things. First, there is no one set of scientifically valid, conclusive variables that accurately predict risk for either method (Cohen, Groth and Seigel, 1978; Hall, 1990; Tink, 1990). Instead, risk (or dangerousness) is often overpredicted when assessing sexual perpetrators (from as little as 54% to as much as 99%) (Monahan, 1976).

Secondly, studies indicate that mental health clinicians have used a variety of variables to assess risk. For example, Rabkin (1979) summarized the variables most often used in clinical decision-making to predict the dangerousness of sex offenders to re-offend: age, race, sex, marital status, educational level, criminal history (including whether the latest crime was brutally violent or sadistic), deviant arousal pattern, employment history, current job prospects, level of psychopathology (DSM diagnosis, if there is one), drug dependency, sup-
portive relationships and acquaintances.

Interestingly, a past study by Steadman and Cocozza (1974) found that, having supportive relationships when released bore no relationship to whether the offender would recidivate. Moreover, Dix (1976) studied factors used to release sex offenders from a state mental hospital. Dix found that both the offender's willingness to accept guilt, and his willingness to accept personal responsibility for the governing offense, were significant predictor variables for mental health clinicians. Similarly, Williams and Miller (1977) found an emphasis on guilt and remorse. And, Skodal and Karosue (1978) found an emphasis on aggressive fantasies (their presence or absence) when assessing and determining risk.

In addition to the above factors, Dougher (1988) added the following four variables to the assessment of offender risk.

1. Awareness of feelings. Is the offender aware of his own emotions or feelings? Often feelings of tension, anger, inferiority and arousal go unrecognized or denied by offenders who present a fake-good image when seeking release and/or a positive psychological report/evaluation. Hence, the inability of the offender to accurately identify, display and manage his feelings can indicate a high level of dangerousness or risk (Dougher, 1988).

2. Level of anger. Does the offender harbor sub-
stantial anger toward women? While usually more prevalent among rapists and exhibitionists, anger is also present with many pedophiles. Consequently, the inability to manage anger effectively indicates a high level of risk or dangerousness (Dougher, 1988).

3. Ability to empathize. What is the sex offender’s ability to empathize? The offender’s ability to empathize is a barometer of how well he is able to internalize the lessons of treatment. Here caution is in order. When assessing risk, the clinician should not mistake the offender’s own personal suffering (selfish pain) for victim empathy. Bright and well-educated offenders can appear empathic. When questioned in-depth however, superficiality is often revealed. Therefore, the more the offender lacks empathy, the greater his level of risk or dangerousness (Dougher, 1988).

4. Cognitive distortions. Does the offender still have irrational beliefs or cognitive distortions about who is responsible for his behavior and the impact of his crime(s)? Frequently these beliefs or ideas are concerned with what it means to be a man, the psychology of women and the vulnerability of children. Thus, when the following are present, (a) projections of masculine dominance, power, and control, (b) beliefs that women are rejecting, calculating and domineering, and (c) ideas that children enjoy sexual encounters and benefit from
them, the offender's level of risk or dangerousness re­
mains high (Dougher, 1988).

In a recent paper presented at the 98th Annual
Convention of the American Psychological Association,
Tink (1990) suggested two additional predictor variables:
rage and denial. Emphasizing the fact that a large pro­
portion of sex offenders were themselves abused as chil­
dren (the victim to victimizer cycle), Tink argued that
rage from the past is a crucial element in the activation
of sexual crimes. Subsequently, Tink concluded that of­
fenders who learn how to release, diffuse and manage
their rage (while in treatment) present a lower risk to
re-offend.

Regarding denial, Tink (1990) concluded that there
are two clear markers when assessing risk. First, at
some point the offender must take full responsibility for
his deviance by spelling out in-depth the extent of his
aberrant behavior. Second, the offender cannot minimize
the following: prior criminal behavior, present sexual
fantasies, the impact of his behavior on his victim(s),
his ideas about dangerousness to his own family and im­
mediate community.

Finally, of the preceding variables used to assess
risk, sex, age, race, socioeconomic status, drug abuse
and criminal history remain the main predictors of sexual
assault (Monahan, 1981). Statistically speaking, the
most important predictor variable is the offender's criminal past (Gottfredson and Tonry, 1987; Hall, 1990; Quinsey, 1981; Wenk, Robinson and Smith, 1972; Wolfgang, 1970). Subsequently, most clinicians use the following rule when assessing risk: the best predictor of future assault is the offender's criminal past (Mischel, 1968; Rabkin, 1979).

Lastly, in a recent review of current methods used to predict adult male sexual aggression, Hall (1990) concluded the following:

The prediction of sexual aggression is at a relatively early stage of development, and no method of prediction has been clearly superior. Consistent with Monahan’s (1981) theory of violent behavior, past sexual aggression against adults tends to be predictive of future sexual aggression against adults (Hall and Proctor, 1987). While it is useful to know that past sexual offending may be predictive of future sexual offending, it is equally important to know how persons who have not previously been sexually aggressive become sexually aggressive. Proposed variables related to the development of sexually aggressive behavior have included past sexual victimization, amount of past sexual experiences and tendencies to discuss these experiences, dominance as a motive for sexual acts, deviant sexual arousal, hostile and adversarial relationships with women, impulsivity, a lack of respect for the rule of society, social skills deficits, and tendencies to lose control under the influence of alcohol (Lisak and Roth, 1988; Malamuth, 1986). However, any of these variables considered individually have generally accounted for a limited amount of the variance in sexually aggressive behavior (p. 239).
Assessment and Denial

The preceding review indicates that with the exception of physiologic measures, the assessment of sex offenders is similar in content to the clinical evaluation of other individuals. Also apparent is the fact that mental health practitioners have no magic formula to determine (with certainty) whether specific offenders are guilty or innocent of particular crimes.

Next, it is obvious that, with or without psychological testing, the clinical interview only reveals what the offender is willing to self-disclose and discuss. Although topical areas are pursued that seek to identify issues clinicians deem clinically significant, in reality clinicians often receive an incomplete picture of the offender's life and sexual deviance.

In other words, it is unlikely that the individual offender, who in all probability has extraordinary difficulty with issues of trust and responsibility, will share the full details of his life with a relative stranger (simply because that stranger says he or she is trustworthy). Therefore, sex offenders commonly deny culpability and reject responsibility for their deviance. Given the social and legal consequences of self-disclosure (even when incarcerated), they typically do not tell the truth about themselves, their crimes or their

Currently, there exists no satisfactory method that identifies sexual deviates in the general population and measures their denial simultaneously. Instead the assessment of denial (or a fake-good profile) requires scales or indices that are designed to evaluate individual offenders who have been identified as sexual perpetrators by the criminal justice system (Lanyon, Dannenbaum and Brown, 1991).

A good example is the MSI, the inventory used in this study. It assesses denial in identified sex offenders. Its limitation is that it does not distinguish between: (a) individuals who have committed sexually deviant acts, who possess sexually deviant attitudes and have never been discovered, and (b) individuals who have never committed sexually deviant acts, who possess no sexually deviant attitudes and have nothing to disclose. In other words, the MSI would automatically label both
groups dishonest (Kalichman, 1992; Nicholas and Molinder, 1984; Simkins, Ward and Bowman, 1989).

Interestingly, in a study by Lanyon and Lutz (1984), MMPI validity scales were able to successfully discriminate offenders who had admitted their crimes versus those who had not. Using a heterogenous group of confirmed sex offenders, i.e., rapists, pedophiles, and exhibitionists, Lanyon and Lutz found that offender responses could be grouped into three distinct categories: (1) no denial, offenders willing to admit all of the deviant behavior in the allegations against them; (2) full denial, offenders not willing to admit any of the aberrant behavior in the allegations against them; (3) partial denial, offenders willing to admit some aspect of the abusive behavior (but substantially less than all of it) in the allegations against them.

Also, a study by Lanyon, Dannenbaum and Brown (1991) found that MMPI validity scales (along with three special indices constructed from them) were able to distinguish 125 denial and no-denial child abusers and spouses. Of particular interest was the ratio of denial to no-denial by gender. The ratio showed a similar distribution among females and males suggesting a high degree of homogeneity in denial behavior. Nonetheless, Lanyon, Dannenbaum and Brown concluded that further work needs to be done in this area to fully determine the applicability of the re-
suits.

In a more recent study, Lanyon (1993) compared 130 male sex offenders to 239 male controls on five special MMPI scales of sexual deviance: (1) the 24-item Pedophile (Pe) scale (Toobert, Bartelme and Jones, 1958), (2) the 100-item Sexual Deviation (Sv) scale (Marsh, Hillard and Liechte, 1955), (3) the 25-item Aggravated Sex (Ssx) scale (Panton, 1970), (4) the 27-item Sex Morbidity (Sm) scale (Dahlstrom, Welsh and Dahlstrom, 1975), and (5) the 27-item Impotence and Frigidity (IF) scale (Finney, 1965). These scales were originally constructed to: (a) distinguish sex offenders from non-sex offenders (Pe, Sv, Sm), (b) assess sex-related violence (Asx), and (c) measure normal sexual dysfunction (IF).

Interestingly, the subjects in Lanyon's study were not a random sample of felony sex offenders. Instead, the sex offenders were men referred for assessment regarding their mental state at the time of offense, their competency to stand trial and potential for rehabilitation. The controls were a heterogeneous group of non-sex offenders who had been referred for outpatient and inpatient evaluations (for child custody cases, personal injury suits, sensitive management positions, and competency to stand trial). Also, each group was divided into admitter and nonadmitter categories, and every subject was administered the MMPI in booklet form.
Overall, Lanyon (1993) found that:

1. The Pe, Sv, and Sm sexual deviance scales, and the MMPI F and K scales, differentiated the sexually deviant men from the controls.

2. The differences between the two groups were accounted for by the subgroup of deviant sex admitters.

3. The sexually deviant admitters continued to have higher scores on the Pe, Sv, and Sm scales when degree of psychopathology was equated (i.e., the difference not being due to between group differences in overall psychopathology).

4. The sexually deviant nonadmitters differed from control group nonadmitters when degree of defensiveness was equated (i.e., the difference not being due to between group differences in overall defensiveness).

In general, it should be noted that Lanyon's results only applied to child molesters. Because 95 of the 130 male sex offenders were child molesters, and most of the others were exhibitionists, the generalizability of the study is limited. For example, it cannot be applied to violent rapists.

Nonetheless, the study does suggest the possibility that a paper-and-pencil test, which controls for defensiveness, may be able to identify nonadmitters if special norms on defensiveness are developed. More specifically, the study suggests that the development of content-
specific scales, to assess deception and deceit, may be more useful than reliance on the more global approach of the MMPI.

Despite these studies, clinicians typically find denial a complex subject for study. With regard to sex offenders, denial is often considered a deeply ingrained pattern developed over a long period of time (Carnes, 1983, 1990). Not only does the pattern encompass identified crimes, it also includes the following: (a) the environmental conditions and/or states of mind that contribute to crimes not unidentified, (b) the impact of these assaults on their victims, (c) the current fantasies and thoughts of the offender, (d) the ongoing dangerousness the offender represents to others and (e) the offender’s assessment of his own future (Dougher, 1988).

To change this pattern sex offenders have to examine (in-depth) all of the above areas. Also, clinicians monitor these areas to measure progress in treatment. In other words, when a given offender starts to self-disclose and work in therapy, the clinician looks for a decline in those fears that sustain denial, e.g., the fear of loosing family and friends, the fear of loosing employment and income, the fear of loosing integrity, the fear of retaliation, the fear of going to prison or being institutionalized, the fear of being crazy for having done such an act(s), the fear of change itself, the fear
of relapse and the fear of not being able to establish new interpersonal/vocational relationships. Therefore, as Tink (1990) pointed out, "Denial, in its full range of implications, is a powerful indicator of treatment progress and risk reduction in comparison to many of the factors typically used in clinical assessment" (p. 17).

Finally, there is no widely recognized or accepted typology of denial, i.e., used to classify offenders when assessing them for treatment. However, clinicians who use the model of treatment known as Relapse Prevention, do speak of "levels" or "forms" of denial (Freeman—Longo and Pithers, 1992). Briefly, these levels or forms are as follows: denial of responsibility, denial of intent or forethought, denial of harm, denial of frequency, denial of intrusiveness, denial of fantasy, and denial of seriousness and gravity.

In the Relapse Prevention model, assessment of the offender is accomplished through clinical interviews, group therapy and client-specific homework (Freeman—Longo and Bays, 1988; Freeman—Longo and Pithers, 1990; Laws, 1990; Marlatt and Gordon, 1985; Pithers, 1990; Pithers, Cumming, Beal, Young and Turner, 1988). In addition, to reducing denial and increasing self-disclosure, the following techniques are used: creating a "yes" response set, demythologizing stereotypes about sex offenders, mixing confrontation with supportive feedback, emphazis—

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ing the relief of acknowledged secrets, reinforcing the
strength demonstrated by self-disclosure, stressing the
importance of not making a second mistake, making use of
strong religious beliefs, asking successive approximation
questions, confronting contradictions and repeating par-
ticular questions periodically (Pithers, Beal, Armstrong
and Petty, 1989).

Finally, to this investigator's knowledge, Salter
(1988) is the only clinician who has developed a typology
of denial for use when assessing sex offenders. After
its publication it was adopted by the U.S. Department of
Justice for the training of criminal psychologists and
correctional administrators at the National Institute of
Corrections in Boulder, Colorado. A brief summation of
Salter's typology is given below.

For example, Salter observed that "Denial is more of
a spectrum than a single state" (p. 97). In other words,
Salter stated that there are six components to denial
that span a continuum of denial types. Salter's compon-
ents are as follows:

... (1) denial of the acts themselves (type
and period of time the abuse occurred), (2)
denial of fantasy and planning, (3) denial of
responsibility for the acts, (4) denial of the
seriousness of the behavior, (5) denial of
internal guilt for the behavior, and (6) denial
of the difficulty in changing abusive patterns
(p. 97).

Therefore, contrary to the old axiom that sex offenders
either deny everything or admit the whole truth, Salter proposed the opposite - that offenders typically expose only a fraction of their deviance when being assessed. Salter proposed seven types or categories of denial in response to questions regarding all six components.

The first is admission with justification. These men admit the acts they have committed, however, they do not take responsibility for them. To the contrary, they justify their deviance through their own fantasies about their victim's feelings and thoughts, needs and wants, attitudes and behaviors.

These men do not blame their victims directly. They rarely appreciate the seriousness of their behavior. Instead they justify their actions by saying they were educating their victims, that they were offering love and friendship, or that they were indirectly provoked by some victim mannerism. They may even justify their behavior by referencing some imaginary characteristic associated with their victim.

Whatever the case, according to Salter these men feel little guilt or shame when discovered. If they do feel such, typically it is guilt and shame over what they have done to themselves. They do not admit to pre-assault fantasies or plans, and it is hard for them to see any real need to change.

Physical denial with or without family denial is
Salter’s second type. With this type the sex offender denies his crime on a specific day at a given time and place. Focused on the details of the day, the offender provides an alibi for the offense. Sometimes, despite strong evidence to the contrary, he will have family support and support from friends who will cling to his alibi.

With this type of denial, the offender does not accept any form of responsibility. He either contends the crime never happened, or he contends it did not involve him. Never involved, the offender cannot admit to any fantasy or plan. Since there was no crime, he sees no adverse consequences to his behavior. He has no guilt or shame. Often he reacts with righteous indignation complaining that his victim(s) and/or the system is out to get him. He plays the victim role and sees no need to change. Subsequently, he is not amenable to treatment, especially when pressured to continue his denial by family and/or friends.

Salter’s third type is psychological denial with or without family denial. Without focusing on the concrete details of the offense, the offender denies the crime and any additional aberrant behavior. Rather than saying, “I couldn’t have done it because I wasn’t there at the time,” the offender says, “I’m not cut like that. I’m not that kind of person. I could never do such a thing.”
I ain't no baby-raper! No rapist or pervert either. I tell you I didn't do it and that's it. It's all a lie!"

Although the sex offender's family may support his denial and help him produce a false alibi, typically the family's denial is less pathological in character because it does not entail outright lying to protect the offender. In families where lying is not present, members can initially believe the offender is innocent. Often these families are more amenable to treatment when they find out the sex offender has been lying to them - that he is guilty as charged.

Obviously, offenders who psychologically deny committing a sex offense do not acknowledge their deviance has harmed someone. Nor do they acknowledge pre-assault plans or fantasies. Instead they show little evidence of guilt and shame. They see no reason to change behavioral patterns that do not exist.

Minimizing the extent of the deviance is Salter's fourth type of denial. Salter points out that sex offenders will frequently admit part of their aberrant behavior but deny the rest. This often occurs when the offender is caught with one victim but not with others. Subsequently, the offender asks for help but he withholds information about the scope of his sexual deviance for fear of additional adjudication.

With this type of denial, it is not uncommon to find
the offender minimizing the frequency of the abuse as well as its form. For example, offenders will typically admit to fondling and oral sex but vehemently deny any form of penetration. They will also minimize the period of time over which the abuse occurred. And, as with other types of denial, fantasies and plans are minimized as well.

Naturally, type five offenders who admit only a part of their deviance are not assuming responsibility for the totality of their problem. They typically equivocate and minimize harm they have caused. When asked to describe the impact of their behavior, they are often unable to delineate any detrimental effects. Thus, while these offenders are sometimes distraught and remorseful upon discovery, there is no deep sense of internal guilt. Often these offenders underestimate the difficulty of change. They promise, "I'll never do it again," thinking that their word is sufficient to prevent relapse.

Salter's next type is denial of the seriousness of the behavior and a need for treatment. Once sex offenders admit the extent of their deviancy, they often minimize the seriousness of it. It takes considerable empathy on the part of offenders to imagine their crimes from the victim's perspective. Also, it takes considerable courage to face the extent to which their crimes are not redeemable.
Type five offenders display a superoptimism that implies what they did was not so bad after all. They are quick to believe their victims have recovered, and they tend to see their victims as just like the way they were before. Therefore, by denying the seriousness of their deviance, these offenders protect themselves from the guilt and remorse that empathy would entail. If any negative affect is felt, typically it is some sense of shame associated with their discovery.

According to Salter, these offenders are at particular risk to reoffend. The cognitive distortions and thinking errors that justified their aberrant behavior (that gave permission for it) have their foundation in their underestimating the impact of their sexual deviance. In other words, it is only one short step from thinking "It really didn't do her any harm" to thinking "One more time won't hurt."

With regard to treatment, this type of denial is associated with the belief that change comes easily. These men typically request treatment and, when separated from their families, press for quick reunification by saying they are responsible for their deviance. Also, once in treatment these men try to abbreviate the therapeutic process by saying they have acknowledged guilt.

Nonetheless, some offenders reject treatment on the following basis, "It is just better not to talk or think.
about it." Treatment would make things worse in their eyes because they would have to dwell on their deviance. Nevertheless, without treatment this type of offender has no new coping strategies to use in the future when confronted with arousal in high-risk situations. Therefore, according to Salter a high probability of relapse exists with this type of denial.

The religious or moral conversion is Salter's sixth type of denial. This occurs when the individual sex offender claims he has been cured or saved - that he has no need of treatment because of spiritual transformation and moral change. In other words, after discovery it is not uncommon to see offenders and their families seek spiritual guidance by becoming active in a church and/or religious organization. In collusion, family members and the offender decide to rely on God for protection, guidance and change.

According to Salter, the reliance on God or faith (on some form of a higher power or belief in a recently awakened sense of morality) only serves to protect offenders and their families from the painful work of treatment. It does next to nothing to reduce risk.

Instead, Salter suggests that the recently-converted take seriously the old saying, "God helps those who help themselves." Salter recommends that offenders, when asking for God's forgiveness, demonstrate their faith and
prove their sincerity by: (a) participating in therapy, (b) completing homework assignments and (c) not looking to God to do the work of treatment but asking God to assist them in their doing the work themselves.

Salter's last type of denial is the denial of full responsibility. This category includes sex offenders who initially admit their offense, who acknowledge the seriousness of their crime (as a means to enter treatment) but who later deny primary responsibility.

Unlike offenders who acknowledge their crimes and justify them, these men admit their deviance but do not take complete responsibility for it. Sometimes this type of denial is very blatant - as when the offender attributes his deviance to alcohol or drugs, or when he insists that he needs therapy for chemical dependence and not sexual aberrance.

Some offenders are less overt. They will say they are responsible, yet they will externalize the responsibility. Blame will be placed on a nagging spouse, problems at work, victim provocation, their own neediness or a lack of care and attention from the world at large. These men find numerous excuses for their deviance, many of them external but some of them internal. Their excuses have the cumulative effect of saying, "Yes it happened, but there were a lot of extenuating circumstances, so you see I just couldn't help myself."
Inevitably, the offender presents himself as the victim. Protrayed is a mixture of self-pity and anger at the world for not meeting his needs. The offender cannot openly admit that his offense(s) was sexually exciting or pleasurable. Nor can he honestly admit the extensiveness of his fantasies or plans. The acknowledgement of his fantasies would imply sexual pleasure on his part. The admission of plans would suggest manipulation of the victim(s) - the recognition of which is antithetical to externalized responsibility.

Contrary to what the offender might say, in reality he accepts little responsibility for his own behavior. Instead he tries to persuade others (or at least his therapist) that he has suffered as much as the victim. When interviewed he exhibits little internalized guilt.

Typically, these men do not refuse treatment but express confidence in their ability to never reoffend. Often they are euphoric over having controlled their impulses while in therapy. Consequently, according to Salter they find it easy to underestimate their old compulsion and overestimate their new found sense of control. Although they often seek premature termination from therapy, in actuality they have not fully owned their sexual deviance. Instead they have displaced responsibility for it.

In summation Salter (1988) concluded that denial is
not a binary concept but a complex, multifaceted phenomenon that requires careful examination when assessing treatment amenability, therapy progress and the risk to reoffend. Salter observed the following:

The continuum from admission with justification to admission with guilt is a continuum from more pathological to less. It is not true, however, that offenders jump from one end of the continuum to the other. Typically, offenders either begin with an admission with justification, with physical denial, with psychological denial, or with minimizing the extent of the behavior. If an offender begins with psychological denial, he then typically proceeds to minimizing the extent of the behavior. Whatever the initial stance, offenders rarely move from their initial stance to a full admission with responsibility and guilt in one step. From the point of entry, they will often go through the progression described in the chart. From minimizing they will admit the extent of the behavior, but deny the seriousness of it and the need for treatment. Through therapy, they will begin to accept the seriousness, but externalize responsibility. Finally they will admit the offenses and the seriousness of the behaviors and assume the responsibility for them (p. 109).

Lastly, the offender who does not deny is the individual who acknowledges the extensiveness of his sexual deviance. His story matches that of the victim(s). In addition he is able to describe thoughts and fantasies antecedent to the crime(s). He admits: (a) the extent to which his behavior was preceded by fantasy and (b) the extent to which he planned the offense(s) and groomed the victim(s). He is aware of his urge to reoffend and his current struggle with deviant sexual ideas. He feels guilt over the impact of his behavior, and he recognizes
he cannot undo the harm he has done. He appreciates the seriousness of his problem, and he acknowledges the fact that personal change will not be easy.
CHAPTER III

METHOD

This research study investigated whether or not a structured interview with the MTF Therapy Review Board reduced sex offender denial and increased self-disclosure prior to treatment. It utilized the Multiphasic Sex Inventory by Nichols and Molinder (1984) as a measure of change or effect - specifically the four Lie Scales, the Social Sexual Desirability Scale, the Treatment Attitudes Scale and the Justification Scale.

Methodologically, this study employed a pretest-posttest, nonrandomized control-group design to compare pretest and posttest means and standard deviations for two groups of incarcerated sex offenders at MTF, one control group and one experimental (Cook and Campbell, 1979; Isaac and Michael, 1987; Van Dalen, 1979). The design had a number of limitations associated with it.

Design Limitations

In a true experimental study, all variables of concern are held constant except for the one condition or experimental treatment being presented by the researcher to the experimental group. Typically, the control group acts as a baseline against which the experimental group
can be compared. Such a study requires the investigator to rigorously manage all variables and conditions through either direct manipulation or true randomization. This study approached but did not achieve this goal.

Internal Validity

The inability to randomize both groups limited this study's internal validity. To be specific, it limited this investigator's ability to answer the question: Did the structured interview with the Therapy Review Board in fact reduce denial and increase self-disclosure prior to treatment?

In other words, the lack of true randomization increased the probability that any meaningful effects were not the result of the Therapy Review Board interview but were the result of extraneous variables. Hence, steps were taken to control the variables.

Selection Bias

To control for the possible effects of non-randomization and selection bias, this investigator took names from MTF's sex offender group therapy waiting list but did not read cases ahead of time in an attempt to match individuals on the basis of specific variables like age, race, or marital status. For the legal reasons given later in this Chapter, the two groups in this study con-
consisted of sex offenders closest to their earliest possible outdate or past it. Moreover, it was decided that, because MTF housed over 12.1% of all sex offenders in the MDOC, a large sample of 120 or more subjects from MTF's sex offender group therapy waiting list would greatly reduce the effects of nonrandomization and selection bias, thus reducing sampling error. Furthermore, it was felt that, if a large enough sample could be drawn, then the study's results might have relevance for other sex offender populations in minimum security prisons across the State.

**Intervening Variables Affecting Intra-interview Attitudes and Behaviors**

To control for variables such as age, race, type of sex offense, level of education, marital status and personal victimization, each subject completed the MTF Life History Questionnaire which covered a variety of background variables (See Appendix A).

**Intra-interview Variance**

To control for one offender's intra-interview experience being different from another's, each Therapy Review Board interview was structured with each psychologist assuming a specific role (see operational definition of the independent stimulus variable in this Chapter).
Board Member Personality Differences

To control for Therapy Review Board member personality differences affecting the attitudes and expectations of the subjects when interviewed, members of the Therapy Review Board switched roles between each interview.

Intra-interview Bias

To control for MSI pretest scores being known before Therapy Review Board interviews, no MSI pretests were scored until after experimental group members were interviewed by the Board.

Test and Intra-interview Irrelevancies

To control for room lighting, temperature, arrangement and background noise interacting with test administration and the interviews, all tests and interviews were given and held in the same location and under the same conditions.

Instructional Set and Examiner

To control for variation in the instructional set and personality of the examiner, only this investigator administered the MSI in the same room with the same instructional set every time the test was given.
Improper Scoring

To control for the MSI being improperly scored, all MSI pretest and posttest answer sheets were scored by this investigator.

Experimental Mortality

To control for offenders taking the pretest and then being paroled or transferred (either before or after their interview) but before their posttest, the investigator did not use scores from paroled or transferred offenders.

Hawthorne Effect

To control for experimental group subjects learning that they had been scheduled for the assessment interview before taking the pretest (thus contaminating the validity of pretest results), all experimental group subjects were scheduled for their MSI pretest before they were scheduled for the interview with the Therapy Review Board. When the question of being interviewed arose, the subject was told that all interviews were scheduled in accord with MDOC policy (that MTF’s sex offender waiting list was maintained on a time to potential minimum outdated basis and that all interviews were scheduled accordingly).
John Henry Effect

To control for control group subjects learning their status before and after administration of the MSI pretest (thus contaminating pretest results by trying to outperform experimental group members), all subjects in the study were not told their group status.

Confidentiality of Case-specific Information

Given the study's design, and given the fact that no offense-specific information was used, the confidentiality of case-specific information was not an issue.

External Validity

To the investigator's knowledge, no subject in the study discovered his group affiliation and responded differently to the MSI or Therapy Review Board interview. Instead, all subjects received equal information regarding MTF's sex offender assessment process.

Secondly, during the course of the study, no subject reported, either in person or on the Life History Questionnaire, a traumatic event or atypical condition affecting his participation (e.g., a physical assault, sexual attack, judicial loss, death of a spouse/parent, divorce, etc.). Furthermore, no subject claimed undue stress or a disabling condition refusing thereby to co-
operate.

Finally, the pretest-posttest, nonrandomized control-group design does not control for the reactive or interactive effects of pretesting. Therefore, whether or not the MSI pretest sensitized or altered subjects in some way, i.e., so that they responded differently to the Therapy Review Board or MSI posttest during the study, was indeterminable.

Population and Sample Selection

The subjects for the study consisted of 136 sex offenders housed at the Muskegon Temporary Facility in Muskegon, Michigan. At the time, MTF's total population consisted of 960 inmates. There were 523 men incarcerated for Criminal Sexual Conduct (CSC), or 12.1% of all sex offenders housed by the MDOC. Of these 523, 455 (87%) were incarcerated for CSC first, second or third degree. Only 57 (10.8%) were incarcerated for Assault with Intent to Commit CSC in the first or second degree. And only 11 (2.2%) were incarcerated for Gross Indecency.

Currently, the MDOC does not statistically classify inmates for therapy purposes on the basis of pedophilia, rape or exhibitionism. Instead, each prison is required to maintain a group psychotherapy waiting list for sex offenders. According to MDOC Policy Directive No. 42.03, this list is to be maintained on a time to potential...
minimum outdate basis.

Of the 523 sex offenders at MTF, 367 were on MTF’s waiting list - 305 child molesters and 62 adult rapists. Of the remaining 156 sex offenders, 109 were in treatment and 47 had (a) no group therapy recommendation, (b) refused treatment when offered or (c) been screened from treatment.

The study’s 136 subjects were taken from MTF’s sex offender group psychotherapy waiting list. There were 73 experimental group subjects that came from the first 90 names on the list (not all produced useable profiles or agreed to be in the study). This group took the MSI twice, once before and then after the interview with the Therapy Review Board.

The control group consisted of 63 subjects beginning with offender No. 100 and going to No. 180 on MTF’s waiting list (i.e., not all producing useable profiles or agreeing to be in the study). Members in this group took the MSI twice before being scheduled for a Therapy Review Board interview.

Finally, from the standpoint of design it is essential to explain why true random assignment was not possible. True randomization would have led to grievances and lawsuits. Inmates would have been quick to allege discrimination, favoritism and “cruel and unusual punishment.” In other words, inmates would have been able to
say that, as a result of randomization, some sex offenders with "later outdates" were assessed first - that the Therapy Review Board gave preferential treatment to sex offenders with "later outdates" thereby denying men with "earlier outdates" the opportunity to complete their "therapy requirement" and be released first. Hence, inmates would have been able to claim that MTF's Therapy Review Board unfairly extended sentences, i.e., beyond State guidelines, therefore the Board inflicts cruel and unusual punishment which violates the 8th Amendment to the Constitution of the United States.

Operational Definitions

Independent Stimulus Variable

The independent stimulus variable in this study was the one-hour, structured interview with three psychologists. All four people sat at an oblong table in the prisoner services conference room at MTF. The offender sat across from one psychologist while the other two psychologists occupied the ends of the table. Each psychologist assumed one of three roles. The roles were rotated between assessment interviews.

Secondly, one psychologist brought the perpetrator into the room, then introduced himself and fellow Board members. This psychologist assumed a very neutral,
tached role throughout the entire interview. He explained the purpose of the interview, emphasized confidentiality and asked a few initial, factual questions to set the offender at ease (e.g., How long have you been down?; How long have you been at MTF?; What other facilities have you been at?). Eventually, this psychologist asked the following question, "As best you can, tell us in detail what you did to come to prison, how it all happened?"

Thirdly, after responding to the above question, the inmate was asked additional, case-specific questions by a second psychologist (i.e., to elicit more information and seek clarification). If the inmate appeared physically uncomfortable and became reluctant to talk, this psychologist would assume an empathic role. He would reflect the inmate’s apprehension, stress confidentiality and acknowledge how difficult it is to speak with three psychologists at once. Also, seeking more detail about the offender and his crime, this psychologist would try to communicate understanding and positive regard.

Often, as the offender began to feel more comfortable telling his story, he would contradict, discount and/or deny information in his pre-sentence investigation report (e.g., the type and/or frequency of abuse, the victim’s response and/or role, the victim’s character and/or credibility, the use of threat, force, and/or a weapon). Hence, statements like the following were writ-
ten down exactly or as close to verbatim as possible.

I'm a teacher and I love kids. I was only rubbing his stomach. My hand did not go down his pants like they say it did. I'd put my arm around my students to encourage them, but that's all. You know it's good for their esteem. You know how young kids can misinterpret things. It's all a lie, a big mistake. But I want therapy anyway so I'll know how to avoid these kinds of situations in the future.

That bitch turned me in because I didn't give her the crack after she gave me head. I ain't no rapist, man. No sex offender either. I never did nothing to her. She agreed to it all man. She was a crackhead but the courts never believe you, especially if you are a man. You know what I mean.

Next, because some offenders only gave "lip service" to accepting responsibility, the third psychologist began to challenge the offender. This psychologist assumed a very confrontational role. Using direct feedback, he pointed out specific discrepancies and/or absurdities in the offender's story. For example, this psychologist might say:

You mean you expect us to believe that your 7-year-old daughter learned all about sex, about fellatio, because she once walked in on you and your wife while you were having oral sex. That the whole thing with your daughter just happened spontaneously, and that it happened only once. That you weren't thinking at the time and you know now, without a single doubt, that you will never do it again.

Needless to say, as the offender's anxiety began to rise (i.e., with three psychologists staring at him in disbelief), perspiration and hand tremors were not uncommon. As his speech began to falter, and his tone became
defensive, the offender was told firmly that his story was not credible; that he is still a threat to his family and community because he is so impulsive (e.g., because it just happened; because he wasn’t thinking at the time; and because he wasn’t aware of what he was doing when he was doing it). He was advised that admittance into MTF’s treatment program requires total honesty and truthfulness, if he is to have any chance at early parole.

Interestingly, some sex offenders continued to deny and minimize their crime. Nonetheless, most offenders began to change their song. Tears were not uncommon as details began to flow — details usually far in excess of what was in the offender’s official file.

Also, before concluding the interview some offenders admitted additional crimes and victims, as well as their own victimization, extensive use of pronography and fear of being exposed at MTF as a "tree jumper" or "baby raper." Hence, the first psychologist reinforced confidentiality and briefly explained MTF’s program. He then terminated the interview.

Overall, the Therapy Review Board interview tried to create a state of cognitive dissonance for offenders. Knowing that offenders typically lie about, minimize and/or rationalize their crimes, the Board sought to produce a double bind. Feeling sufficient discomfort to know they were not believed, offenders were encouraged to
tell the truth if they wanted treatment and, ostensibly, early release. Therefore, although this technique might appear to engender resentment, anger and outright lying, in reality it appeared to produce confession, catharsis and commitment to the treatment process (for those eventually accepted into MTF's treatment program).

**Dependent Outcome Variable**

In this study the dependent outcome variable was the Multiphasic Sex Inventory or MSI (Nichols and Molinder, 1984). Published in 1984, the MSI has grown in recognition and use. Not only has it been used in English speaking countries such as Canada, England, Ireland, New Zealand, Australia and the United States, it has also been used in Europe and has been translated into Spanish, Dutch and German. Currently, there are over 1,400 private clinicians, clinics, universities, hospitals and government agencies using the MSI in the United States.

In design, the MSI is like the MMPI but it is not a personality test. The MSI consists of 300 true/false items which produce 20 scales and a sex history. It is to be used following discovery and cannot be used to determine whether or not an individual is a sex offender. As Nichols and Molinder (1984) state, "No test, no device, has the power to pick out a sexually deviant person from any other person in a crowd" (p. 3). Table 1
illustrates the MSI's 20 scales by subset (see page 158).

To this investigator's knowledge, no other tests of sexual deviance were available in the field of personality assessment. As noted in Chapter II, the MMPI has been used to construct profile patterns for rapists and pedophiles and to recently differentiate admitters from nonadmitters, but that is all.

Consequently, when Nichols and Molinder developed the MSI, they formulated five propositions about sexual deviance and the offender.

1. An act of sexual deviance does not exist until it is discovered; that no test has the capacity to pick out a sexually deviant person from any other person in a crowd.

2. There is a cognitive progression to a deviant sexual act or offense; that the act must first be contemplated through a progression of thinking errors before the offender carries it out.

3. There are identifiable behavioral correlates which are universal to sex offenders and correspond to the thinking errors mentioned in proposition two (e.g., stalking, cruising, grooming, etc).

4. There are expected differences between offender subsets (rapists, child molesters, exposers) and from one offender to another within the same subset, not only in terms of magnitude, duration and style but also in terms
Table 1

Multiphasic Sex Inventory Scales

<table>
<thead>
<tr>
<th>Scales by Subset</th>
<th>Number Per Subset</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Validity Subset</strong></td>
<td><strong>6</strong></td>
</tr>
<tr>
<td>Parallel Items Scale (15 items on the MMPI)</td>
<td></td>
</tr>
<tr>
<td>Sexual Obsessions Scale</td>
<td></td>
</tr>
<tr>
<td>Social/Sexual Desirability Scale</td>
<td></td>
</tr>
<tr>
<td>Cognitive Distortions &amp; Immaturity Scale</td>
<td></td>
</tr>
<tr>
<td>Justification Scale</td>
<td></td>
</tr>
<tr>
<td>Four Lie Scales: Child Molestation, Rape, Exhibitionism, and Incest (only the subject-relevant one is used)</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Deviation Subset</strong></td>
<td><strong>3</strong></td>
</tr>
<tr>
<td>Child Molestion Scale</td>
<td></td>
</tr>
<tr>
<td>Rape Scale</td>
<td></td>
</tr>
<tr>
<td>Exhibition Scale</td>
<td></td>
</tr>
<tr>
<td><strong>Atypical Sexual Behavior Subset</strong></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td>Fetish Scale</td>
<td></td>
</tr>
<tr>
<td>Obscene Call Scale</td>
<td></td>
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<tr>
<td>Voyeurism Scale</td>
<td></td>
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<tr>
<td>Bondage and Discipline Scale</td>
<td></td>
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<tr>
<td>Sado-Masochism Scale</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Dysfunction Subset</strong></td>
<td><strong>4</strong></td>
</tr>
<tr>
<td>Sexual Inadequacy Scale</td>
<td></td>
</tr>
<tr>
<td>Premature Ejaculation Scale</td>
<td></td>
</tr>
<tr>
<td>Physical Disabilities Scale</td>
<td></td>
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<tr>
<td>Impotence Scale</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Knowledge and Beliefs Scale</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td>Treatment Attitudes Scale</td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

Total Number of Scales - 20

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of other sexual characteristics such as fetishism, voyeurism, sado-masochism, sex knowledge and even sexual dysfunction.

5. The belief that sex offenders vigorously defend their deviance through all manner of deception (to self and to others); that there are primarily three types of deception: dishonesty, distortion and denial.

Lastly, it should be noted that, in general Nichols and Molinder (1984) hypothesized the following:

Therefore, our conceptual framework hypothesizes that for every discovered sexual offender, there are universal sexual characteristics, that there are individual differences, and that there is a deceptive variable which confounds the true condition of the offender's sexual deviance - a source of variance which needs to be accounted for if the offender is to be understood and diagnosed properly (p. 5).

Validation, Reliability and Standardization

Validation. To construct a valid instrument, the first strategy Nichols and Molinder (1984) employed was to develop a large pool of sex-related items that were clear and very direct. In 1977 Nichols and Molinder conducted a pilot study of 90 pedophiles. They discovered that their subjects responded best to straightforward, behaviorally-oriented items, even if they were self-damaging. As a result they made every effort to develop a large pool of items that were both easily understood and well-matched to the specific behaviors and character-
istics of three offender groups - rapists, child molesters and exhibitionists. Basically, Nichols and Molinder reasoned that a large pool of items would enhance validity because it would permit more direct comparisons between the three groups (i.e., based on item acceptance or rejection).

In 1983 Nichols and Molinder asked 11 judges to logically sort over 200 items into 14 categories. All 11 judges were specialists in the treatment of sexual deviance. Of the 14 categories, 13 resulted in the various subtests and scales of the MSI today. The fourteenth category was designated a "no category." If the rater was uncertain as to where a specific item should go, it was to be placed into the "no category."

There was high overall agreement between the judges as to where items belonged - to what subtest or scale. For example, in 1983 all the judges agreed on 94 items, 10 agreed on 45 items, nine agreed on 18 items, eight agreed on 19 items, seven agreed on 8 items, six agreed on 8 items, five agreed on 2 items and four agreed on 6 items.

In 1983 Nichols and Molinder (1984) also added 22 nonsorted items to strengthen the various subtests and scales of the MSI. Hence, in 1983 the MSI consisted of 272 items, i.e., 222 items plus a 50 item sex history. Finally, in 1984 Nichols and Molinder expanded the MSI to
its current form, 300 items.

Three validation studies were conducted in 1983. Initially, Wing (1983) gave the MSI to 48 inpatient sex offenders at the Western Washington State Hospital in Fort Steilacoom, Washington. This group consisted of both child molesters and rapists. Wing correlated the Child Molest Scale and Rape Scale with steps of progress in treatment. She found a slight but positive correlation (r=.21) between steps of progress in treatment and the Child Molest Scale for the child molesters. For the rapists she found a moderately high correlation (r=.74) between steps of progress in treatment and the Rape Scale.

Next, using a much larger sample (N=126) at the same hospital, Wing (1983) again found that the MSI was able to differentiate rapists and child molesters on the Rape and Child Molest Scales. In an unpublished paper Wing (1983) reported, "T-tests for differences between groups attained significance at the .01 level in only two instances: rapists obtained higher scores on the Rape Scale than did molesters of female children; and the latter obtained higher scores than rapists on the Child Molest Scale" (p. 9).

The third study was conducted by Nichols and Molinder (1984) using a control-comparison group design. Six groups were formed totalling 322 male subjects. They
were:

Group I - a pre-treatment group of 140 male heterosexual, homosexual and bisexual pedophiles who were both state hospital and community referrals.

Group II - a pre-treatment group of 30 male rapists who were both state hospital and community referrals.

Group III - a pre-treatment group of 20 male exhibitions who were community referrals.

Group IV - a control group of 56 male college students who were paid volunteers.

Group V - a post-treatment group of 54 male heterosexual, homosexual and bisexual pedophiles who were state hospital and community referrals.

Group VI - a post-treatment group of 22 male rapists who were both state hospital and community referrals.

After administering the MSI, means and standard deviations were calculated for each group on the MSI's subtests and scales. In addition, all 322 subjects were given the MMPI with the control group of college males taking the MMPI short form. In abbreviated form, the results of this study were as follows:

1. That the child molesters and rapists were identified by their higher score-patterns when compared with the control group of "normals".

2. That the post-treatment sex offenders, both the pedophiles and rapists, were more open about their devi-
ance and less deceptive than the pre-treatment offenders; that between the two general categories there were significant $t$ values on all scales and subtests except for the Sexual Dysfunction Subtest.

3. That on the validity scales the posttreatment sex offenders, both rapists and pedophiles, scored significantly lower on the Lie Scales than the pretreatment offenders; that the treated sex offenders were more like the college males in terms of openness in expressing normal sexual desires and interests, while the untreated offenders were inclined to be more defended about sex in general.

4. That all three groups (pedophiles, rapists, and college males) showed consistency in their score patterns when MSI scales were intercorrelated.

Finally, Nichols and Molinder (1984) checked whether all MSI scales and subtests correlated with six external variables: (1) age, (2) IQ, (3) education level, (4) the L Scale, (5) the F Scale, and (6) the K Scale of the MMPI. They found that no correlation exceeded .20 leading them to conclude "The MSI tends to be independent of the several external variables of age, race, IQ, education level and MMPI validity scales which could otherwise contaminate or confound MSI results" (p. 14).

Reliability. To check for reliability Nichols and
Molinder (1984) retested 32 sex offenders with the MSI. Time frames ranged from 6 to 67 days. The average time between tests was 21 days. Overall they discovered the MSI to be quite reliable with a test-retest correlation of $r = .86$ for all items on the MSI. No test-retest correlation fell below a low $r = .58$ on any one scale (e.g., the Sex Knowledge and Beliefs Scale being the lowest correlation at $r = .58$). Therefore, Nichols and Molinder concluded, "The MSI subtests and scales are reliable and for the most part appear to be consistently measuring each of the various traits being assessed" (p. 15).

**Standardization.** To standardize the three sexual deviance scales or the Paraphilias Subtest, Nichols and Molinder (1984) took 52 rapists and 300 pedophiles and divided each group on the basis of "treated" or "untreated" (276 untreated rapists and pedophiles; 76 treated rapists and pedophiles). The raw scores for each group were then converted to T-scale scores and plotted on the MSI Profile Form. With means of 20.16 and 19.09 respectively, both the treated rapists and pedophiles scored consistently higher than the untreated offenders who obtained an mean of 15. Subsequently, because the treated groups exceeded the untreated groups by at least one standard deviation, Nichols and Molinder found the Child Molest and Rape Scales to be valid.
Formal standardization of part three of the Paraphilias Subtest, the Exhibitionism Scale, was not undertaken because of too few subjects (N=20). Additionally, the Atypical Sexual Outlet Subtest was not standardized because there were too few items within each of its five scales (Fetish Scale, nine items; Obscene Call Scale, four items; Voyeurism, nine items; Bondage and Discipline Scale, six items; Sado-Masochism Scale, 10 items). Nonetheless, these scales are considered valuable because they provide information about the individuality and uniqueness of the offender; they help the examiner learn more about the offender's offending pattern.

Standardization of the Sexual Dysfunction Subtest was not possible for the same reason as the preceding set of scales. In total, this subtest consists of 32 items divided among four scales (Sexual Inadequacies Scale, nine items; Premature Ejaculation Scale, four items; Physical Disabilities Scale, eight items; Impotence Scale, 12 items). Generally speaking, all 32 items of the Sexual Dysfunction Subtest are straightforward statements designed to assess problems with sexual functioning. Eight of the 32 are considered critical items, the endorsement of which should be considered a red flag requiring further evaluation (e.g., "I have or have had a venereal disease.").

The Sex Knowledge and Belief Scale consists of 24
items related to human physiology and sexual anatomy but not to the intricacies of gender-specific reproductive systems. Standardization of this scale was achieved by Nichols and Molinder comparing their 1983 groups of treated and untreated offenders with their control group of 56 male college students. Overall the sex offender groups and the non-sex offender control group demonstrated a good fund of knowledge about sex: most of the sex offenders having as much knowledge as the control group (the sex offenders average score being 18 and the control group's average score being 19).

Six scales make up the Validity Subtest of the MSI. The first scale, the Parallel Items Scale, was not standardized in the usual way. Instead, 15 matching MSI-MMPI items were given to 40 offenders using a test-retest design. All of the offenders were in treatment for sexual deviance at the time. Prior to one hour of treatment, all 40 were given the 15 items from the MMPI. After treatment all 40 were given the slightly re-phrased items from the MSI. The correlation between the two sets of items was .87.

The Social Sexual Desirability Scale was standardized on a sample of 40 "normal" college males because the scale is a list of normal sexual interests and desires. Out of the 35 items making up this scale, the raw score mean was 30.87 with a standard deviation of 3.21 for the
group. For Nichols and Molinder this mean became the norm for normal male sexual interests and desires. Subsequently, when comparing the scores of untreated sex offenders to this norm, Nichols and Molinder discovered that untreated offenders, who typically scored two to three standard deviations below the mean (23 or less), had trouble admitting normal sexual interests and desires; that they were in denial regarding their interest in sex. And, for those who scored very low, there was a definite attempt to portray a "fake good" image, to project an asexual image indicating massive denial regarding sexual interests and desires.

In standardizing the Sexual Obsessions (SO) Scale, the test's authors used the mean scores of 40 normal males and 40 normal females. They compared the mean scores of these two groups with the mean scores of the treated sex offenders in their 1983 research (child molesters and rapists). Again, using the 80 normals to establish a norm, Nichols and Molinder found that offenders scoring low on the SO Scale (2 points or less) were denying any interest in sex, thus producing a "fake good" response, while those scoring high (17 points of more) were malingering, thus producing a "fake bad" profile.

Built into the MSI are four Lie Scales (Lcm = Child Molest Lie; Lr = Rape Lie; Lex = Exhibitionism Lie; Lin = Incest Lie. Two of the four Lie Scales (the Lcm and Lr)
have been normed. Each contains 13 items. Both scales were normed on the two posttreatment sex offender groups that were included in Nichols and Molinder's 1983 research. The posttreatment pedophiles had a mean of 1.040 and the posttreatment rapists a mean of 1.33. Meanwhile, the non-treated rapists and non-treated pedophiles had means of 5.06 and 4.91 respectively. Subsequently, those post-treatment offenders who scored high on their paraphilic scale (Lcm or Lr), who endorsed five or more items, were seen as still defending their deviance through dishonesty and denial. Again, the two Lie Scales for exhibitionism and incest were not standardized because of insufficient items (only six and four items respectively).

The MSI's Cognitive Distortion and Immaturity Scale was standardized with a small clinical sample of 31 untreated sex offenders. They were given the CDI Scale as part of the MSI battery. They obtained a mean of 6.34 with a standard deviation of 2.41. Hence, the untreated sex offender who scores two or more standard deviations below the mean of 6.34 has few, if any, cognitive distortions, whereas the untreated sex offender who scores above 10 may perceive himself as the victim alleging that society is unjust and uncaring. A score of 15 or more suggests the offender has great difficulty accepting responsibility for his actions.
Again, the same sample was given the Justification (Ju) Scale and achieved a mean of 5.62 with a standard deviation of 3.76. Thus, Nichols and Molinder decided to use one standard deviation below the mean to identify the typical untreated sex offender who uses justifications to excuse away his offense(s). A score of one deviation above the mean would then suggest heavy projection or the offender blaming something or someone for his assaultive behavior. A score two deviations above the mean would indicate a severe lack of accountability for one's sexual deviance.

Finally, the last MSI scale to be standardized was the Treatment Attitudes Scale. Like the preceding two scales, this scale was also given to the small clinical sample of 31 untreated sex offenders. A mean of 4.0 and a standard deviation of 1.52 were obtained. Basically, a score of two or less on this scales suggests that the offender is not interested in treatment despite what he might say. A score of seven or more suggests the offender is openly admitting he has a problem with deviant sexual behavior and wants help.

**Brief MSI Scale Descriptions**

**Child Molest Scale.** This scale was created to identify the child molester who manipulates and coerces his victim(s) into compliance with his demands. It was not
designed to identify the offender who perpetrates a sudden attack or assault. Instead, it points to the offender who usually knows his victim and deviously attempts some type of "nice-man" image to get his way and thereby return again and again to the same victim. This type of offender may even attempt to play-down his behavior so as to not frighten his victim. Thirty-nine items make up this scale, and its scoring keys differentiate victim-gender-preference and the incest type of offender.

**Rape Scale.** This scale identifies the blitz rapist. He may strike without warning and always frightens his victim. His victim is usually a teen or adult, related or unrelated to him. As opposed to the child molester, his behavior is more aggressive and less manipulative. When the 28 items of the Rape Scale are computed together with the Sado-Masochism Scale, the rapist may be sadomasochistic in character and a cause for immediate concern.

**Exhibitionism Scale.** The Exhibitionism Scale identifies the four stages in an exposers's pattern: fantasy, cruising, exposure and frequency of the behavior (e.g., the item "I have exposed myself more than 100 times."). This scale contains 19 items. Overall most exposers are highly open about their behavior because they do not see themselves as physically harming their victims.
Fetish Scale. Consisting of nine items, this scale is not cumulative in the usual manner. The endorsement of any single item is considered a statement of pathology because each item presumes a fetish (e.g., "I have stolen women's underclothes").

Obscene Call Scale. This scale contains only four items. All relate directly to the behavior of obscene phone calling. When this scale is elevated, the offender should not be passed off as just a prank caller.

Voyeurism Scale. All nine items in this scale are very straightforward statements like, "I have reached orgasm while secretly watching someone." Therefore, this scale was designed to identify the offender who is preoccupied with peeping as a special sexual outlet. For example, many rapists use peeping as a cruising behavior before an assault.

Bondage and Discipline Scale. The six items in this scale are straightforward regarding the behaviors of sexual bondage and discipline. When there is elevation on this scale, there is cause for concern; homosexual pedophiles most often endorse these items.

Sado-Masochism Scale. Made up of 10 items, this scale focuses on some of the most frightening aspects of sexual assault. Items like, "I have beaten a person
during a sexual encounter," seek to identify offenders who have sadistic tendencies. Any endorsement of these 10 items is a cause for concern.

**Sexual Inadequacies Scale.** This scale is one of the four scales that make up the sexual dysfunction subtest. Consisting of eight items, this scale's purpose is to identify the offender who feels socially inadequate, who wants to perform sexually but feels too inadequate and insecure to try.

**Premature Ejaculation Scale.** This scale is one of the four scales that make up the sexual dysfunction subtest. Its purpose is to assess the offender's perception of orgasmic control. The scale consists of four very straightforward items.

**Physical Disabilities Scale.** This scale is one of the four scales that make up the sexual dysfunction subtest. It consists of eight items that address physiological problems which may affect sexual functioning, e.g., back injury and etc.

**Impotence Scale.** This scale is one of four scales that make up the sexual dysfunction subtest. Its purpose is to measure the helplessness and hopelessness the offender feels when he cannot perform sexually. This scale consists of 12 items and older offenders tend to report
more dysfunction than younger ones.

**Sex Knowledge and Beliefs Scale.** This scale consists of 24 items. It was designed to assess whether or not the offender has a good fund of knowledge about sex. The items on this scale relate to human anatomy and physiology but not the intricacies of the male and female reproductive systems.

**Parallel Items Scale.** Consisting of 15 items that match with 15 items on the MMPI-I, this scale serves two functions. First, it indirectly assesses the offender's response set to the MSI by reflecting his test taking attitude on the MMPI-I. Secondly, it assesses the offender's response consistency as noted by a high or low score. For example, a high score shows that the offender often changes his mind and is unreliable while a low score suggests consistency in scoring if he were to take both tests.

Unfortunately, this investigator was unable to use the PI Scale in this study for six reasons.

1. Because of staff and time constraints, not every sex offender at MTF took the MMPI when going through the MDOC's Reception and Guidance Center.

2. Because the department switched to the MMPI-II in 1991, some MTF sex offenders have MMPI-I profiles and some have MMPI-II. the MMPI-II in 1991.
3. Revisions of the MMPI-I resulted in old items being changed and new items being added.

4. The MMPI-II is a more diverse and ethnically balanced instrument.

5. The optimal T score used to determine clinical significance changed from 70 on the MMPI-I to 65 on the MMPI-II.

6. During the inventory's revision, several F scale items were deleted due to objectionable content, i.e., the F scale being one of the MMPI's four validity scales.

Social Sexual Desirability Scale. This scale was designed to measure normal sexual interests and desires and to help identify persons who are responding to the MSI in a conservative light. For example, child molesters will frequently score low in an attempt to show themselves as not interested in normal sexual interests and desires. In fact, offenders who score very low suffer from massive denial and try to project an asexual image. Meanwhile, offenders who score high are more likely knowledgeable about the social sexual role adult males play in American society, and they are not embarrassed to admit it.

Sexual Obsessions Scale. This scale has two purposes: (1) to measure the offender's tendency to exaggerate his problem and (2) to assess the offender's obses-
sion with sex. The scale is composed of 20 items like, "I need sex or masturbation daily to reduce tension." On this scale high and low scorers can be identified in terms of fake good or fake bad response sets. Offenders who score 17 points or more are likely to malingering or fake illness in order to avoid accountability for their deviance. Offenders who score two points or less are denying they have any interest in sex at all, that is to say, a fake good profile. Between the extremes are those who are honest about their high interest in sex, and who may have problems controlling their sexual thoughts and impulses.

Lie Scales. The four MSI Lie Scales (Child Molest Lie, Rape Lie, Exhibitionism Lie, and Incest Lie) are designed to measure offender openness versus dishonesty when it comes to admitting sexually deviant thoughts and behaviors. Sex offenders who score high on their particular Lie scale tend to defend their deviance via denial and dishonesty. Offenders who score low tend to admit their deviance - that they find such behavior pleasurable. Since many sex offenders deny the depth of their deviant interest, as well as the extent of their deviant behavior, the Lie Scales assess how serious the problem of denial is.

Cognitive Distortion and Immaturity Scale. Composed
of 21 items, this scale reflects cognitive distortions offenders have used for years to excuse their deviance and set the stage for their assaults. Also, this scale was designed to measure the distorted view that most of society is unjust and uncaring—offenders feeling they have been victimized themselves. Therefore, a high score suggests offender unwillingness to accept responsibility for sexually deviant acts.

**Justification Scale (Ju).** This scale consists of 24 items, all of which are stated in the form of justifications for sexually deviant crimes. The sole purpose of this scale is to measure the degree to which the individual sex offender attempts to justify his sexually deviant behavior. The Ju scale is based on the assumption that the sex offender commits his assault because he wants to. It assumes that he did not commit his crime because of poor communication with his wife, or that the victim wanted sex with him, or because he was not taught about sex when growing up and etc. According to Nichols and Molinder, most sex offenders cannot resist endorsing these items even though they are easily transparent. On this scale a high score on this scale suggests the projection of blame and a severe lack of accountability for one's actions.

**Treatment Attitudes Scale.** This scale is composed
of eight items such as, "I need help because I cannot control my sex thoughts." In essence this scale is an expression of the offender's attitude regarding treatment. A low score of two or less suggests no motivation for treatment. A high score of seven suggests the offender is openly admitting he needs help.

**Sex History.** The Sex History portion of the MSI provides the clinician a rather comprehensive and quick look at the offender's sexual development. It is divided into five parts: (1) sex deviance development, 11 items; (2) marriage development, 10 items; (3) gender development, six items; (4) gender identity development, three items; and (5) sexual assault behavior, 20 items.

**Intervening Control Variables**

Questionnaires have been widely used by researchers to control for unwanted and extraneous variables. They have been used to obtain a variety of data (e.g., age, race, marital status, level of education, etc). Typically, subjects receive them in one of two ways, through the mail or face-to-face (Van Dalen, 1962; Isaac and Michael, 1981).

In this study every subject received the Muskegon Temporary Facility Life History Questionnaire (LHQ) after taking the MSI pretest. The LHQ was presented face-to-
face at the prison medical clinic to avoid any denial of its receipt and/or alleged loss via institutional mail.

Structurally, the LHQ covered several background and organismic variables that could affect offender performance when interviewed or taking the MSI. It was divided into two parts, and it contained both closed and open items.

Part one covered the following: personal data (name, age, sex, date of birth, etc.), family of origin, childhood and adolescence, educational background, military experience, employment history, marriages and/or live-in-partnerships, friendships and other relationships, offense history and personal health.

Part two contained six non-historical sections: (1) sentence completion, (2) behaviors, (3) feelings, (4) images, (5) thoughts and (6) treatment expectations. Unlike the MSI, the LHQ was not a copyrighted document. A copy can be found in Appendix A.

To provide for the tabulation, categorization and summarization of LHQ data, many of the items required a fixed response (e.g., "yes" or "no"; checks; circles; etc.). Also, clarification, amplification and qualification were required on some items to discriminate shades of meaning and give the offender the opportunity to reveal his motives, attitudes and frame of reference.

Finally, for this study, 10 LHQ variables were used.
control variables: (1) age, (2) race, (3) religious preference, (4) marital status, (5) level of education, (6) military experience, (7) living arrangement prior to incarceration, (8) sexual offense history, (9) nonsexual offense history, (10) history of sexual, physical and/or emotional victimization/abuse. To have used the entire LHQ, over 250 separate variables would have required analysis: a project far beyond the scope of this study.

Data Collection

Each subject took the MSI twice. For the experimental group, there were be 36 separate administrations of the MSI, 18 pretest sessions and 18 posttest sessions. Beginning on 8/9/93 and ending on 11/29/93, every Monday morning at 9a.m. five sex offenders met the investigator to take the pretest.

Subjects took the MSI in MTF's school building. Inmates reported to a private conference room available to MTF psychologists in the school's main office. Upon arrival, each subject: (a) gave his pass to the investigator, (b) was directed to a specific seat and (c) was asked to remain silent. Names were not announced.

Next, after briefly introducing himself, this investigator obtained consent from each offender. Each offender was asked to silently read the Informed Consent Form (see Appendix B) as it was read aloud. After an in—
formal summary of its content, subjects were given the opportunity to ask questions. All questions were answered by the investigator. No subject was coerced, deceived or forced into giving consent. Those who decided to participate signed and dated two copies of the Informed Consent Form. After signing the copies, the investigator returned one copy to each participant.

After obtaining informed consent, each subject was given a numerically coded MSI answer sheet and a copy of the test. No individual identifiers were placed on the answer sheet or inventory. After reading the test’s instructions, the investigator asked the subjects to begin. When done, each subject turned in the test and answer sheet directly to the investigator. The offender was given his pass and dismissed quietly. No talking was allowed from beginning to end.

Regarding the one-hour assessment interviews, they began on 8/20/93 and ended on 12/10/93. Each experimental group member was informed (in writing) that he would see the Therapy Review Board the second Friday after his pretest. The interviews were not video- or audiotaped, nor were any transcriptions or written narratives made. To assure no breach of privacy, all interview communication was kept strictly confidential. Only the interviewing psychologists discussed each subject to determine treatment amenability.
After being interviewed, every experimental group subject took the MSI posttest the next Tuesday (four days later. They took the MSI posttest in the same location as the pretest. The total amount of time between the pretest and the posttest was 15 days.

The same basic procedure was used with the control group. However, instead of five offenders being tested each week over a 18 week period, eight groups of 10 subjects each were tested and retested beginning 9/1/93. Sex offenders making up the control group also met the investigator at MTF's school. They took the MSI pretest on a Wednesday morning, and the MSI posttest 15 days later on a Thursday afternoon. The control group posttest sessions ended on 11/4/93. Control group Therapy Review Board Interviews began on 1/7/94.

Secondly, upon completing the pretest, all subjects received, in a gum-sealed envelope at the prison health clinic, a copy of the MTF Life History Questionnaire. All subjects were instructed by the investigator to return it to the MTF clinic, in the same envelope, 5 days later. The returned questionnaires were kept in a locked file cabinet in the clinic.

Next, after collecting the test data, the investigator scored the pre- and posttest answer sheets for both groups. All MSI profile forms were coded with the same research numbers on the answer sheets. The answer sheets
and profile forms were only traceable through a master list of subject names and code numbers kept in a locked file cabinet at MTF.

Depending on the subject's group status, all questionnaires were coded C or E. Although the questionnaires contained data already available in different institutional records (e.g., age, race, education level, marital status, job history, etc), each questionnaire was considered a confidential document. Like all psychological reports, tests and inventories, the questionnaires were not available to correction officers, nurses, school teachers, prison administrators and/or prisoners in general. By policy, only "qualified mental health persons," the Michigan Parole Board, and/or prison wardens are allowed to have access to psychological documents (MDOC Operating Procedure No. 23.01).

Once all the data were tabulated and analyzed, this investigator wrote each subject's name and prison identification number on the appropriate MSI profile forms and answer sheets. Next, both the profile forms and the answer sheets were given to the MTF Medical Records Technician to file in the FOIA Exempt Psychological Test Envelope in each offender's health record. Therefore, the data will be kept on file for at least 3 years.

Finally, three special pretest and posttest sessions were scheduled for offenders who could not read. At each
session the investigator read the MSI in monotonic voice as subjects marked T or F on the numerically coded answer sheets.

Data Analysis

This study used t-tests and the one-way analysis of covariance to answer the question: Are there significant differences between the means of the experimental group and the control group when compared on pretest and posttest administrations of the MSI? Structurally, the pretest-posttest, nonrandomized control-group design allows for a variety of comparisons. To illustrate, a comparison of pretest and posttest means on the MSI Sexual Dysfunction Subtest can be diagrammed as follows:

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xe pre = 13.93</td>
<td>Xe post = 22.6</td>
<td></td>
</tr>
<tr>
<td><strong>Control Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xc pre = 13.06</td>
<td>Xc post = 13.2</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. A Sample Comparison of Pretest and Posttest Means on the MSI Sexual Dysfunction Subtest.
In other words, one question asked in this study was: Were there significant group differences in sexual inadequacy, physical disabilities, impotence and premature ejaculation (i.e., the Sexual Dysfunction Subtest) when comparing experimental and control group means? Hypothetically, it was proposed that once experimental group members were interviewed by the Therapy Review Board, they would disclose more sexual dysfunction on the MSI than control group members who were not interviewed before the posttest.

Having computed the means for each group on the Sexual Dysfunction Subtest, a two-tailed t-test was computed at the .05 significance level to test for differences between means. This study used the significance level of .05 (probability of meaningful effects occurring only five times out of 100) to avoid the risk of Type I Error (of falsely concluding meaningful effects exist in the data when in fact they do not). However, it should be noted that this significance level did include the risk of Type II Error (of concluding meaningful effects did not exist when they did).

In addition to the aforementioned group comparisons, it was possible to make other comparisons with the MSI because its sex pattern deviance scales identified child molesters, rapists and exhibitionists. In other words, pre- and posttest data were analyzable on the basis of...
offender-type.

To make these comparisons, a one-way analysis of covariance (ANCOVA) was computed. Statistically, this approach combined the groups and analyzed the data all at once to look for meaningful effects. The analysis was actually done on MSI posttest means with the pre-test means acting as the covariate. Conceptually, the one-way analysis of covariance can be illustrated as follows:

<table>
<thead>
<tr>
<th>Group Type</th>
<th>Rapists</th>
<th>Child Molesters</th>
<th>Exhib</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>E - Group Means</td>
<td>$\bar{X}_r$</td>
<td>$\bar{X}_{cm}$</td>
<td>$\bar{X}_e$</td>
<td>$X_e$</td>
</tr>
<tr>
<td>C - Group Means</td>
<td>$\bar{X}_r$</td>
<td>$\bar{X}_{cm}$</td>
<td>$\bar{X}_e$</td>
<td>$X_c$</td>
</tr>
<tr>
<td>Total</td>
<td>$\bar{X}_r$</td>
<td>$\bar{X}_{cm}$</td>
<td>$\bar{X}_e$</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2. Comparison of Groups on the MSI on the Basis of Offender-type.

Finally, regarding data collected on the MTF Life History Questionnaire, simple descriptive statistics were used to present the demographics of the two main study groups, experimental and control. They were also used to discuss demographics pertaining to the three MSI sex de-
viance patterns. Therefore, variables like age, race, and marital status are discussed in Chapter IV.
CHAPTER IV

RESULTS

This study investigated whether or not the one-hour structured assessment interview used by the MTF Therapy Review Board decreased denial and increased self-disclosure among incarcerated sex offenders prior to their starting the MTF Sex Offender Treatment Program. The study used the pretest-posttest, nonrandomized control group design with two groups of sex offenders at MTF.

The independent or stimulus variable was the one-hour Review Board interview. The dependent or outcome variable was the 300-item, true/false Multiphasic Sex Inventory (MSI), its 20 scales and 50-item Sex History (Nichols and Molinder, 1984).

To help control for unwanted and extraneous variables, each subject completed the MTF Life History Questionnaire (LHQ). Ten variables from the questionnaire were used in the study: (1) age, (2) race, (3) level of education, (4) marital status, (5) religious preference, (6) military service, (7) living arrangement prior to incarceration, (8) index or instant offense, (9) criminal history and (10) childhood abuse.

The analysis of study data required two general
steps. One, variables from the Life History Questionnaire were examined to see if the two main groups, experimental and control, were similar and comparable. The analysis produced a positive result.

Step two was the analysis of MSI data. This step produced limited results. A description of each step is given below. A summary of study findings and future recommendations are given in Chapter V.

Statistical Review of Questionnaire Data

Sexual Deviation Patterns and Age

In the study there were 30 self-identified rapists, 103 child molesters and three exhibitionists. The breakdown by group is shown in Table 2.

The mean age for all subjects was 37.25 years. The sample's standard deviation was 10.41 years. Of the complete sample, 71% fell within the ages of 27 and 47, or one standard deviation plus or minus the sample mean.

For the experimental group the mean age was three years younger, 35.78 years. The standard deviation for this group was 10.29 years. With this group, 73% fell between the ages of 26 and 46, i.e., plus or minus one standard deviation from the experimental group mean.

In the control group the mean was somewhat older, 38.98 years. The standard deviation for this group was
Table 2

Sex Deviance Patterns of Subjects by Group and Sample

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group (En=73)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM</td>
<td>56</td>
<td>74.0</td>
<td>56</td>
<td>74.0</td>
</tr>
<tr>
<td>R</td>
<td>16</td>
<td>24.7</td>
<td>72</td>
<td>98.6</td>
</tr>
<tr>
<td>Ex</td>
<td>1</td>
<td>1.4</td>
<td>73</td>
<td>100.0</td>
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<tr>
<td>Control (Rn=30)</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>CM</td>
<td>47</td>
<td>74.6</td>
<td>47</td>
<td>74.6</td>
</tr>
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<td>14</td>
<td>22.2</td>
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<td>96.8</td>
</tr>
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<td>63</td>
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<tr>
<td>Total Sample (N=136)</td>
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<tr>
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<td>103</td>
<td>74.2</td>
</tr>
<tr>
<td>R</td>
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<td>136</td>
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</tr>
</tbody>
</table>

CM = Child Molester; R = Rapist; Ex = Exhibitionist

10.54 years. In this group, 63% of the subjects fell between the ages of 28 and 29, or plus or minus one standard deviation from the control group mean.

Generally, the experimental and control groups were very similar in age. As Table 3 illustrates, 79% of the entire sample fell within the age range of 26 to 40.

Interestingly, the groups did vary somewhat by age range. The experimental group had 32 subjects between ages 26 and 35 while the control group had only 19.
### Table 3
Age Ranges for Study Subjects by Groups and Sample

<table>
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<tr>
<th>Age Ranges</th>
<th>E Group</th>
<th>C Group</th>
<th>Total Sample</th>
</tr>
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<tr>
<td></td>
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<td>No. of CS</td>
</tr>
<tr>
<td>20-25</td>
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<td>36-40</td>
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<td><strong>Totals</strong></td>
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<td>100.0</td>
<td>63</td>
</tr>
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</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects in the sample.

All other age ranges were similar except for four subjects who fell between the ages 56 and 60 in the control group. Therefore, as mentioned initially, the
experimental group was younger in its composition.

Regarding age by sex deviance patterns, the child molesters were older than the rapists. The mean age for the 103 child molesters was 38.97 years with a standard deviation of 10.60 years. For the 56 experimental group child molesters, the mean age was 37.57 years with a standard deviation of 10.33 years. For the 47 control group child molesters, the mean age was 40.67 years with a standard deviation of 10.93 years.

The 30 rapists in the study had a mean age of 32.63 years with a standard deviation of 6.34 years. For the 16 experimental group rapists, the mean age was 30.12 years with a standard deviation of 6.33 years. For the 14 control group rapists, the mean age was 35.5 years with a standard deviation of 6.36 years.

Overall, for comparative purposes the experimental and control group child molesters and rapists were close in age. The three exhibitionists in the study were not. The one experimental group exhibitionist was age 26, and the two in the control group were ages 36 and 56.

Racial Composition of the Sample

The racial composition of the complete sample was primarily White (N=103) and secondarily Black (N=23). Specifically, there were 75.71% of the subjects who identified themselves as White, 16.9% as Black, 4.4% as
Hispanic, and 3% as either Native or Asian American. As illustrated in Table 4, the within group racial composition was similar for both groups.

Table 4

Racial Composition of Subjects for Entire Sample

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<td>57</td>
<td>78.1</td>
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<td>73.0</td>
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<td>87.3</td>
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<td>7.9</td>
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</tr>
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<td>White</td>
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<td>75.7</td>
<td>103</td>
<td>75.7</td>
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<td>Black</td>
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<td>Asian Am.</td>
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<td>.8</td>
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<td>100.0</td>
</tr>
</tbody>
</table>

When each group was analyzed on the basis of sex deviation patterns, it was found that the child molestors in both groups were predominately White. Of interest were the rapists in the study. In both the experimental...
and control groups, there was a higher proportion of Blacks. As shown in Table 5, 43.3% of the rapists were Black as compared to only 9.7% of the child molesters. All of the exhibitionists were White.

Table 5
Racial Composition of Subjects and Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Racial Status of Subjects</th>
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<th>Sample</th>
<th>Pattern</th>
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<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>of ES</td>
<td>of CS</td>
<td>of TS</td>
</tr>
<tr>
<td>Child Molesters (CM=103)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>White</td>
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</tr>
<tr>
<td>Native Am.</td>
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<td>Rapists (Rn=30)</td>
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<td>Exhibitionists (EXn=3)</td>
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<tr>
<td>Totals</td>
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<td>63</td>
<td>136</td>
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</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.
Educational Status

Educationally, all subjects in the study said they began school at age five or six. The age at which subjects left school did vary from age 12 to age 21. As illustrated in Table 6, a substantial number of subjects in each group, as well as in the sample, left school between the ages of 16 and 18. For the entire sample, 72.7% left school between those ages. The mean for the entire study sample was 16.89.

For the experimental group, 74% left between ages 16 and 18, and for the control group 71.4%. The mean for the experimental group was 17.16. For the control group it was 16.60. In general, the two group were alike as to when subjects left school.

Interestingly, Table 7 reveals that more rapists remained in school until age 18. Whereas only 18 child molesters out of 103 remained in school until age 18 (17.5% of that sex deviance pattern), of the rapists 11 subjects (36.7%) remained in school until age 18. Of the three exhibitionists, two remained in school until ages 17 and 18. In the complete sample, 14.1% or 19 subjects left school before age 16 (Table 6).

When asked if they had graduated, and if so, their highest diploma or degree, 95 subjects (69.8%) reported
Table 6
Age When Subjects Left/Finished School for Entire Sample

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Table 7
Age When Subjects Left/Finished School and Sex Deviance Patterns

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<th>Age When Left</th>
<th>No. of ES</th>
<th>No. of CS</th>
<th>No. of TS</th>
<th>% of TS</th>
<th>% of SDP</th>
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<tr>
<td>Age</td>
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<td>33.3</td>
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</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

achieving some form of educational certificate. Forty-one subjects, or 30.2% of the entire sample, said they
never graduated from school.

In the experimental group, 54 subjects said they had received recognition for academic work in the form of a diploma or degree. In the control group 41 subjects said they had completed school with a diploma or degree. As Table 8 reveals, the within group distributions of general education and high school diplomas, Associate's and

| Table 8 |

Diplomas/Degrees Received by Subjects for Entire Sample

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<tr>
<td>GED</td>
<td>19</td>
<td>30.1</td>
<td>19</td>
<td>30.1</td>
</tr>
<tr>
<td>HS Diploma</td>
<td>18</td>
<td>28.6</td>
<td>37</td>
<td>58.7</td>
</tr>
<tr>
<td>Associates</td>
<td>3</td>
<td>4.8</td>
<td>40</td>
<td>63.5</td>
</tr>
<tr>
<td>Masters</td>
<td>1</td>
<td>1.6</td>
<td>41</td>
<td>65.1</td>
</tr>
<tr>
<td>None</td>
<td>22</td>
<td>34.9</td>
<td>63</td>
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</tr>
<tr>
<td><strong>Total Sample (N=136)</strong></td>
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<tr>
<td>GED</td>
<td>39</td>
<td>28.7</td>
<td>39</td>
<td>28.7</td>
</tr>
<tr>
<td>HS Diploma</td>
<td>46</td>
<td>33.8</td>
<td>85</td>
<td>62.5</td>
</tr>
<tr>
<td>Associates</td>
<td>7</td>
<td>5.1</td>
<td>92</td>
<td>67.6</td>
</tr>
<tr>
<td>Masters</td>
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<td>2.2</td>
<td>95</td>
<td>69.8</td>
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<tr>
<td>None</td>
<td>41</td>
<td>30.2</td>
<td>136</td>
<td>100.0</td>
</tr>
</tbody>
</table>

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Master's degrees, were similar for the two groups.

All of the subjects completing advanced degrees were child molesters (10 subjects). As revealed in Table 9, of the 103 child molesters in the study, 73 subjects received some form of educational certificate. Of the 30 rapists, 20 subjects received the same.

The within group percentage of those completing some form of educational program for a diploma or degree were similar. The within group percentage for the molesters was 70.8%, for the rapists and exhibitionists 66.7%.

Finally, when examined from the standpoint of sex deviance patterns, all three categories were similar with regard to graduation from school. Small as it was, the only trend of interest was the 10 child molesters with some form of college graduation.

Marital Status

For the entire sample, more subjects reported being divorced than married, married than single, single than separated, and separated than engaged. As Table 10 indicates, the total sample was primarily unmarried at the time of the study (87 subjects being either divorced, single, or engaged).

Secondly, the within group distributions varied as illustrated in Table 10. For example, in the experiment-
Table 9
Diplomas/Degrees Received by Subjects and Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diplomas/Degrees Received by Subjects</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GED</td>
<td>17</td>
<td>13</td>
</tr>
<tr>
<td>HS Diploma</td>
<td>18</td>
<td>15</td>
</tr>
<tr>
<td>Associates</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Masters</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GED</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>HS Diploma</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GED</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HS Diploma</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

In the child molesters group there were more divorces followed by subjects stating they were single rather than married. In the control group there were more subjects married followed by subjects saying they were divorced rather than single.

Regarding separations and engagements, the experi-
Table 10
Marital Status of Subjects for Entire Sample

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group (En=73)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<tr>
<td>Married</td>
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<td>45</td>
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<td>24.7</td>
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<tr>
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<td>70</td>
<td>95.9</td>
</tr>
<tr>
<td>Engaged</td>
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<td>4.1</td>
<td>73</td>
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</tr>
<tr>
<td>Control Group (Cn=63)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>33.3</td>
<td>21</td>
<td>33.3</td>
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<tr>
<td>Married</td>
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<td>36.5</td>
<td>44</td>
<td>69.8</td>
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<tr>
<td>Single</td>
<td>15</td>
<td>23.8</td>
<td>59</td>
<td>93.6</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
<td>3.2</td>
<td>61</td>
<td>96.8</td>
</tr>
<tr>
<td>Engaged</td>
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<td>100.0</td>
</tr>
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<td>Total Sample (N=136)</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>36.0</td>
<td>49</td>
<td>36.0</td>
</tr>
<tr>
<td>Married</td>
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<td>89</td>
<td>65.4</td>
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<td>122</td>
<td>89.7</td>
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<tr>
<td>Separated</td>
<td>9</td>
<td>6.6</td>
<td>131</td>
<td>96.3</td>
</tr>
<tr>
<td>Engaged</td>
<td>5</td>
<td>3.7</td>
<td>136</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The experimental group had more than double the number of separations (seven subjects in the experimental group to two in the control group). Overall, the two main groups were similar regarding divorce, marriage, separation, engagement and individuals being single.

When examining the marital status of the two groups by the sex deviance patterns, the trend toward divorce...
Table 11
Marital Status of Subjects and
Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Marital Status of Subjects</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
</tbody>
</table>

Child Molesters (CMn=103)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Divorced</td>
<td>23</td>
<td>15</td>
<td>38</td>
<td>27.9</td>
<td>36.9</td>
</tr>
<tr>
<td>Married</td>
<td>13</td>
<td>18</td>
<td>31</td>
<td>22.8</td>
<td>30.1</td>
</tr>
<tr>
<td>Single</td>
<td>12</td>
<td>10</td>
<td>22</td>
<td>16.2</td>
<td>21.4</td>
</tr>
<tr>
<td>Separated</td>
<td>6</td>
<td>2</td>
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<tr>
<td>Engaged</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2.9</td>
<td>3.9</td>
</tr>
</tbody>
</table>

Rapists (Rn=30)

<p>| | | | | | |</p>
<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>Divorced</td>
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<td>5</td>
<td>9</td>
<td>6.6</td>
<td>30.0</td>
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<tr>
<td>Married</td>
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<td>9</td>
<td>6.6</td>
<td>30.0</td>
</tr>
<tr>
<td>Single</td>
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<td>4</td>
<td>10</td>
<td>7.4</td>
<td>33.3</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>1</td>
<td></td>
<td>.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Engaged</td>
<td>1</td>
<td>1</td>
<td></td>
<td>.7</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Exhibitionists (EXn=3)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<td>Single</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>33.3</td>
</tr>
</tbody>
</table>

Totals          | 73     | 63     | 136    | 100.0  |

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

did not change. As revealed in Table 11, the trend of more subjects reporting some form of single-like status, of being either divorced, single or engaged, continues to
predominate as in the entire sample (64% of all the study subjects).

In addition to giving current marital status, subjects were requested to indicate how many times they had been married. Below Table 12 portrays the results. Of the 136 subjects, 70 had been married at least once and

Table 12
Number of Marriages by Subjects for Entire Sample

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental Group (En=73)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>38</td>
<td>52.1</td>
<td>38</td>
<td>52.1</td>
</tr>
<tr>
<td>Two</td>
<td>12</td>
<td>16.4</td>
<td>50</td>
<td>68.5</td>
</tr>
<tr>
<td>Three</td>
<td>5</td>
<td>6.8</td>
<td>55</td>
<td>75.3</td>
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<tr>
<td>Four +</td>
<td>1</td>
<td>1.4</td>
<td>56</td>
<td>76.7</td>
</tr>
<tr>
<td>None</td>
<td>17</td>
<td>23.3</td>
<td>73</td>
<td>100.0</td>
</tr>
<tr>
<td>Control Group (Cn=63)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>32</td>
<td>50.8</td>
<td>32</td>
<td>50.8</td>
</tr>
<tr>
<td>Two</td>
<td>10</td>
<td>15.9</td>
<td>42</td>
<td>66.7</td>
</tr>
<tr>
<td>Three</td>
<td>5</td>
<td>7.9</td>
<td>47</td>
<td>74.6</td>
</tr>
<tr>
<td>Four +</td>
<td>1</td>
<td>1.6</td>
<td>48</td>
<td>76.2</td>
</tr>
<tr>
<td>None</td>
<td>15</td>
<td>23.8</td>
<td>63</td>
<td>100.0</td>
</tr>
<tr>
<td>Total Sample (N=136)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>70</td>
<td>51.5</td>
<td>70</td>
<td>51.5</td>
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<tr>
<td>Two</td>
<td>22</td>
<td>16.2</td>
<td>92</td>
<td>67.7</td>
</tr>
<tr>
<td>Three</td>
<td>10</td>
<td>7.3</td>
<td>102</td>
<td>75.0</td>
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<tr>
<td>Four +</td>
<td>2</td>
<td>1.5</td>
<td>104</td>
<td>76.5</td>
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<tr>
<td>None</td>
<td>32</td>
<td>23.5</td>
<td>136</td>
<td>100.0</td>
</tr>
</tbody>
</table>

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34 reported being married two times or more. Therefore, 76.5% of the sample or 104 subjects reported some form of experience with the institution of marriage. As shown in Table 10, 29.4% said they were married at the time of the study.

Finally, when examining the number of marriages and the three sex deviance patterns, it became apparent that the child molesters had a higher percentage of additional marriages than did the rapists. As Table 13 illustrates, 30 child molesters out 103 had second, third, and fourth marriages whereas only three subjects out of 30 rapists had more than one marriage. Again, the exhibitionist group was too small to make any meaningful statistical or interpretative statement.

Current Religious Preference

The religious preference of the entire sample was primarily Christian. There were 75 subjects who identified themselves as Protestant and 28 who identified themselves as Catholic. All other categories of religious preference were barely represented in the sample (as illustrated in Table 14).

Interestingly, out of the entire sample 21 subjects said they had no religious preference whatsoever. Moreover, except for the two Buddhists in the control group,
Table 13
Number of Marriages by Subjects 
and Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Marriages</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>for Subjects</td>
<td>of ES</td>
<td>of CS</td>
</tr>
</tbody>
</table>

Child Molestors (CMn=103)

- One  | 29 | 23 | 52 | 38.2 | 50.5 |
- Two  | 12 | 8  | 20 | 14.7 | 19.4 |
- Three| 4  | 8  | 8  | 5.9  | 7.7  |
- Four+| 1  | 1  | 2  | 1.5  | 1.9  |
- None | 10 | 11 | 21 | 15.4 | 20.4 |

Rapists (Rn=30)

- One  | 8  | 8  | 16 | 11.8 | 53.3 |
- Two  | 1  | 1  | 7  | .7   | 3.3  |
- Three| 1  | 1  | 2  | 1.5  | 6.7  |
- None | 7  | 4  | 11 | 8.1  | 36.7 |

Exhibitionists (EXn=3)

- One  | 1  | 1  | 1  | .7   | 33.3 |
- Two  | 1  | 1  | 1  | .7   | 33.3 |
- None | 1  | 1  | 1  | .7   | 33.3 |

Totals  | 73 | 63 | 136| 100.0|

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

the within group distributions were very similar for each group.

When examined from the perspective of sex deviance
Table 14
Religious Preference of Subjects for the Entire Sample

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group (En=73)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>44</td>
<td>60.3</td>
<td>44</td>
<td>60.3</td>
</tr>
<tr>
<td>Catholic</td>
<td>11</td>
<td>15.0</td>
<td>55</td>
<td>75.3</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>1.4</td>
<td>56</td>
<td>76.7</td>
</tr>
<tr>
<td>Islamic</td>
<td>3</td>
<td>4.1</td>
<td>59</td>
<td>80.8</td>
</tr>
<tr>
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<td>1.4</td>
<td>60</td>
<td>82.2</td>
</tr>
<tr>
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<td>13</td>
<td>17.8</td>
<td>73</td>
<td>100.0</td>
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<td><strong>Control Group (Cn=63)</strong></td>
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<td></td>
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</tr>
<tr>
<td>Protestant</td>
<td>31</td>
<td>49.2</td>
<td>31</td>
<td>49.2</td>
</tr>
<tr>
<td>Catholic</td>
<td>17</td>
<td>26.9</td>
<td>48</td>
<td>76.1</td>
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<tr>
<td>Islamic</td>
<td>3</td>
<td>4.8</td>
<td>51</td>
<td>80.9</td>
</tr>
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<td>3.2</td>
<td>53</td>
<td>84.1</td>
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<tr>
<td>Buddhist</td>
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<td>55</td>
<td>87.3</td>
</tr>
<tr>
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<td>8</td>
<td>12.7</td>
<td>63</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total Sample (N=136)</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>55.2</td>
<td>75</td>
<td>55.2</td>
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<tr>
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<td>28</td>
<td>20.6</td>
<td>103</td>
<td>75.8</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>.7</td>
<td>104</td>
<td>76.5</td>
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<td>Islamic</td>
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<td>84.6</td>
</tr>
<tr>
<td>None</td>
<td>21</td>
<td>15.4</td>
<td>136</td>
<td>100.0</td>
</tr>
</tbody>
</table>

patterns (Table 15), the data revealed the following concerning religious preference. Both child molesters and rapists were predominately Protestant. Only men of the Islamic faith represented a higher proportion of rapists.
Table 15
Religious Preference of Subjects and Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Sex Deviance</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>Pattern</td>
<td>ES</td>
<td>CS</td>
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</table>

Child Molesters (CMn=103)

<p>| | | | | |</p>
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<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>36</td>
<td>23</td>
<td>59</td>
<td>43.4</td>
</tr>
<tr>
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<td>10</td>
<td>13</td>
<td>23</td>
<td>16.9</td>
</tr>
<tr>
<td>Jewish</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Islamic</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Native Am.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2.2</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>None</td>
<td>8</td>
<td>6</td>
<td>14</td>
<td>10.3</td>
</tr>
</tbody>
</table>

Rapists (Rn=30)

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>7</td>
<td>6</td>
<td>13</td>
<td>9.6</td>
</tr>
<tr>
<td>Catholic</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Islamic</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>2.9</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>None</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Exhibitionists (EXn=3)

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Totals</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>73</td>
<td>63</td>
<td>136</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

versus child molesters. However, because the total number of Islamic subjects was small (N=6), it would be unwise to interpret any significance.
Military Experience

Overall, 40 subjects out of the 136 participating in the study served time in the United States military. Of these, the overwhelming majority were child molesters, (N=31) as opposed to rapists (N=9) and no exhibitionists. As Table 16 shows, 29.4% of the study’s subjects indicated 2 years or more of military service.

Interestingly, only nine subjects out of the 40 reported combat experience, and only two as having been diagnosed with Post Traumatic Stress Disorder. Again, there were only nine subjects who re-enlisted for more than one tour of duty.

As Table 17 illustrates, most of the 40 subjects served in the Army (22 subjects). Eight subjects served in the Navy, four in the Air Force and two in the United State Marines. All but four of the 40 subjects received honorable discharges from the military (two general discharges and two dishonorable).

Living Arrangements Prior to Prison

Out of the entire sample of 136 subjects, 91 were living in a home prior to incarceration. Twenty said they were living in an apartment and 11 said a mobile home or trailer. Only one subject said he was living in
Table 16
Military Service of Subjects for Entire Sample

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Military Service of Subjects</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>of</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Military Service Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child Molesters (CMn=103)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rapists (Rn=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exhibitionists (EXn=3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

a hotel. No one reported living in an adult foster home, a public shelter or on the street.

Of greater interest was the question, Who were you living with before incarceration? The data revealed that both experimental group members and members of the control group were residing primarily with adult relatives.
Table 17
Factors Related to Military Service for Study Subjects

<table>
<thead>
<tr>
<th>Factors Related to Military Service</th>
<th>Groups</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>ES</td>
<td>CS</td>
</tr>
<tr>
<td>Branch of Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Army</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Navy</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Air Force</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Marines</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Combat Experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Diagnosed PTSD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Re-enlistments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>Discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honorable</td>
<td>19</td>
<td>13</td>
</tr>
<tr>
<td>General</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Dishonorable</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; PTSD = Post Traumatic Stress Disorder.
before prison. Only 11 subjects said they were living alone before entering the MDOC. When examined from the perspective of sex deviance patterns, the data revealed the same trend as illustrated in Table 18.

When asked to indicate the specific adult lived with

Table 18
Relationship Status of Adults Lived With and Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Status of Adults</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>No.</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>41</td>
<td>33</td>
</tr>
<tr>
<td>Nonrelative</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Alone</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Nonrelative</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Alone</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nonrelative</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>73</td>
<td>63</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.
before incarceration, 51 subjects indicated a spouse, 39 a parent, 17 a female friend, seven a male friend, five some other relative (e.g., grandparent), and three just a friend. Interestingly, 12 of the 30 rapists or 40% were living with a parent prior to prison whereas only 26% of the child molesters and none of the exhibitionists were doing the same. Table 19 gives a breakdown by sex deviance patterns and the number of subjects living with what adult by group.

Additionally, subjects were asked if they were living with children prior to incarceration. In the experimental group, 51 subjects said they were living with a child related to them. Five said they were living with a child not related to them, and two said they were living with both a relative and nonrelative child. For the control group the breakdown was similar (41 subjects living with a relative child, six with a nonrelative and four with both.

When examined from the perspective of sex deviance patterns, the child molesters exceeded the rapists by 31% in living with children. Table 20 gives the breakdown by both sex deviance patterns and group. Subsequently, from the standpoint of accessibility, it would appear that the child molesters had the highest level of availability of potential victims.
Table 19
Specific Adult Lived With
Before Incarceration

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Adult Lived With</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>26</td>
<td>18</td>
</tr>
<tr>
<td>Parent(s)</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Grandparent(s)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sister/Brother</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Female Friend</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Male Friend</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Parent(s)</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Sister/Brother</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Aunt</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Female Friend</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Male Friend</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Female Friend</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Male Friend</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

Finally, Table 21 indicates the specific relationship of children lived with prior to incarceration. For
<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Status of Children</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>of Children ES</td>
<td>of CS</td>
<td>of TS</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>44</td>
<td>33</td>
</tr>
<tr>
<td>Nonrelative</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Both</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>No Child</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Nonrelative</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Both</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>No Child</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>No Child</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

both child molesters and rapists, daughters and sons were the primary relative children. The next two categories were stepdaughter and nonrelated girl.

When examining gender only, 51 out of the 103 child molesters and 14 out of the 30 rapists were living with at least one female child. Hence, within these two sex
deviance patterns, the percentages would be 49.5 and 46.7 respectively.

Table 21
Specific Children Lived With Before Incarceration

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Children</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Lived With</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
</tbody>
</table>

Child Molesters (CMn=103)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Daughter</td>
<td>19</td>
<td>12</td>
<td>30</td>
<td>22.1</td>
<td>29.1</td>
</tr>
<tr>
<td>Son</td>
<td>16</td>
<td>7</td>
<td>23</td>
<td>16.9</td>
<td>22.3</td>
</tr>
<tr>
<td>Stepdaughter</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>7.4</td>
<td>9.7</td>
</tr>
<tr>
<td>Stepson</td>
<td>6</td>
<td>3</td>
<td>9</td>
<td>6.6</td>
<td>8.7</td>
</tr>
<tr>
<td>Niece/Nephew</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>1.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Nonrelative Girl</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>7.4</td>
<td>9.7</td>
</tr>
<tr>
<td>Nonrelative Boy</td>
<td>3</td>
<td>4</td>
<td>7</td>
<td>5.1</td>
<td>6.8</td>
</tr>
</tbody>
</table>

Rapists (Rn=30)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Daughter</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>5.1</td>
<td>23.3</td>
</tr>
<tr>
<td>Son</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>5.9</td>
<td>26.6</td>
</tr>
<tr>
<td>Stepdaughter</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Stepson</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Granddaughter</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Grandson</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>3.3</td>
</tr>
<tr>
<td>Nonrelative Girl</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Nonrelative Boy</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1.5</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Exhibitionists (EXn=3)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Son</td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>Stepdaughter</td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>33.3</td>
<td></td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.
Index or Instant Offense

As part of the study, subjects were asked to talk about their index or instant offense on the study questionnaire. Within the experimental group, 42 subjects out of 73 said they had been convicted of molesting a female child; 24 a relative child and 18 a nonrelative child. Twelve subjects said they had been convicted of molesting a male child; six a relative child and six a nonrelative child. Eight subjects said they had been convicted of rape and one said self-exposure.

In the control group the breakdown was similar. As Table 22 indicates, 43 subjects out 63 said they had been convicted of molesting a female child (28 men a relative child and 15 a nonrelative child). Five subjects reported they had been convicted of molesting a male child (one a relative child and four a nonrelative child). Thirteen subjects said they had been convicted of rape and two of self-exposure.

In total there were three self-exposure convictions, 17 convictions for molestation of a male child, 31 convictions for rape, and 85 convictions for molestation of a female child. Interestingly, four subjects identified as child molesters on the MSI indicated they had been convicted of rape on their questionnaire.
<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex Offense Conviction</td>
<td>No. of</td>
<td>No. of</td>
</tr>
<tr>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM F-Relative</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>CM M-Relative</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>CM F-Nonrelative</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>CM M-Nonrelative</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Rape</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM F-Relative</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CM F-Nonrelative</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rape</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Exposure</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>73</td>
<td>63</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

Similarly, three subjects identified as rapists on the MSI said they had been convicted of female child molestation on their questionnaire. Also, when examined from the standpoint of sex deviance patterns, the data showed that only the rapists reported their victims as
100% female.

When asked what specific sexual acts were performed during their index offense, 86 subjects indicated fondling, 63 said intercourse, 41 fellatio, 35 cunnilingus, 32 masturbation, 20 sodomy and eight self-exposure. The breakdown for each deviance pattern is given in Table 23. Of interest is that fact that 80% of the rapists reported intercourse whereas only 37.9% of the child molesters reported the same.

Besides being asked to indicate their index offense and sexual acts performed, subjects were asked to report the number of victims at the time of their instant offense: Out of the 136 subjects in the study, 109 reported only one victim (79.4% of the entire sample population). Eighteen subjects indicated two victims, and nine subjects reported three or more.

The within group distribution of the number of victims did not vary significantly between the two main groups, experimental and control. However, this was not true when the data were examined on the basis of sex deviance patterns. As Table 24 illustrates, 90% of study rapists reported only one victim. Except for the three rapists and one exhibitionist who reported more than one victim at the time of their crime, all offenses involving multiple victims were perpetrated by 23 of the identified child molesters.
Table 23
Index Offense Sexual Acts and Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Sexual Acts</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committed</td>
<td>No. of</td>
<td>No. of</td>
<td>No. of</td>
</tr>
<tr>
<td></td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
</tbody>
</table>

Child Molesters (CMn=103)

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>4</th>
<th>5</th>
<th>3.7</th>
<th>4.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Exposure</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>3.7</td>
<td>4.9</td>
</tr>
<tr>
<td>Fondling</td>
<td>44</td>
<td>42</td>
<td>86</td>
<td>63.2</td>
<td>83.5</td>
</tr>
<tr>
<td>Masturbation</td>
<td>15</td>
<td>12</td>
<td>27</td>
<td>19.9</td>
<td>26.2</td>
</tr>
<tr>
<td>Fellatio</td>
<td>21</td>
<td>15</td>
<td>36</td>
<td>26.5</td>
<td>35.0</td>
</tr>
<tr>
<td>Cunnilingus</td>
<td>19</td>
<td>13</td>
<td>32</td>
<td>23.5</td>
<td>31.1</td>
</tr>
<tr>
<td>Intercourse</td>
<td>16</td>
<td>23</td>
<td>39</td>
<td>28.7</td>
<td>37.9</td>
</tr>
<tr>
<td>Sodomy</td>
<td>8</td>
<td>10</td>
<td>18</td>
<td>17.5</td>
<td>13.2</td>
</tr>
</tbody>
</table>

Rapists (Rn=30)

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>4</th>
<th>5</th>
<th>3.7</th>
<th>4.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fondling</td>
<td>11</td>
<td>5</td>
<td>16</td>
<td>11.8</td>
<td>53.3</td>
</tr>
<tr>
<td>Masturbation</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Fellatio</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3.7</td>
<td>16.7</td>
</tr>
<tr>
<td>Cunnilingus</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>2.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Intercourse</td>
<td>13</td>
<td>11</td>
<td>24</td>
<td>17.6</td>
<td>80.0</td>
</tr>
<tr>
<td>Sodomy</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Exhibitionists (EXn=3)

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>4</th>
<th>5</th>
<th>3.7</th>
<th>4.9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-Exposure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Masturbation</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
<td>66.7</td>
<td></td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because some subjects reported more than one type of act at the time of the crime.

Subjects were also asked to give the age of their index offense victim(s) on the study questionnaire. For the 56 child molesters in the experimental group, 36 in-
Table 24
Number of Index Offense Victims and Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Index</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Offense Victims</td>
<td>of ES</td>
<td>of CS</td>
</tr>
</tbody>
</table>

Child Molesters (CMn=103)

<table>
<thead>
<tr>
<th></th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Four</th>
<th>Five +</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. ES</td>
<td>44</td>
<td>10</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>73</td>
</tr>
<tr>
<td>No. CS</td>
<td>36</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>63</td>
</tr>
<tr>
<td>% TS</td>
<td>80</td>
<td>16</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>136</td>
</tr>
<tr>
<td>% SDP</td>
<td>58.8</td>
<td>11.8</td>
<td>2.9</td>
<td>1.5</td>
<td>1.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Rapists (Rn=30)

<table>
<thead>
<tr>
<th></th>
<th>One</th>
<th>Two</th>
<th>Three</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>No.</td>
<td>12</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>%</td>
<td>27</td>
<td>2</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>%</td>
<td>19.9</td>
<td>1.5</td>
<td>0.7</td>
<td>66.7</td>
</tr>
</tbody>
</table>

Exhibitionists (EXn=3)

<table>
<thead>
<tr>
<th></th>
<th>One</th>
<th>Five</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>%</td>
<td>2</td>
<td>.7</td>
<td>66.7</td>
</tr>
</tbody>
</table>

| Totals | 73   | 63   | 136    | 100.0 |

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

...dicated victims between ages 8 and 13. Fifteen said their victims were 7 years old or younger, and five said they had victims age 14 or older. The mean age for the child molesters in the experimental group was 9.62 years.
with a standard deviation of 6.55 years. The mode for the group was 13 years.

For the 47 control group child molesters, 28 subjects reported victims between ages 8 and 13. Twelve said they had victims 7 years old or younger, and seven said they had victims age 14 or older. The mean age for the child molesters in the control group was 9.76 years with a standard deviation of 6 years. The mode for the group was 11 years.

Interestingly, the experimental group rapists revealed a split. Of the 16 rapists in that group, five reported victims between ages 11 and 15. Also, five reported victims between ages 26 and 30. Three said they had victims between ages 16 and 25, and three said their victims were over age 30. The mean age for the rapists in the experimental group was 25.25 years with a standard deviation of 10.98 years. The mode for the group was 15 years.

In the control group, seven of the 14 rapists had victims between ages 16 and 20. Two reported victims between ages 21 and 30, and five reported victims over age 30. The mean age for the control group was 25.35 years with a standard deviation of 12.03 years. The mode for this group was 19 years.

Overall, 9.69 years was the mean age for the victims of the 103 child molesters in the study. For the victims
of the 30 rapists, it was 25.30 years. The three exhibitionists had victims ages 18, 30 and 37. Appendices D, E and F give the age ranges of victims for the three sex deviance patterns.

Along with the age of their victim(s), subjects were asked how they gained victim compliance. Eighty-nine subjects out of the 136 said they used verbal persuasion. Seventy-seven said verbal intimidation, and 45 said verbal threat. Finally, 49 said they used physical force or coercion, and 12 subjects would not say how they achieved victim compliance.

As the data in Table 25 points out, the 103 child molesters said they relied more on verbal persuasion and intimidation than on physical force and/or verbal threat. Meanwhile, the 30 rapists in the study displayed a much greater propensity to admit using physical force, threat and intimidation to gain compliance. All three exhibitionists gave no reply on this variable.

Of interest was also the question of whether study subjects used weapons to achieve victim compliance. As Table 26 illustrates, only 10 subjects admitted using a weapon when committing their index offense. Of the 10 subjects, eight were rapists using a knife, gun, tire-iron, hammer, hair curler, or salad dressing bottle to gain compliance.
Table 25
Methods Used to Gain Victim Compliance and Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Compliance Methods Used</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of</td>
<td>No. of</td>
<td>No. of</td>
</tr>
<tr>
<td></td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persuasion</td>
<td>46</td>
<td>33</td>
<td>79</td>
</tr>
<tr>
<td>Intimidation</td>
<td>30</td>
<td>31</td>
<td>61</td>
</tr>
<tr>
<td>Threat</td>
<td>13</td>
<td>17</td>
<td>30</td>
</tr>
<tr>
<td>Physical force</td>
<td>11</td>
<td>15</td>
<td>26</td>
</tr>
<tr>
<td>Would not say</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Persuasion</td>
<td>6</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Intimidation</td>
<td>7</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Threat</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Physical force</td>
<td>11</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>Would not say</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reply</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because subjects in each deviance pattern reported more than one method to achieve victim compliance.

Finally, the question of whether subjects were using drugs/chemicals at the time of their instant offense was examined. Out of the entire sample of 136 subjects, 74 offenders responded affirmatively (54.4% of the entire
Table 26

Weapons Used to Gain Victim Compliance

<table>
<thead>
<tr>
<th>Weapons used to Gain Compliance</th>
<th>No. of Experimental Subjects</th>
<th>No. of Control Subjects</th>
<th>No. of Total Subjects</th>
<th>% of Experimental Subjects</th>
<th>% of Control Subjects</th>
<th>% of Total Subjects</th>
<th>% of Sex Deviance Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>7.4</td>
<td>NA</td>
<td>92.6</td>
<td>NA</td>
</tr>
<tr>
<td>No</td>
<td>69</td>
<td>57</td>
<td>126</td>
<td>92.6</td>
<td>NA</td>
<td>92.6</td>
<td>NA</td>
</tr>
</tbody>
</table>

Child Molesters (CMn=103)

<table>
<thead>
<tr>
<th>Weapon</th>
<th>No. of Experimental Subjects</th>
<th>No. of Control Subjects</th>
<th>No. of Total Subjects</th>
<th>% of Experimental Subjects</th>
<th>% of Control Subjects</th>
<th>% of Total Subjects</th>
<th>% of Sex Deviance Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knife</td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>.9</td>
<td>.9</td>
<td>.9</td>
<td>.9</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>13.3</td>
<td>13.3</td>
<td>13.3</td>
<td>13.3</td>
</tr>
</tbody>
</table>

Rapists (Rn=30)

<table>
<thead>
<tr>
<th>Weapon</th>
<th>No. of Experimental Subjects</th>
<th>No. of Control Subjects</th>
<th>No. of Total Subjects</th>
<th>% of Experimental Subjects</th>
<th>% of Control Subjects</th>
<th>% of Total Subjects</th>
<th>% of Sex Deviance Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knife</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
<td>6.7</td>
<td>6.7</td>
<td>6.7</td>
</tr>
<tr>
<td>Gun</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
<td>6.7</td>
<td>6.7</td>
<td>6.7</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2.9</td>
<td>13.3</td>
<td>13.3</td>
<td>13.3</td>
</tr>
</tbody>
</table>

NA = Not Apply; ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. The five weapons in the other category were a tire iron, a hammer, a cooking fork, a salad dressing bottle and a hair curler.

sample population. Twenty-eight subjects said they were using only alcohol, and 11 subjects said they were using only drugs. Thirty-five subjects said they were using both when they committed their index offense.

For two of the three sex deviance patterns, the most popular combination was alcohol and marijuana. As Table
27 indicates, the primary drugs of subject choice were alcohol, marijuana, and cocaine. Other drugs used at the time of the crime were reported as lysergic acid diethylamide (LSD), phencyclidine (PCP), heroin and valium.

Table 27
Specific Chemicals Used During Index Offense

<table>
<thead>
<tr>
<th>Chemicals Used in Offense</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td>Alcohol</td>
<td>23</td>
<td>17</td>
<td>40</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Marijuana</td>
<td>9</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>Other drugs</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

Child Molesters (CMn=103)

| Alcohol                  | 12     | 10     | 22      | 16.2   | 73.3   |
| Cocaine                 | 1      | 2      | 3       | 2.2    | 10.0   |
| Marijuana               | 4      | 5      | 9       | 6.6    | 30.0   |
| Other drugs             | 4      | 2      | 6       | 4.4    | 20.0   |

Rapists (Rn=30)

| Alcohol                  | 1      | 1      | .7      | 33.3   |
| Other drugs             | 1      | 1      | .7      | 33.3   |

Exhibitionists (EXn=3)

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because some subjects reported using two chemicals when committing their index offense.

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Criminal History

Out of the 136 subjects in the study, 30 reported previous convictions for criminal sexual conduct (CSC). There were 20 child molesters, seven rapists and three exhibitionists.

When examined from the perspective of between group differences, a simple chi square computation ($X^2=1.44/NS$) revealed no significant difference between the two main groups, experimental and control, at the .05 level of significance. Also, as Table 28 indicates, the within group percentages for the child molesters and rapists on additional convictions for criminal sexual conduct were less than one percent apart. Only the exhibitionists stood out, in that all three had previous convictions for sexual misconduct.

Besides being asked about previous CSC convictions, subjects were also asked to indicate other convictions for property and nonproperty crimes on the Life History Questionnaire. Eighty of the study's subjects said they had been convicted of these types of nonsexual offenses. The 80 represented 58.8% of the study's entire population.

Of the 80 reporting additional crimes, 37 reported only nonproperty crimes. Twenty-three reported only pro-
Table 20

Additional Subject Convictions for Criminal Sexual Conduct (CSC)

<table>
<thead>
<tr>
<th>Additional Convictions for</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>of CSC</td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
</tbody>
</table>

Other CSC Convictions

Yes | 19 | 11 | 30 | 22.1 | NA |
No  | 54 | 52 | 106| 77.9 | NA |

Child Molesters (CMn=103)

<table>
<thead>
<tr>
<th></th>
<th>One</th>
<th>Two</th>
<th>None</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>11</td>
<td>7</td>
<td>18</td>
<td>13.2</td>
<td>17.5</td>
</tr>
<tr>
<td>Two</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1.5</td>
<td>1.9</td>
</tr>
<tr>
<td>None</td>
<td>44</td>
<td>39</td>
<td>83</td>
<td>61.0</td>
<td>80.6</td>
</tr>
</tbody>
</table>

Rapists (Rn=30)

<table>
<thead>
<tr>
<th></th>
<th>One</th>
<th>Two</th>
<th>Three +</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>3.7</td>
<td>16.7</td>
</tr>
<tr>
<td>Two</td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>Three +</td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>3.3</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>10</td>
<td>13</td>
<td>23</td>
<td>16.9</td>
<td>76.7</td>
</tr>
</tbody>
</table>

Exhibitionists (EXn=3)

<table>
<thead>
<tr>
<th></th>
<th>One</th>
<th>Two</th>
<th>Three +</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>1</td>
<td></td>
<td>.7</td>
<td>33.3</td>
<td></td>
</tr>
<tr>
<td>Two</td>
<td>1</td>
<td>.7</td>
<td>33.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three +</td>
<td>1</td>
<td>.7</td>
<td>33.3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

As Table 29 reveals, the number of sexual offenders property crimes and 20 reported having been convicted of both.
convicted of additional crimes was not the same in the experimental and control groups. Therefore, to check for any significant difference between the two main groups, the chi square test was used. A meaningful difference was found between the groups at the .05 level of significance ($X^2=4.31/5$) level. The control group had significantly more convictions for nonsex crimes.

Interestingly, when examined at from the perspective of sex deviance patterns, the picture changes. Of the 30 rapists in the study, 23 of them or 76.6% were convicted of nonsexual crimes. Meanwhile, only 54 of the 103 child molesters or 52.4% acknowledged the same. Again, as with previous CSC convictions, the exhibitionists stood out with all three having prior convictions for nonsexual offenses.

Finally, Table 30 shows some of the nonsexual crimes committed by study subjects. Of the crimes listed breaking and entering, larceny, and assault and battery stand out. In addition, 55 crimes composed the "other" category across all three deviance patterns. Some of these crimes were as follows: accosting and soliciting, auto theft, credit card fraud, pandering, retail fraud, kidnapping, welfare fraud, arson, nonpayment of child support, manufacturing of an explosive device, burglary, and manslaughter.
### Table 29

**Convictions for Nonsexual Crimes Committed by Subjects**

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonsexual Crimes</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Committed by</td>
<td>of ES</td>
<td>of CS</td>
</tr>
<tr>
<td>Subjects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonsexual Crimes</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>37</td>
<td>43</td>
</tr>
<tr>
<td>No</td>
<td>36</td>
<td>20</td>
</tr>
<tr>
<td>Category of Crimes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonproperty</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Property</td>
<td>15</td>
<td>8</td>
</tr>
<tr>
<td>Both</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonproperty</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Property</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Both</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonproperty</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Property</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Both</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonproperty</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Property</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Both</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. NA = Not Apply.

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Table 30
Specific Nonsexual Crimes
Committed by Subjects

<table>
<thead>
<tr>
<th>Nonsexual Crimes</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Committed by Subjects</td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault &amp; Battery</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Robbery Unarmed</td>
<td>2</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Break &amp; Enter</td>
<td>12</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Larceny</td>
<td>8</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Poss. &amp; Delivery</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>CCS</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>MD of Property</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>24</td>
<td>40</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assault &amp; Battery</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Robbery Armed</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Break &amp; Enter</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Larceny</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Poss. &amp; Delivery</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>CCW</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>MD of Property</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Break &amp; Enter</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Larceny</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MD of Property</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. CCW = Carrying a concealed weapon; MD = Malicious Destruction of property. Columns cannot be totaled because some study subjects reported convictions form more than one nonsexual crime.
**Childhood Abuse**

The last variable examined from the MTF LHQ was that of childhood abuse. For the total sample, 52 subjects said they were sexually molested as a child or young adult. Seventy out of the 136 subjects said they were physically abused, and 54 said they were emotionally abused.

In the experimental group, 33 subjects said they had been sexually molested; 37 said they had been physically abused; and 30 said they had been emotionally abused. In the control group the distribution was similar. Nineteen said they had been sexually molested; 33 said they had been physically abuse; and 26 said they had been emotionally abused.

Interestingly, there was a 14 subject difference in the area of childhood sexual abuse between the two main groups. As a result, the chi square test was conducted. No meaningful difference was found between the two main groups at the .05 level of significance ($\chi^2=3.24/NS$). Consequently, proportionately speaking, the experimental group did not acknowledged significantly more childhood sexual abuse.

Nevertheless, as Table 31 illustrates, it was the 103 child molesters who reported significantly more sexual abuse when compared to the rapists. Again, a simple
Table 31
Forms of Childhood Abuse and Sex Deviance Patterns

<table>
<thead>
<tr>
<th>Form of Abuse &amp; Deviance</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>of ES</td>
<td>of CS</td>
<td>of TS</td>
</tr>
</tbody>
</table>

Sexual Abuse

Child Molesters (CMn=103)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No. of</th>
<th>No. of</th>
<th>No. of</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>30</td>
<td>16</td>
<td>46</td>
<td>33.8</td>
<td>44.7</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>26</td>
<td>31</td>
<td>57</td>
<td>66.2</td>
<td>55.3</td>
</tr>
</tbody>
</table>

Rapists (Rn=30)

<table>
<thead>
<tr>
<th></th>
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<th>No. of</th>
<th>No. of</th>
<th>No. of</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3.7</td>
<td>6.8</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>14</td>
<td>11</td>
<td>25</td>
<td>18.3</td>
<td>93.2</td>
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</tbody>
</table>

Exhibitionists (EXn=3)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No. of</th>
<th>No. of</th>
<th>No. of</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>1</td>
<td>1</td>
<td>.7</td>
<td>33.3</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>2</td>
<td>3</td>
<td>2.2</td>
<td>66.7</td>
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</table>

Physical Abuse

Child Molesters (CMn=103)

<table>
<thead>
<tr>
<th></th>
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<th>No. of</th>
<th>No. of</th>
<th>No. of</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>28</td>
<td>26</td>
<td>54</td>
<td>39.7</td>
<td>52.4</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>28</td>
<td>21</td>
<td>49</td>
<td>36.0</td>
<td>47.6</td>
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</table>

Rapists (Rn=30)

<table>
<thead>
<tr>
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<th>No. of</th>
<th>No. of</th>
<th>No. of</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>8</td>
<td>5</td>
<td>13</td>
<td>9.6</td>
<td>43.3</td>
</tr>
<tr>
<td>No</td>
<td></td>
<td>8</td>
<td>9</td>
<td>17</td>
<td>12.5</td>
<td>56.7</td>
</tr>
</tbody>
</table>

Exhibitionists (EXn=3)

<table>
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<th>No. of</th>
<th>No. of</th>
<th>No. of</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2.2</td>
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</tbody>
</table>
### Table 31 - Continued

<table>
<thead>
<tr>
<th>Form of Abuse &amp; Deviance</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>of ES</td>
<td>of CS</td>
<td>of TS</td>
</tr>
</tbody>
</table>

**Emotional Abuse**

**Child Molesters (CMn=103)**

<table>
<thead>
<tr>
<th></th>
<th>26</th>
<th>19</th>
<th>45</th>
<th>33.1</th>
<th>43.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td>28</td>
<td>58</td>
<td>42.6</td>
<td>56.3</td>
</tr>
</tbody>
</table>

**Rapists (Rn=30)**

<table>
<thead>
<tr>
<th></th>
<th>3</th>
<th>6</th>
<th>9</th>
<th>6.6</th>
<th>30.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>8</td>
<td>21</td>
<td>15.4</td>
<td>70.0</td>
</tr>
</tbody>
</table>

**Exhibitionists (EXn=3)**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>1</th>
<th>2</th>
<th>1.5</th>
<th>66.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>1</td>
<td></td>
<td>.7</td>
<td>33.3</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

Chi square computation revealed the difference to be significant at the .01 significance level \((X^2=7.87/S)\).

Regarding levels of reported physical and emotional abuse, the two main sex deviance patterns revealed no significant differences. As before, the exhibitionists were too few in number to make any meaningful comparison.

In addition to being asked if they were abused, subjects were asked to give the relationship status of their perpetrators. As the data in Table 32 shows, the sexual
Table 32
Relationship Status of Perpetrator of Childhood Abuse

<table>
<thead>
<tr>
<th>Relationship Status of Perpetrator</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Relative</td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>10</td>
<td>8</td>
<td>18</td>
</tr>
<tr>
<td>Nonrelative</td>
<td>17</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>Both</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nonrelative</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Both</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relative</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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Table 32 - Continued

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Status of Perpetrator</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
</tbody>
</table>

Emotional Abuse

Child Molesters (CMn=103)

| Relative | 21 | 12 | 33 | 24.3 | 32.0 |
| Nonrelative | 5 | 5 | 10 | 7.4 | 9.7 |
| Both | 2 | 2 | 1.5 | 1.9 |

Rapists (Rn=30)

| Relative | 2 | 6 | 8 | 5.9 | 26.7 |
| Both | 1 | 1 | .7 | 3.3 |

Exhibitionists (EXn=3)

| Relative | 1 | 1 | 2 | 1.5 | 66.7 |

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

abuse experienced by 46 child molesters was equally perpetrated by relatives and nonrelatives alike. For five rapists and one exhibitionist, the trend was the same.

When looking at physical abuse, all three sex deviance patterns reported an overwhelming majority of relative perpetrators. The same was also true for subjects in the study reporting emotional abuse.
Sexual Abuse

Next, subjects were asked to indicate specific acts of abuse, the person who abused them, how often and at what age. Regarding sexual abuse, the primary acts were fondling, masturbation and oral sex. As Table 33 shows, this was true for both the study's child molesters and rapists.

As to specific perpetrators, of the 46 molesters who reported sexual abuse, the primary perpetrator for the experimental group was a neighbor. For control group molesters it was an uncle followed by a cousin. For the five rapists who reported sexual abuse, there was a small range of perpetrators, primarily relatives. This was true for both experimental and control group rapists as illustrated in Table 34. For the one exhibitionist who said he had been sexually abused, he indicated two perpetrators, his mother and a neighbor.

Concerning the age when sexually abused and the frequency of it, the 46 child molesters reported most of the abuse occurring between the ages 6 to 12 with ages 7 and 8 being the years of greatest abuse. This was true for both experimental and control group molesters.

For the five rapists who reported sexual abuse, in the experimental group the primary ages were 6 and 12.
Table 33
Specific Acts of Sexual Abuse Experienced by Subjects

<table>
<thead>
<tr>
<th>Acts of Sexual Abuse Experienced</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
<td>--------</td>
<td>---------</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fondling</td>
<td>26</td>
<td>15</td>
<td>41</td>
</tr>
<tr>
<td>Masturbation</td>
<td>11</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Oral Sex</td>
<td>21</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>Vaginal Sex</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Anal Sex</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fondling</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Masturbation</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Oral Sex</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Anal Sex</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fondling</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Masturbation</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Oral Sex</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Vaginal Sex</td>
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<td>1</td>
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</tr>
<tr>
<td>Anal Sex</td>
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<td>1</td>
<td>.7</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because some subjects reported more than one form of sexual abuse.

In the control group the primary ages were 9 and 10. A complete breakdown of when subjects were sexually abused is given in Table 35.
Table 34
Specific Perpetrators of Sexual Abuse
Experienced by Subjects

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Perpetrators of Sexual Abuse</td>
<td>ES</td>
<td>CS</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Sister</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Brother</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Stepsister</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Aunt</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Uncle</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Cousin</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Parent Boyfriend</td>
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<td>2</td>
</tr>
<tr>
<td>Neighbor</td>
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<td>2</td>
</tr>
<tr>
<td>Classmate</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Would Not Say</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
</tr>
<tr>
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<td>1</td>
</tr>
<tr>
<td>Sister</td>
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<td>2</td>
</tr>
<tr>
<td>Brother</td>
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<td>1</td>
</tr>
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<td>Stepsister</td>
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<td>1</td>
</tr>
<tr>
<td>Stepbrother</td>
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<tr>
<td>Classmate</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Would not say</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Neighbor</td>
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</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because some subjects reported sexual abuse by more than one perpetrator.
### Table 35
Ages When Acts of Sexual Abuse Occurred

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages When Acts of Sexual Abuse Occurred</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Five</td>
<td>6</td>
<td>2</td>
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<tr>
<td>Six</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Seven</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>Eight</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Nine</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Ten (none given)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Eleven</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Twelve</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Thirteen</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Fourteen</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Fifteen</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Six</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Seven</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Eight</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nine</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ten</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Eleven</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Twelve</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
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<td></td>
</tr>
<tr>
<td>Six</td>
<td>1</td>
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<td>Seven</td>
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<td>1</td>
</tr>
<tr>
<td>Eight</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nine</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ten</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.
The frequency of reported sexual abuse did not vary significantly among the two main groups or the three sex deviance patterns. For the 46 child molesters, sexual abuse was reported as weekly, monthly, sporadic or once. For the five rapists it was weekly and sporadic dependent on the perpetrator. A breakdown of the frequency of sexual abuse by relative and nonrelative perpetrators, as well as by sex deviance patterns, is given in Appendix G.

**Physical Abuse**

Regarding acts of physical abuse, the primary acts were being whipped, slapped and punched. As Table 36 reveals, this was true for the experimental and control groups as well as all three sex deviance patterns in the study.

Of the 54 child molesters who reported physical abuse, parents were the primary perpetrators for the experimental and control groups. For the 13 rapists who reported being physically abused, the situation was the same. The same was also true for the exhibitionists. The breakdown regarding various perpetrators is given in Table 37.

As to the age when physically abused and the frequency of the abuse, child molesters and rapists alike reported the abuse beginning at age 5 and ending at age
Table 36
Specific Acts of Physical Abuse Experienced by Subjects

<table>
<thead>
<tr>
<th>Acts of Physical Abuse Experienced</th>
<th>No.</th>
<th>No.</th>
<th>No.</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
<td>TS</td>
<td>SDP</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Punched</td>
<td>18</td>
<td>9</td>
<td>27</td>
<td>19.9</td>
<td>26.2</td>
</tr>
<tr>
<td>Kicked</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>6.6</td>
<td>8.7</td>
</tr>
<tr>
<td>Choked</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3.7</td>
<td>4.8</td>
</tr>
<tr>
<td>Poked</td>
<td>11</td>
<td>1</td>
<td>12</td>
<td>8.8</td>
<td>11.6</td>
</tr>
<tr>
<td>Scratched</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>5.1</td>
<td>6.8</td>
</tr>
<tr>
<td>Whipped</td>
<td>22</td>
<td>24</td>
<td>46</td>
<td>33.8</td>
<td>44.7</td>
</tr>
<tr>
<td>Slapped</td>
<td>20</td>
<td>19</td>
<td>39</td>
<td>28.6</td>
<td>37.9</td>
</tr>
<tr>
<td>Burned</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1.5</td>
<td>1.9</td>
</tr>
<tr>
<td>Cut</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2.2</td>
<td>2.9</td>
</tr>
<tr>
<td>Shook</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
<td>1.9</td>
<td></td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>3</td>
<td>7</td>
<td>5.1</td>
<td>23.3</td>
</tr>
<tr>
<td>Kicked</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Choked</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2.9</td>
<td>13.3</td>
</tr>
<tr>
<td>Poked</td>
<td>3</td>
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<td>4</td>
<td>2.9</td>
<td>13.3</td>
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<tr>
<td>Scratched</td>
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<td>2</td>
<td>3</td>
<td>2.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Whipped</td>
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<td>4</td>
<td>10</td>
<td>7.4</td>
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</tr>
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<td>5</td>
<td>10</td>
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<td>Cut</td>
<td>2</td>
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<td>1.5</td>
<td>6.7</td>
<td></td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>1</td>
<td>1</td>
<td></td>
<td>.7</td>
<td>33.3</td>
</tr>
<tr>
<td>Whipped</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Slapped</td>
<td>1</td>
<td>1</td>
<td></td>
<td>.7</td>
<td>33.3</td>
</tr>
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</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because of multiple acts experienced.
Table 37
Specific Perpetrators of Physical Abuse Experienced by Subjects

<table>
<thead>
<tr>
<th>Specific Perpetrators of Phys. Abuse</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
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<tbody>
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<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td></td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>11</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Father</td>
<td>15</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td>Stepmother</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Stepfather</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Grandmother</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sister</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Brother</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Aunt</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Uncle</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Parent Boyfriend</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Foster Parent</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Neighbor</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Classmate</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Father</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Stepfather</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sister</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Brother</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Neighbor</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Classmate</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Exhibitionists (Exn=3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.
15. As Table 38 illustrates, a large number of subjects said the physical abuse occurred between ages 8 and 11 (most sex offenders giving more than one age when they were physically abused).

Typically, the frequency of physical abuse was weekly and sporadic. The frequency did not vary significantly among the two main groups or the three sex deviance patterns. A breakdown of the frequency of physical abuse by relative and nonrelative perpetrators, as well as by sex deviance patterns, is given in Appendix H.

**Emotional Abuse**

Of the 136 subjects in the study, 56 reported some form of emotional abuse. Out of the 103 child molesters, 45 subjects reported being emotionally abused (43.7% of that deviance pattern). Meanwhile, only nine rapists out of 30 reported any form of childhood emotional abuse (30% of that deviance pattern).

The primary acts of emotional abuse indicated by both experimental and control group members were cruel teasing, name calling and belittlement. Other forms of abuse mentioned were bondage, abandonment, blackmail and dirty tricks. As Table 39 shows, the acts of emotional abuse were not unique to any sex deviance pattern.

As with physical abuse, the primary perpetrators of
### Table 38

### Ages When Acts of Physical Abuse Occurred

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Ages When Acts of</td>
<td>ES</td>
<td>CS</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>Occurred</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Five</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Six</td>
<td>13</td>
<td>13</td>
</tr>
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<td>Seven</td>
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<td>13</td>
</tr>
<tr>
<td>Eight</td>
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<td>Ten</td>
<td>17</td>
<td>18</td>
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<td>16</td>
<td>16</td>
</tr>
<tr>
<td>Twelve</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Thirteen</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Fourteen</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Fifteen</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Five</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Six</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Seven</td>
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<td>4</td>
</tr>
<tr>
<td>Eight</td>
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<td>4</td>
</tr>
<tr>
<td>Nine</td>
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<td>2</td>
</tr>
<tr>
<td>Ten</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Eleven</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Twelve</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Thirteen</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fourteen</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Fifteen</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Exhibitionists (Exn=3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seven</td>
<td>1</td>
<td>1</td>
</tr>
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<td>Eight</td>
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</tr>
<tr>
<td>Nine</td>
<td>1</td>
<td>2</td>
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</tbody>
</table>

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Table 38 - Continued

<table>
<thead>
<tr>
<th>Ages When Acts of Physical Abuse Occurred</th>
<th>No. of ES</th>
<th>No. of CS</th>
<th>No. of TS</th>
<th>% of TS</th>
<th>% of SDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ten</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Eleven</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
<td>66.7</td>
</tr>
<tr>
<td>Twelve</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1.5</td>
<td>66.7</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because some subjects reported physical abuse at more than one age.

of emotional abuse for subjects in the two main groups were parents or other close relatives. This was also true for the two primary sex deviance patterns, rapists and child molesters. The breakdown regarding specific perpetrators is given in Table 40.

The ages when the 56 subjects were emotionally abused are given in Table 41. As with physical abuse, both subjects in the experimental group and the control group reported emotional abuse as early as age 6 and as late as age 15. Again, the majority of the abuse appears to have occurred between the ages of 8 and 12 with some study subjects giving more than one age when they were emotionally abused.
Table 39

Specific Acts of Emotional Abuse Experienced by Subjects

<table>
<thead>
<tr>
<th>Acts of Emotional Abuse Experienced</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
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<td></td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
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<td>31</td>
</tr>
<tr>
<td>Name Calling</td>
<td>15</td>
<td>14</td>
<td>29</td>
</tr>
<tr>
<td>Cruel Teasing</td>
<td>7</td>
<td>12</td>
<td>19</td>
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<tr>
<td>Harassment</td>
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<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
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<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

Child Molesters (CMn=103)

<table>
<thead>
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<th>Acts of Emotional Abuse Experienced</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belittlement</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Name Calling</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Cruel Teasing</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>3</td>
<td>6</td>
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</tbody>
</table>

Rapists (Rn=30)

<table>
<thead>
<tr>
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<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belittlement</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Name Calling</td>
<td>1</td>
<td>1</td>
<td>.7</td>
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</table>

Exhibitionists (EXn=3)

<table>
<thead>
<tr>
<th>Acts of Emotional Abuse Experienced</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belittlement</td>
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<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Name Calling</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because some subjects reported more than one form of emotionally abusive acts.

Finally, the frequency of the emotional abuse was reported as both weekly and sporadic. The frequency did not vary drastically between experimental and control group members. Most of the abuse appears to have been
<table>
<thead>
<tr>
<th>Specific Perpetrators of Emotional Abuse Experienced by Subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>Specific Perpetrators of Emot. Abuse</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
</tr>
<tr>
<td>Mother</td>
</tr>
<tr>
<td>Father</td>
</tr>
<tr>
<td>Stepmother</td>
</tr>
<tr>
<td>Stepmother</td>
</tr>
<tr>
<td>Uncle</td>
</tr>
<tr>
<td>Parent Boyfriend</td>
</tr>
<tr>
<td>Teacher</td>
</tr>
<tr>
<td>Classmates</td>
</tr>
<tr>
<td>Neighbor</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
</tr>
<tr>
<td>Mother</td>
</tr>
<tr>
<td>Father</td>
</tr>
<tr>
<td>Stepmother</td>
</tr>
<tr>
<td>Stepmother</td>
</tr>
<tr>
<td>Parent Boyfriend</td>
</tr>
<tr>
<td>Neighbor</td>
</tr>
<tr>
<td>Exhibitionists (Exn=3)</td>
</tr>
<tr>
<td>Mother</td>
</tr>
<tr>
<td>Father</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because some subjects reported emotional abuse by more than one perpetrator.

weekly and therefore ongoing. A breakdown of the frequency of emotional abuse by relative and nonrelative.
Table 41

Ages When Acts of Emotional Abuse Occurred

<table>
<thead>
<tr>
<th>Ages When Acts of Emotional Abuse Occurred</th>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Child Molesters (CMn=103)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Five</td>
<td>6</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Six</td>
<td>13</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>Seven</td>
<td>14</td>
<td>11</td>
<td>25</td>
</tr>
<tr>
<td>Eight</td>
<td>15</td>
<td>10</td>
<td>25</td>
</tr>
<tr>
<td>Nine</td>
<td>15</td>
<td>12</td>
<td>27</td>
</tr>
<tr>
<td>Ten</td>
<td>17</td>
<td>13</td>
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</tr>
<tr>
<td>Eleven</td>
<td>14</td>
<td>13</td>
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</tr>
<tr>
<td>Twelve</td>
<td>14</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>Thirteen</td>
<td>11</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Fourteen</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Fifteen</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Rapists (Rn=30)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Five</td>
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<td>Eight</td>
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<td>Nine</td>
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<td>Ten</td>
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<td>Eleven</td>
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<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Twelve</td>
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<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Fifteen</td>
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<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Exhibitionists (EXn=3)</td>
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<td></td>
</tr>
<tr>
<td>Six</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Seven</td>
<td>1</td>
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<td>1</td>
</tr>
<tr>
<td>Eight</td>
<td>1</td>
<td>1</td>
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</tr>
<tr>
<td>Nine</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Ten</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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Table 41 - Continued

<table>
<thead>
<tr>
<th>Ages When Acts of Emotional Abuse of Emotional Abuse Occurred</th>
<th>No.</th>
<th>No.</th>
<th>No.</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern. Columns cannot be totaled because some subjects reported emotional abuse at more than one age.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

perpetrators, as well as by sex deviance patterns, is given in Appendix I.

Statistical Analysis of MSI Data

The purpose of this study was to investigate whether or not the MTF Therapy Review Board reduced sex offender denial and increased self-disclosure prior to treatment. The study's dependent variable was the Multiphasic Sex Inventory (Nichols and Molinder, 1984). Using the pre-test-posttest, nonrandomized control-group design, two groups of incarcerated sex offenders were compared at a prison in Muskegon, Michigan.
Both groups were considered equivalent based on the forementioned variables found on the MTF Life History Questionnaire. The experimental group contained 56 child molesters, 16 rapists and one exhibitionist. The control group consisted of 47 child molesters, 14 rapists and two exhibitionists (see Table 2).

Comparisons were made on the basis of group identification, experimental and control. No meaningful treatment effects were found on the MSI scales when computing multiple one-way analyses of covariance (ANCOVA) (keeping the pretest as the covariate to compare adjusted posttest means). As a result, the hypothesis that the one-hour interview with the Therapy Review Board would reduce denial and increase self-disclosure was not sustained. In this study the null was sustained.

**T Test Comparisons of Pretest Means**

Before conducting the ANCOVA to locate any treatment effects, MSI pretest means were compared to check for experimental and control group equivalence. Separate $t$ tests were computed on 20 MSI scales (see Appendix J). The Parallel Items Scale was not used because of the reasons given in Chapter III. Individual $t$ tests were also computed on the five sections of the MSI Sex History.

Of the 20 scales, 17 of the group comparisons were not significant. This meant that the two groups did not
differ significantly when comparing pretest means. For research purposes they were found to be equivalent.

The three scales that revealed a significant difference were the Exhibitionism Scale, Treatment Attitudes Scale and Bondage and Discipline Scale. The first was the result of the there being only three self-identified exhibitionists in the entire study (one in the experimental group and two in the control group). Therefore, because of insufficient subjects, a meaningful comparison between the two groups on the Exhibitionism deviance pattern was not possible.

Regarding the Treatment Attitudes (TA) Scale, individual items were checked for significance. Out of the eight items that constitute the scale, a significant difference was found on only one item. The meaningful difference between the experimental and control group was on MSI item number 1: "Occasionally I think of things too bad to talk to others about." On this item subjects in the control group answered true more often than subjects in the experimental group.

On the Bondage and Discipline (BD) Scale, only one item out of a total of six proved to be significant. Item 201 which says "I have tied someone up during a sexual encounter" was answered affirmatively by more subjects in the experimental group than in the control group.
Finally, because the above differences involved only one item on each scale, both the TA and BD scales were checked for homogeneity of regression slopes when computing the ANCOVA.

**Analysis of Covariance (ANCOVA)**

A one-way ANCOVA was computed on 19 scales of the MSI and the MSI Sex History (see Appendix K). The analysis involved two separate stages or the testing of two statistical hypotheses.

First, the regression slopes of the 19 scales and the Sex History were checked for homogeneity regarding the two groups. The hypothesis \( H_0: \beta_1 = \beta_2 \), or the linear regression coefficient of \( Y \) on \( X \), was tested (\( X \) being the pretest and \( Y \) being the posttest or dependent variable). This was stage one.

On 16 of the scales, as well as the five sections of the test's sex history, the regression slopes were homogeneous. No statistically significant variability was found on the covariate (pretest). Thus, it was not possible to adjust posttest means for any significant pre-existing covariate differences.

In other words, it was not possible to use stage two of the ANCOVA, to use adjusted posttest means as adequate descriptors of treatment effect for 16 scales and the Sex History. Simply put, it was not possible to account for
covariate variability and use adjusted posttest means to test the stage two hypothesis that the adjusted means would equal zero (the null).

The three scales showing statistical significance at stage one were the Child Molest Lie (Lcm) Scale, the Rape Lie (Lr) Scale and the Obscene Call (OC) Scale. Hence, stage two of the ANCOVA checked for treatment effects (meaningful differences) on these three scales. It compared the adjusted posttest means of the two main groups, experimental and control.

The Child Molest Lie and the Rape Lie Scales were designed to measure openness versus dishonesty regarding the sexually deviant thoughts and behaviors of child molesters and rapists. A low score on either scale means the molester or rapist is admitting his deviance. A high score means he is not.

Starting with the Rape Lie Scale, stage two of the ANCOVA produced a statistically significant difference at the .025 significance levels. The experimental group adjusted posttest mean was 9.90. The control group adjusted posttest mean was 11.45.

Although the Rape Lie Scale had a statistically significant difference between the adjusted means above, this investigator was not willing to claim any treatment effect. With only 30 rapists the study, and with only a 1.55 difference between adjusted posttest means, it would
be unsafe to conclude that the one-hour Therapy Review
Board interview had a meaningful effect on the 16 rapists
in the experimental group who experienced the procedure.

With an adjusted posttest mean of 9.90, the experi­
mental group rapists primarily stayed in the interpreta­
tion category of "dishonest about sexually deviant inter­
est." as initially developed by Nichols and Molinder
(1984). Along with the three other interpretation cate­
gories for the Rape Lie Scale, this category is shown in
Table 42.

For the Child Molest Lie Scale and the Obscene Call
Scale, stage two of the ANCOVA produced no statistically
significant differences when comparing adjusted posttest
means for the two scales. The adjusted posttest means
for the Child Molest Lie Scale were 7.17 for the experi­
mental group and 7.94 for the control group.

Interestingly, from a frequency standpoint the child
molesters spread themselves across more interpretation
categories than did the rapists (as the smaller adjusted
posttest means would suggest for the experimental and
control groups). Nonetheless, as Table 42 reveals the
category of "dishonest about sexually deviant interest"
had the highest concentration of child molesters on both
administrations of the MSI. Therefore, it is important
to remember that neither sex deviance pattern displayed
an abundance of openness on the MSI.
Table 42
Child Molest Lie and Rape Lie Scales (Lcm and Lr Scales)

<table>
<thead>
<tr>
<th>Lie Scale/ Deviance Pattern</th>
<th>Open About Sexual Deviance</th>
<th>Questionable Range</th>
<th>Deviant Interests</th>
<th>Suppressed Dishonest About Sex Interests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape Lie Scale (Lr=30)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-Group Pre</td>
<td></td>
<td>1</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>E-Group Post</td>
<td></td>
<td>4</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>C-Group Pre</td>
<td></td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>C-Group Post</td>
<td></td>
<td>1</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Child Molest Lie Scale (Lcm=103)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-Group Pre</td>
<td>5</td>
<td>8</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>E-Group Post</td>
<td>6</td>
<td>11</td>
<td>12</td>
<td>27</td>
</tr>
<tr>
<td>C-Group Pre</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>27</td>
</tr>
<tr>
<td>C-Group Post</td>
<td>6</td>
<td>5</td>
<td>9</td>
<td>27</td>
</tr>
</tbody>
</table>

E = Experimental Group; C = Control Group.

Lastly, as for the Obscene Call Scale, the adjusted posttest means were 1.41 for the experimental group and 1.39 for the control group. Hence, all that can be said regarding this scale is that each group averaged only one item on the scale; that study subjects admitted almost no intimidation of others by making obscene phone calls.
Validity Scales

Of the remaining 16 scales examined in the ANCOVA, the Treatment Attitudes (TA) Scale, Social Sexual Desire-ability (SSD) Scale and Justifications (Ju) Scale were of particular interest for this study. For example, the TA Scale was designed to measure the offender's interest or disinterest in treatment - the willingness to admit deviance and seek help.

On the TA scale subjects exhibited no large shift in interest or disinterest in treatment when retested on the MSI. As Table 43 reveals, 94 subjects fell in the categories of motivated and highly motivated for treatment when first tested, and 92 indicated the same upon retest.

The Ju Scale was developed to measure typical justifications used by offenders to rationalize the commission of a sex offense (e.g., "My sex offense would not have occurred if I had not had to take care of the child's personal hygiene."). On this scale experimental group subjects showed no significant change in their willingness to blame or not blame something or someone for their sexually assaultive behavior.

Therefore, for those who attended the one-hour Review Board interview, and who were not willing to accept accountability for their crime(s), justification remained a form of denial. They did not demonstrate a significant
Table 43
Treatment Attitudes Scale (TA Scale)

<table>
<thead>
<tr>
<th>Number of Subjects in Interpretation Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group and Deviance Pattern</td>
</tr>
<tr>
<td>--------------------------------</td>
</tr>
<tr>
<td>Experimental Group (En=73)</td>
</tr>
<tr>
<td>CM-Pre</td>
</tr>
<tr>
<td>CM-Post</td>
</tr>
<tr>
<td>R-Pre</td>
</tr>
<tr>
<td>R-Post</td>
</tr>
<tr>
<td>Ex-Pre</td>
</tr>
<tr>
<td>Ex-Post</td>
</tr>
<tr>
<td>Control Group (Cn=63)</td>
</tr>
<tr>
<td>CM-Pre</td>
</tr>
<tr>
<td>CM-Post</td>
</tr>
<tr>
<td>R-Pre</td>
</tr>
<tr>
<td>R-Post</td>
</tr>
<tr>
<td>Ex-Pre</td>
</tr>
<tr>
<td>Ex-Post</td>
</tr>
<tr>
<td>Total Sample (N=136)</td>
</tr>
<tr>
<td>CM-Pre</td>
</tr>
<tr>
<td>CM-Post</td>
</tr>
<tr>
<td>R-Pre</td>
</tr>
<tr>
<td>R-Post</td>
</tr>
<tr>
<td>Ex-Pre</td>
</tr>
<tr>
<td>Ex-Post</td>
</tr>
</tbody>
</table>

CM = Child Molesters; R = Rapists; Ex = Exhibitionists; Pre = Pretest; Post = Posttest.
reduction in denial on the MSI posttest as Table 44 illustrates.

The Social Sexual Desireability (SSD) Scale was constructed to measure normal sexual interest and drive. For example, items 137 and 224 state, "I like to look at sexually attractive women" and "I like sex play."

Typically, untreated sex offenders who want to sustain denial present themselves as asexual, as not interested in sex whatsoever. They score low on this scale and present themselves in a conservative light (Nichols and Molinder, 1984).

In this study experimental group subjects revealed no meaningful change in their willingness to admit normal desires and sexual interests. After the one-hour interview with the Therapy Review Board, those presenting as asexual on the MSI pretest sustained their denial on the posttest. Those willing to acknowledge the reverse did so consistently. Statistically, there was no significant change as Table 45 points out.

As to the other validity scales of the MSI, the one-way ANCOVA yielded no significant results. For example, the Sexual Obsessions (SO) Scale was designed to measure the offender's tendency to exaggerate his deviance and reveal an obsession with sex (e.g., "It seems that every time I do and everywhere I go I constantly think about sex.").

On this scale most subjects scored in the expected
Table 44

Justifications Scale
(Ju Scale)

<table>
<thead>
<tr>
<th>Group and Deviance Pattern</th>
<th>Accepts Accountability</th>
<th>Justifies Sexual Deviance</th>
<th>Marked Justification</th>
<th>Lack of Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group (En=73)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>13</td>
<td>40</td>
<td></td>
<td>3</td>
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<tr>
<td>CM-Post</td>
<td>15</td>
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<td>5</td>
</tr>
<tr>
<td>R-Pre</td>
<td>5</td>
<td>11</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>R-Post</td>
<td>8</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>1</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Control Group (Cn=63)</strong></td>
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<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>10</td>
<td>33</td>
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<td>4</td>
</tr>
<tr>
<td>CM-Post</td>
<td>16</td>
<td>26</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>R-Pre</td>
<td>5</td>
<td>8</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>R-Post</td>
<td>5</td>
<td>8</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
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<td><strong>Total Sample (N=136)</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>23</td>
<td>73</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>CM-Post</td>
<td>31</td>
<td>62</td>
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<td>10</td>
</tr>
<tr>
<td>R-Pre</td>
<td>10</td>
<td>19</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>R-Post</td>
<td>13</td>
<td>15</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>3</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
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<td></td>
</tr>
</tbody>
</table>

CM = Child Molesters; R = Rapists; Ex = Exhibitionists; Pre = Pretest; Post = Posttest.
Table 45
Social Sexual Desirability Scale
(SSID Scale)

<table>
<thead>
<tr>
<th>Number of Subjects in Interpretation Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group and Deviance Pattern</td>
</tr>
<tr>
<td>------------------------------</td>
</tr>
<tr>
<td><strong>Experimental Group (En=73)</strong></td>
</tr>
<tr>
<td>CM-Pre</td>
</tr>
<tr>
<td>CM-Post</td>
</tr>
<tr>
<td>R-Pre</td>
</tr>
<tr>
<td>R-Post</td>
</tr>
<tr>
<td>Ex-Pre</td>
</tr>
<tr>
<td>Ex-Post</td>
</tr>
<tr>
<td><strong>Control Group (Cn=63)</strong></td>
</tr>
<tr>
<td>CM-Pre</td>
</tr>
<tr>
<td>CM-Post</td>
</tr>
<tr>
<td>R-Pre</td>
</tr>
<tr>
<td>R-Post</td>
</tr>
<tr>
<td>Ex-Pre</td>
</tr>
<tr>
<td>Ex-Post</td>
</tr>
<tr>
<td><strong>Total Sample (N=136)</strong></td>
</tr>
<tr>
<td>CM-Pre</td>
</tr>
<tr>
<td>CM-Post</td>
</tr>
<tr>
<td>R-Pre</td>
</tr>
<tr>
<td>R-Post</td>
</tr>
<tr>
<td>Ex-Pre</td>
</tr>
<tr>
<td>Ex-Post</td>
</tr>
</tbody>
</table>

CM = Child Molesters; R = Rapists; Ex = Exhibitionists; Pre = Pretest; Post = Posttest.

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deviant and questionable fake good ranges on both administrations of the MSI. As Table 46 shows, only a small number of child molesters and one rapist scored in the sexually obsessed or malingering categories as originally developed by Nichols and Molinder (1984).

The Cognitive Distortion and Immaturity (CDI) Scale is a characterological scale. It also assesses accountability. It was constructed to assess early childhood cognitive distortions that can stay with the offender and provide him an excuse for sexually deviant behavior.

The CDI scale also measures the victim stance of the offender. For example, two scale items are: "My problem is not sexual, it is that I really do love children" and "I have suffered more hurt in my life than most people."

On the CDI Scale sample subjects scored either in the acceptable range of accountability or in the cognitive distortions and immaturity category. Only 19 out of the study's 136 subjects scored in the victim stance category on the MSI pretest, and only 20 subjects scored in the same category on the posttest.

As to the category "severe lack of accountability," only one subject scored in that category on both administrations of the MSI. Therefore, in general subjects appeared willing to take limited responsibility for their deviance and were willing to use cognitive distortions to rationalize their sexual aberrance. The breakdown for
Table 46

Sexual Obessions Scale
(SO Scale)

<table>
<thead>
<tr>
<th>Group and Deviance Pattern</th>
<th>Expected Deviant Range</th>
<th>Fake Deviant Range</th>
<th>Sexually Obsessed Range</th>
<th>Malinger Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group (En=73)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>21</td>
<td>28</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>CM-Post</td>
<td>23</td>
<td>28</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>R-Pre</td>
<td>4</td>
<td>12</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>R-Post</td>
<td>4</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Control Group (Cn=63)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>19</td>
<td>24</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>CM-Post</td>
<td>15</td>
<td>25</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>R-Pre</td>
<td>4</td>
<td>9</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>R-Post</td>
<td>1</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Sample (N=136)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>40</td>
<td>52</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>CM-Post</td>
<td>38</td>
<td>53</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>R-Pre</td>
<td>8</td>
<td>21</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>R-Post</td>
<td>5</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CM = Child Molesters; R = Rapists; Ex = Exhibitionists; Pre = Pretest; Post = Posttest.
this scale is given in Table 47.

**Sexual Deviation Scales**

Of the several scales that make up the MSI battery, the three sex deviance pattern scales were constructed to assess child molesters, rapists and exhibitionists. The three scales assess cognitions and behaviors typically associated with each type of offender.

In the study there was no pattern-switching by subjects when retaking the MSI. Subjects who responded as child molesters on the pretest did so on the posttest. No child molester, for example, tried to portray himself as a rapist on the posttest. No rapist tried to portray himself as a child molester or exhibitionist.

One interesting thing that did occur with the sex deviance pattern scales was a shift toward more honesty among the child molesters in both groups. As can be seen in Table 48, child molesters in both groups, experimental and control, moved from the category of frankly dishonest about their deviant sexual interests to the categories of severe minimization, minimal honesty, probable truthfulness, and definite openness about their sexual deviance.

What produced this change in both groups is unclear. For some unknown reason (other than the one-hour Therapy Review Board procedure) child molesters in both groups became more open on retest. However, as Table 48 shows,
Table 47
Cognitive Distortion and Immaturity Scale (CDI Scale)

<table>
<thead>
<tr>
<th>Group and Deviance Pattern</th>
<th>Accepts Accountability</th>
<th>Cognitive Distortions</th>
<th>Victim Stance</th>
<th>Lack of Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group (En=73)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>16</td>
<td>29</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>CM-Post</td>
<td>19</td>
<td>26</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>R-Pre</td>
<td>11</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>R-Post</td>
<td>13</td>
<td>2</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Control Group (Cn=63)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>11</td>
<td>30</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>CM-Post</td>
<td>15</td>
<td>25</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>R-Pre</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>R-Post</td>
<td>7</td>
<td>6</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>1</td>
<td></td>
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<tr>
<td><strong>Total Sample (N=136)</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>27</td>
<td>59</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>CM-Post</td>
<td>34</td>
<td>51</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>R-Pre</td>
<td>17</td>
<td>10</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>R-Post</td>
<td>20</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

CM = Child Molesters; R = Rapists; Ex = Exhibitionists; Pre = Pretest; Post = Posttest.

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this was only true of the study's child molesters. The study's rapists and exhibitions remained primarily in the category of frankly dishonest from beginning to end.

**Atypical Sexual Behavior Scales**

Next, except for the Obscene Call (OC) Scale, there were no significant differences found on the remaining scales of the Atypical Sexual Outlet Subtest. Besides the OC Scale, this subtest also included the Fetish (F) Scale, the Voyeurism (Vo) Scale, the Sado-Masochism (SM) Scale, and the Bondage and Discipline (BD) Scale.

In other words, no differences were found between the experimental and control groups in their willingness to disclose: (a) particular fetishes, (b) voyeuristic interests and activities, (c) experience with sado-masochistic sexual behavior, and (d) participation in sexual bondage and discipline.

**Sexual Dysfunction Scales**

Similarly, no significant effects were found on the MSI Sexual Dysfunction Subtest. The subtest included the Physical Disabilities (PD) Scale, the Premature Ejaculation (PE) Scale, the Sexual Inadequacies (SI) Scale and the Impotence (Im) Scale. Again, subjects displayed no increase in their willingness to disclose the following: (a) physical disabilities affecting penile tumescence,
Table 48
Three MSI Sex Deviance Pattern Scales
(Child Molest, Rape, Exhibitionism)

<table>
<thead>
<tr>
<th>Group &amp; Deviance Pattern</th>
<th>Frankly Honest</th>
<th>Severe Minimization</th>
<th>Minimal Honesty</th>
<th>Probably Truthful</th>
<th>Very Open About Deviance</th>
</tr>
</thead>
</table>

Experimental Group (En=73)

<table>
<thead>
<tr>
<th></th>
<th>CM-Pre</th>
<th>CM-Post</th>
<th>R-Pre</th>
<th>R-Post</th>
<th>Ex-Pre</th>
<th>Ex-Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM-Pre</td>
<td>47</td>
<td>9</td>
<td>16</td>
<td>14</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CM-Post</td>
<td>6</td>
<td>17</td>
<td>10</td>
<td>10</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>R-Pre</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R-Post</td>
<td>14</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Pre</td>
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<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Control Group (Cn=63)

<table>
<thead>
<tr>
<th></th>
<th>CM-Pre</th>
<th>CM-Post</th>
<th>R-Pre</th>
<th>R-Post</th>
<th>Ex-Pre</th>
<th>Ex-Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM-Pre</td>
<td>39</td>
<td>7</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Post</td>
<td>6</td>
<td>10</td>
<td>20</td>
<td>20</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>R-Pre</td>
<td>14</td>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R-Post</td>
<td>14</td>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Sample (N=136)

<table>
<thead>
<tr>
<th></th>
<th>CM-Pre</th>
<th>CM-Post</th>
<th>R-Pre</th>
<th>R-Post</th>
<th>Ex-Pre</th>
<th>Ex-Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM-Pre</td>
<td>86</td>
<td>16</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Post</td>
<td>12</td>
<td>27</td>
<td>40</td>
<td>40</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>R-Pre</td>
<td>30</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R-Post</td>
<td>28</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>3</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>3</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CM = Child Molesters; R = Rapists; Ex = Exhibitionists; Pre = Pretest; Post = Posttest.

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(b) orgasmic control problems, (c) feelings of sexual inadequacy and (d) difficulties with sexual impotence.

**Sex Knowledge and Beliefs Scale**

The last MSI scale was the Sex Knowledge and Beliefs (SKB) Scale. This scale was designed to assess whether or not the offender has a good fund of knowledge about sex. For example, the research conducted by Nichols and Molinder (1984) found that offenders with a scale score of 17 or below needed more accurate information about sexual anatomy and physiology.

In this study, scores on the SKB were consistent upon retest with the MSI. For example, 29 experimental group subjects revealed a need for more accurate information on their pretest, and 29 experimental group subjects did so on their posttest. For control group subjects, 31 revealed a need for more accurate information on their pretest and 30 on their posttest.

For the entire sample, 44% of the 136 subjects expressed a need for more accurate information about sex. A complete breakdown of the total sample, the study's two groups, and the three sex deviance patterns is given in Table 49.
MSI Sex History

Finally, the 50-item MSI Sex History was examined as part of the study. The MSI Sex History was designed to give clinicians a short description of offender sexual development. It has five sections: (1) Sex Deviance Development (SDD), (2) Marriage Development (MD), (3) Gender Identity Development (GI), (4) Gender Orientation Development (GO) and (5) Sexual Assault Behavior (SAB).

Although the multiple one-way analyses of covariance produced no significant between group differences on the five sections of the Sex History (see Appendix K), the results were examined in relation to the three sex deviance patterns in the study. For instance, in the first section of the history, 73 child molesters, 17 rapists and one exhibitionist indicated they were not curious about sex as a child. Nevertheless, 22 child molesters, four rapists and one exhibitionist said they were punished when they got caught in sexual activity as a child.

By adolescence, 47 child molesters, seven rapists and one exhibitionist (55 subjects) admitted they were secretly excited about sexual matters but were too embarrassed to talk about it with friends. Only 19 molesters, nine rapists and one exhibitionist (29 subjects) said they only became interested in sex after high school age.

Interestingly, on this section of the Sex History,
Table 49

Sex Knowledge and Beliefs Scale (SKB Scale)

<table>
<thead>
<tr>
<th>Group and Deviance Pattern</th>
<th>Need for Accurate Information about Sexual Physiology</th>
<th>No Need for Accurate Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group (En=73)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>23</td>
<td>33</td>
</tr>
<tr>
<td>CM-Post</td>
<td>22</td>
<td>34</td>
</tr>
<tr>
<td>R-Pre</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>R-Post</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ex-Post</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Control Group (Cn=63)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td>CM-Post</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>R-Pre</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>R-Post</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Ex-Post</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total Sample (N=136)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CM-Pre</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>CM-Post</td>
<td>45</td>
<td>58</td>
</tr>
<tr>
<td>R-Pre</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>R-Post</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>Ex-Pre</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Ex-Post</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

CM = Child Molesters; R = Rapists; Ex = Exhibitionists; Pre = Pretest; Post = Posttest.
49 child molesters, four rapists and one exhibitionist (54 subjects) acknowledged an older male (relative, acquaintance, friend or stranger) touching them sexually when they were a child. Also, 34 child molesters, seven rapists and one exhibitionist (42 subjects) reported an older female (relative, acquaintance, friend or stranger) touching them sexually when they were a child.

Comparatively, on the study life history questionnaire, 52 subjects reported that they were molested as a child (46 child molesters, five rapists and one exhibitionist. Finally, of those reporting sexual abuse on the MSI, 27 subjects said their sexual offense occurred as a result of their being abused as a child.

Lastly, on the Sex Deviance Development section of the MSI Sex History, 34 subjects reported a family member in trouble because of sexual deviance, and 12 subjects reported seeing their fathers force sex on their mothers. Also, 35 subjects said they had been "charged" with a sexual offense more than once. This total was similar to the 30 subjects who reported multiple "convictions" for criminal sexual conduct on the MTF questionnaire.

Next, on the Marriage Development section of the MSI Sex History, 14 subjects reported being married more than twice (10.3% of the entire sample). On the MTF questionnaire only 12 subjects reported being married more than twice. Also, on the MTF questionnaire only 32 subjects
said they had never been married while 35 said the same on the MSI. Of the 35 who said on the MSI they had never been married, 33 did report living with someone and having a sexual relationship with them.

What was also interesting on this section of the Sex History was 51 subjects saying they had one or more affairs while married (43 molesters and eight rapists). The 51 subjects represented 37% of the entire sample population.

In addition, 19 child molesters and seven rapists (26 subjects) admitted occasionally using a prostitute, peepshow or massage parlor. Also of interest were the 20 molesters and four rapists who indicated that their wives were more often interested in sex than they were while eight molesters and six rapists said their wives had no interest in sex whatsoever.

Eighteen subjects said they had never taken a close look at a woman's sex organs. Seven said that they had never had sex with another adult as an adult. Finally, six subjects admitted they had never been in love.

On the Gender Identity and Gender Orientation sections of the MSI Sex History, only six subjects admitted wishing they were female. All six were child molesters. Four said they secretly dressed in women's clothes, and three said they felt like a female trapped inside a male body.
An overwhelming majority of subjects (N=118) said they were strictly heterosexual. However, 21 subjects did admit to having sexual contact with both sexes, and 12 child molesters did admit to being privately attracted to men. Seven child molesters said they liked to see a man's sex organ show through his clothes, and six said they thought they were homosexual but were afraid to admit it publicly. In the entire study only two molesters said they were strictly homosexual.

Finally, regarding the Sexual Assault section of the MSI Sex History, 76 child molesters and four rapists admitted molesting a girl, and 24 child molesters and one rapist admitted molesting a boy. Out of the 103 child molesters in the study, 75 said they had specifically touched a child's genital region in a sexual way.

Fifty-nine child molesters reported placing their penises between a child's legs, and 54 admitted penetration of a child with an object like a finger, a tongue or a penis. Also, 47 child molesters and one rapist acknowledged performing oral sex on a child and having a child touch their penis in a sexual way. More specifically, 39 molesters and two rapists said they had a child perform oral sex on them. Interestingly, out of the 103 child molesters, 19 said they showed sexy magazines and nude pictures to their victims to groom them.

Next, 30 child molesters and 18 rapists admitted at-
temping rape or actually raping someone at least once. Moreover, 10 molesters said they had attempted to rape or had raped a male at least once. Twenty-one molesters and three rapists also said they had forced individuals to have oral or anal sex when the individuals did not want to.

In like manner, two child molesters and one rapist said they had become so angry when denied sex that they had physically hurt someone. Also, two molesters and one rapist said they had "beat" a person during a sexual encounter. No subjects in the study admitted getting more thrill and excitement out of physically harming someone than out of sex itself.

On the three items having to do with self-exposure, 58 child molesters and one exhibitionist reported exposing themselves to children. Eight molesters, one rapist and all exhibitionists acknowledged exposing themselves publicly: two molesters saying they became so excited while exposing themselves that they reached out and grabbed someone nearby.

Lastly, seven child molesters and six rapists said they used a weapon to scare their victims into having sex with them. Also, 97 child molesters, 21 rapists and one exhibitionist said they knew or were definitely acquainted with their victim(s) before their offense.
The clinical practice of assessing sex offenders before therapy was the focus of this study. When assessed, sex offenders often deny all or part of their crimes. Typically they offer limited self-disclosure, claim their victims lied or their behavior was misinterpreted.

Using the pretest-posttest, nonrandomized control-group design, this study compared two groups of sex offenders in 1993 at the Muskegon Temporary Facility (MTF) in Muskegon, Michigan. The study investigated whether or not the one-hour assessment interview, conducted by the prison Therapy Review Board, reduced denial and increased self-disclosure. The study also investigated whether or not the groups differed in their responses on the basis of three sex deviance patterns (rapist, child molester or exhibitionist).

The study's independent variable was the one-hour interview with three psychologists. The dependent variable was the Multiphasic Sex Inventory (MSI): a 300-item true/false inventory administered to sex offenders after discovery (Nichols and Molinder, 1984). The MSI measures cognitions and behaviors thought to be common to rapists,
pedophiles and exhibitionists. To check for group equivalence, subjects filled out the MTF Life History Questionnaire. Items from the questionnaire were used to demographically profile both groups.

All 136 subjects gave informed consent. They participated on a time to potential minimum outdate basis and came from the 367 sex offenders awaiting therapy at MTF. Interviewed between pretest and posttest administrations, the experimental group consisted of 73 subjects. The control group consisted of 63 subjects.

True randomization was not possible in this study because of: (a) the 8th Amendment to the United States Constitution which prohibits cruel and unusual punishment, (b) Department of Corrections policies, and (c) potential liberty-interest litigation by offenders. At no time did subjects risk criminal or civil liability. Their constitutional right to privacy was not abridged.

The two groups were compared on MSI scales and subtests using multiple one-way analyses of covariance. Attention was paid to the MSI Lie Scales which measure dishonesty, deception and denial. Although statistical significance was found on the Child Molest Lie Scale, Rape Lie Scale, and Obscene Call Scale at stage one of the ANCOVA, only the adjusted posttest means for the Rape Lie Scale were statistically significant at stage two. Nonetheless, this investigator was not willing to claim any
meaningful treatment effect because the adjusted posttest means were not that divergent for the two groups.

Overall, the hypothesis that the one-hour Therapy Review Board interview would reduce denial and increase self-disclosure was not sustained. Instead, most subjects continued to deny their deviant sexual interests when retested.

One possible reason for why the study did not demonstrate significance (on a majority of MSI scales) was the belief among subjects that true confidentiality does not exist in the Michigan Department of Corrections. Typically, incarcerated sex offenders believe that anything written is not confidential. They watch administrators and corrections officers read institutional and housing unit files with regularity. Almost instinctively, offenders assume that all staff have immediate access to anything written despite policy directives to the contrary.

Additionally, offenders can conclude their medical files are available to nonmedical personnel. Therefore, because their medical files contain psychological reports and test data, offenders want no additional information in their files that could be construed as self-incriminating, or a magnification of their problem with sexual deviance. They fear prison staff using the information for nontherapeutic purposes (e.g., parole board continuances; officer harassment, intimidation and discrimina-
This belief in no confidentiality could explain why, when retested, 105 subjects denied or suppressed deviant sexual interests on the Child Molest and Rape Lie Scales while 102 of them indicated motivation for treatment on the Treatment Attitudes Scale. It could also explain why several subjects, when interviewed by the Board, disclosed more about themselves and their deviance than found in their case records or on the MSI.

Finally, because of design and facility space constraints, this investigator was not able to test all subjects at the same time. Therefore, subjects were able to talk about the MSI in their housing units. Because the pretest-posttest, nonrandomized control group design does not control for reactive and interactive effects, study subjects were free to discuss and compare their pretest experiences - to decide against openness and honesty for fear of the nontherapeutic possibilities given above.

**Summary Discussion**

Sample Demographics

A review of the 10 questionnaire variables revealed that both groups, experimental and control, were comparable for research purposes. The mean age for all subjects was 37.25 years. For the experimental group it was
35.78 years and for the control group 38.98 years.

In other words, the groups were very similar in age. As a deviance category, the child molesters were older than the rapists and the exhibitionists were too few to compare.

The racial composition of the study was primarily White (N=103) and secondarily Black (N=23). The total of Hispanics, Asian and Native Americans in the study came to only 10. Of interest was the fact that among control and experimental group rapists, the proportion of Blacks to Whites increased. The exhibitionists were White.

Educationally, all study subjects began school at age 5 or 6. Most subjects remained in school until age 17. The mean for the complete sample was 16.89 years. Interestingly, the rapists tended to stay in school a little longer—until age 18.

When asked if they had graduated, 95 subjects out of the 136 said they had achieved at least a general education diploma. In general, the within group distributions of general education and high school diplomas, associate and master degrees were similar for the two groups. All of the subjects completing any an advanced degrees were child molesters.

For the entire sample, more subjects reported being divorced than married, married than single, single than separated, and separated than engaged. At the time of
the study, 65% of the sample (87 subjects) said they were unmarried. When both groups were examined from the perspective of sex deviance patterns, the fact of divorce or some form of single-like status remained central.

In addition, out of the 136 subjects, 70 reported being married at least once in their life, and 34 reported multiple marriages. Hence, of the entire sample, 76% reported some form of experience with the institution of marriage.

The religious preference of the entire sample was basically Christian and Protestant. This was true for both groups and all three sex deviance patterns. Jewish, Islamic, Buddhist and Native American spiritual interests were only sparsely represented. Interesting was the fact that 21 subjects expressed no religious preference at all.

Overall, 40 subjects in the study reported serving in the United States military. The overwhelming majority were child molesters who had served in the Army or Navy. Only nine subjects reported any combat experience, and only two reported a problem with post-traumatic stress. Of the 40 only four reported dishonorable discharges. Thus, again the two groups were similar on this demographic variable.

Prior to coming to prison, all but one subject said he was living in his own home. No subject reported stay-
ing in an adult foster home, public shelter or on the street. Ninety-eight subjects were living with at least one relative, 27 with a nonrelative, and 11 were living alone. The within group distributions were similar with most subjects living with either a spouse or a parent. Interestingly, 40% of the rapists were found to be living with a parent before incarceration.

As far as the availability of potential victims, or the living with children, the child molesters exceeded the rapists by 31% in this regard. Yet, when both child molesters and rapists lived with children, they primarily lived with their own offspring rather than stepchildren, other 'young relatives or nonrelatives (e.g., a niece, a girlfriend's daughter, etc.).

As part of the study, subjects were also to give information about their instant offense or index conviction. In the process, the 103 child molesters reported 85 convictions for molestation of a female child. Only 17 child molesters reported assaulting a male child, and only four said they had been convicted of rape. All of the study's rapists indicated their victims were female.

When asked what sexual acts they performed, 86 subjects indicated fondling, 63 intercourse, 41 fellatio, 35 cunnilingus, 32 masturbation, 20 sodomy and eight self-exposure. Of interest was the fact that 80% of rapists reported intercourse while only 37.9% of the molesters
Of the 136 subjects in the study, 109 acknowledged only one victim, and 27 indicated two or more. The mean age for the victims of the child molesters was 9.62 years and for the rapists 25.30 years. Also displayed was the propensity of rapists to use physical force or coercion, as well as weapons, to gain victim compliance.

For two of the three sex deviance patterns, the most common chemical used when offending was alcohol. The most common chemical combination was alcohol and marijuana. In total, 54.4% of the sample (74 subjects) said they were using alcohol and/or a drug when they committed their crime.

Also, 80 subjects (58.8% of the sample) indicated convictions for additional crimes: both nonproperty and property crimes alike. Of the crimes reported, breaking and entering, larceny, and assault and battery were the most common. Also, 30 subjects reported previous convictions for criminal sexual conduct (CSC).

Finally, subjects in both groups said they were sexually, physically, and emotionally abused as children. Fifty-two said they were sexually molested; 70 said they were physically beaten; and 54 said they were emotionally mistreated. In the area of sexual abuse, the experimental group child molesters reported more sexual abuse than the molesters in the control group and more than the
rapists in either group.

In the areas of physical and emotional abuse, there were no significant differences between the experimental and control groups. The perpetrators of the abuse varied depending on the type of abuse experienced. In addition, subjects reported being abused as early as age five and as late as age 16. For all three forms of abuse, the most common age range was age 8 to 11. The most common acts were: (a) fondling, oral sex and masturbation; (b) whipping, slapping, and punching; and (c) belittlement, name-calling, and cruel teasing.

MSI Testing

For this study all subjects took the MSI twice. All scales except the Parallel Item Scale were used. The statistical analysis of data revealed no significant increase in self-disclosure or decrease in denial after the one-hour Therapy Review Board interview. As revealed by the MSI Lie Scales, most of the subjects were dishonest about their sexually deviant interests or suppressed them on both administrations of the MSI.

The MSI Validity Scales revealed no significant effects in several areas. For example, offender willingness to seek treatment did not change. Ninety-four subjects acknowledged motivation for treatment when first tested and 92 when retested.
Subjects showed no significant change in their willingness to blame or not blame someone or something for their sexually deviant behavior. For 91 subjects, justification remained an important form of denial.

Additionally, there was no meaningful change in subject willingness to admit normal sexual interests and desires on the Social Sexual Desireability Scale. On the posttest 83 subjects scored in the asexual, denial, and questionable ranges to minimize any sexual interests (Table 45).

This was also true regarding subject willingness to admit sexually obsessed thinking. On the posttest 124 subjects scored in the expected deviant and fake good ranges on the Sexual Obsessions Scale (Table 46).

On the Cognitive Distortion and Immaturity Scale, sample subjects consistently scored in either the acceptable range of accountability or in the cognitive distortions and immaturity category. Only 19 subjects adopted a victim stance, and only one subject demonstrated no accountability when tested and retested with the MSI.

The Sexual Deviation Scales also revealed no significant differences. There was no pattern-switching by study subjects. However, of interest was a shift toward more honesty by the child molesters in both groups upon retesting. What produced this change is not known. It could not be attributed to the one-hour Therapy Review...
Board interview because it occurred in both groups.

One possible explanation may be test familiarity and "second thoughts" upon retesting. A second possibility may be an unspoken desire among the child molesters to somehow favorably impress this investigator in the hope that treatment could be entered sooner and not later.

The Atypical Sexual Behavior Subtest also manifested no significant changes. No meaningful changes were found between the experimental and control groups in their willingness to admit: (a) specific fetishes, (b) voyeuristic interests or activities, (c) experience with sado-masochistic sexual behavior, and (d) participation in sexual bondage and discipline.

This result was also true for the Sexual Dysfunction Subtest. Subjects revealed no increased willingness to admit physical disabilities affecting penile erection, orgasmic control problems, feelings of sexual inadequacy and difficulties with sexual impotence.

On the Sex Knowledge and Beliefs Scale, scores remained consistent upon retest. Fifty-nine subjects revealed their need for more accurate information about sex. The 59 represented 43.3% of the entire sample population.

Finally, the MSI Sex History was reviewed section by section and item by item. The results of the review can be found on page 267 of this study. In general, the MSI
Sex History reconfirmed information collected on the MTF Life History Questionnaire.

Sex Offender Assessment and Recommendations

Over the last 15 years the number of sex offenders coming to the attention of correctional systems, social welfare agencies, mental health practitioners and the courts has increased substantially. What to do with the offenders has become an important social question. The community demand for safety is at an all-time high while the availability of ever-expensive prison beds is in decline.

The primary goal of sex offender assessment is to protect the public from further sexual aggression. It is to evaluate offenders and assess their treatment amenability so they can learn self-management techniques for offense-free living. As McGrath (1991) pointed out, at least three factors have to be considered when determining treatment amenability. They are:

1. Does the offender acknowledge he committed a sex offense and accept responsibility for his behavior? Obviously, the offender who can not identify his feelings, thoughts, behaviors and situation before and during his crime cannot benefit from treatment. Treatment interventions fundamentally rely on this information.

2. Does the offender acknowledge he has a problem
behavior that he wants to stop? If the offender does not see his behavior as problematic but only a fluke that happened on impulse, then he may not be amenable to the rigorous self-work of therapy.

3. Does the offender acknowledge a willingness to enter treatment and participate fully once the treatment process is explained to him? With a clear understanding of what is expected of him, the offender should be willing to give informed consent.

Typically, incarcerated sex offenders are not voluntary clients. They are individuals referred for psychological services on the basis of departmental policy. Therefore, treatment amenability is not a fixed variable. Some offenders deny their crime and later accept responsibility. Some accept responsibility initially but later decide to retract accountability.

Moreover, sex offenders who continue to deny their crimes and remain intractable are at high risk to recidivate. As researchers have pointed out, low levels of denial are positively correlated with favorable progress in treatment and reduced relapse (Simkins, Ward, Bowman, and Rinck, 1989).

Also, as this study revealed, it is rare to find incarcerated sex offenders who are completely honest about their sexual deviance or history of sexual offending. Instead, offenders engage in a dance with denial to avoid
underlying feelings of shame, confusion, embarrassment, inadequacy and guilt.

Consequently, because sex offenders have a marked propensity to be dishonest about their deviance, the assessment process, primarily the one-hour clinical interview, was of interest to this investigator. Although the study produced no meaningful treatment effects, for Therapy Review Board members it did reinforce the importance of interview strategies when talking with offenders. The specific strategies were:

1. Be familiar with the research on sex offenders and the fact that most sex offenders begin their deviance in adolescence and have multiple paraphilias.

2. View the offender as a whole person and not simply a sexual deviant - as a person who may have a list of more extensive problems.

3. Discuss the purpose of the assessment interview with the offender and inform him about limits to his confidentiality.

4. Let the offender know he is not alone. Inform the offender that a great deal is known about his case but do not go into specifics. Let the offender tell his story in his own words.

5. Never provide the offender with detailed information about sex offenders in general. Do not set the offender up to parrot back what he has been told to justify
or excuse his own behavior.

6. Keep control of the interview and do not allow the offender to circumvent or disrupt the interview process. A sociopath in control cannot be "smoozed."

7. Use collateral sources of information. Do not rely on one source, e.g., a test, pre-sentence investigation report, etc.

8. Do not consult family members by having them attend the interview. Collusion and denial can be maintained through old patterns of fear, secrecy and shame, i.e., especially if family members have not had treatment themselves.

9. Investigate what happened and where it happened regarding the offender's instant offense. Do not get stuck in why. The "why" can be addressed in treatment if the offender is accountable and willing to talk about what he did.

10. Ask the offender when and where his pattern of deviance began. Explain to him the high probability of relapse if he persists in denial. Inform him he has the chance to tell the truth in the interview without anything negative happening to him.

11. Avoid confusion and diversion by using behavioral descriptors. For example, a man who performed cunnilingus on a child may deny he is a molester because the child did not resist.
12. Do not be afraid to ask direct questions in a straightforward and matter-of-fact manner.

13. Try to ask questions that develop a "yes" response set. A yes response set makes it harder for the offender to deny his behavior.


15. Ask only one question at a time to avoid confusion and not allow diversion by the offender.

16. Do not make it easy for the offender to deny his deviance by asking, "Have you ever ...?" Increase the burden of denial on the offender by asking, "How often have you ...?"

17. Use multiple assumption questions so the offender can admit to engaging in comparatively less deviant thoughts and behaviors.

18. Clarify points of confusion, deception or disagreement by rephrasing questions or asking the same question at different points in the interview.

19. Avoid long pauses which allow for premeditation. Questions asked in a continuous manner promote spontaneity and reduce fabrication.

20. Alternate support with confrontation so that the offender feels both supported and held accountable for his deviance.

21. Try to evoke an emotional response from the of-
fender to develop a clear understanding of how his ac-
count of the instant offense differs from that of his
victim(s).

22. Frame self-disclosure as a positive first step
to getting help and coming to terms with his problem of
sexual deviance.

23. Never close the door and say, "Now that you have
told me everything" or "I've have heard enough." Always
leave the door open for additional self-disclosure.

24. Inform the offender that hiding is no longer an
option. During the interview all hats, coats, and sun-
glasses are to come off. Symbolically, the secrecy is to
be over.

Finally, this study placed emphasis on the inter-
woven areas of sex offender assessment and denial. Al-
though the statistical part of this study revealed no
meaningful effects, this investigator still believes the
Therapy Review Board procedure to be valueable. There-
fore, its use is recommended for three main reasons.

One, the procedure collects added factual informa-
tion often missed when offenders enter the prison system.
Institutional records are often incomplete and fail to
reflect the offender's current state of mind. The Review
Board procedure compensate for this problem.

Two, the procedure collects more data about the of-
fender's thoughts, feelings and actions at the time of
the crime(s). Also, each psychologist can pursue specific areas of interest that might be missed by the other two. This collaborative effort produces a broader database for clinical decision-making.

Three, the procedure examines the variables of risk, denial, anger, and motivation for treatment. Subsequently, the procedure produces a more descriptive, collaborative picture of the offender, his problems and amenability to treatment.

In conclusion, this investigator can envision additional research using behavioral descriptors to assess denial and self-disclosure. The effectiveness of MTF's Review Board procedure and sex offender treatment program could be assessed by measuring behaviors observed during the interview process, and/or later in treatment.

Constructed to quantify offender denial and self-disclosure, a checklist of verbal and nonverbal factors could be developed as a "Denial/Disclosure Index." Computing the frequency of denial and self-disclosure behaviors, MTF clinicians could use the checklist/index to help determine treatment amenability, progress, and offender-risk to re-offend.

In addition, this investigator can envision outcome studies that compare untreated, released sex offenders (untreated and released because of lapsed sentences, overcrowding, and program shortages) with sex offenders
assessed and treated at MTF. Typically, this type of research is not easy for at least seven reasons.

1. What are the demographics (measurable characteristics) of the sex offenders being studied?

2. What types of sex offenders (sex deviance patterns and subtypes) are most likely to commit additional crimes?

3. Can certain variables be identified that serve to distinguish repeat sex offenders from nonrepeat sex offenders?

4. What is the criterion used for recidivism - subsequent arrest, reconviction, or recommitment?

5. Does the criterion focus exclusively on subsequent criminal justice system contacts for sex crimes or does recidivism also include subsequent contacts for other crimes?

6. What is the length of the follow-up period?

7. What will be the source(s) of data (self-report, police reports, pre-sentence investigations, federal and State "rap sheets," field investigations, etc.)?

All of these questions would have to be answered in detail before the two groups could be compared. Moreover, because the MTF program excludes sex offenders who are not considered amenable to treatment (e.g., because of psychosis, sado-masochism, denial, and/or insufficient intellectual or verbal skills), the probability of ob-
taining an accurate estimate of success would be reduced. Instead, statistically there would be an increased probability of Type I Error — of concluding meaningful effects when none are present.

Lastly, this investigator recommends that a separate true/false inventory be created to assess sex offender denial. Its items should cover at least eight categories of denial:

1. Denial of the behavior, of the crime itself.
2. Denial of responsibility for the crime.
3. Denial of premeditation and planning.
4. Denial of fantasy and deviant arousal.
5. Denial of the frequency and extent of the abuse.
6. Denial of impact on the victim and of harm done.
7. Denial of the risk of relapse.
8. Denial of the need for help and the difficulty of change.

All items should be evaluated by a panel of judges who specialize in sex offender assessment and therapy. They should be sorted into the above categories and then tested for validity and reliability in penal and nonpenal settings.

It is envisioned that this inventory would provide valuable data to clinicians who assess risk, treat offenders, and have a clear mandate to protect the public. The inventory would be an objective tool for clinicians.
to use in a field where psychological assessment is more art than science.
Appendix A

Approval Letter From the Human Subjects
Institutional Review Board
Date: September 1, 1993
To: Richard M. Happel
From: M. Michele Burnette, Chair
Re: HSIRB Project Number 93-03-20

This letter will serve as confirmation that your research project entitled "The effects of a therapy review board procedure on denial and self-disclosure of incarcerated 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 approval application.

You must seek reapproval for any changes in this design. You must also seek reapproval if the project extends beyond the termination date.

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

Approval Termination: September 1, 1994
xc: Geisler, CECP
INFORMED CONSENT

Psychologist Richard Happel of the Muskegon Temporary Facility (MTF) in cooperation with Western Michigan University is studying how well MTF psychologists screen sex offenders for therapy. The study will measure inmate openness and denial on a simple true-false test, the Multiphasic Sex Inventory (MSI). Should you decide to participate, you will help MTF psychologists improve their ability to assess sex offenders for treatment.

If you choose to be in the study, you will take the MSI twice. Each test session will be one hour long. The two sessions will be 16 days apart. At each session you will mark true or false on the test answer sheet.

There are no risks connected to this study. If, however, you begin to feel uncomfortable during the test, you can return to your housing unit.

All test scores will be strictly confidential. At NO time will your name be used. At NO time will personal information about yourself, crime, victim, or history be used. By participating, your right to privacy will NOT be violated, and you will NOT bring any legal action upon yourself. Participating in the study will NOT hurt or help your eligibility for parole.

ONLY YOUR SCORES FROM THE TEST WILL BE USED IN THE STUDY! All test scores will be kept in a locked file cabinet in MTF's medical clinic.

Finally, you are free to drop out at any time. If you do, it will not be held against you. If you choose not to participate at all, you will still be tested and interviewed for MTF's Sex Offender Treatment Program. If you have any further questions after today, you can contact MTF Health Services and ask to speak with Richard Happel, psychologist.

I ______________________________________ hereby agree that I have read - or have had read to me - the above statement and understand it. I have had all my questions answered and I choose to participate in the study.

Signature: __________________________________________

Date: ________________________________

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Appendix C

MTF Life History Questionnaire
MTF LIFE HISTORY QUESTIONNAIRE - PART I

Sex Offender Program

Date Completed __________

I. PERSONAL DATA

Last Name: _______________ First: _______ M.I. ___

Number: ____________________ Lock: ___

Date of Birth: _____________ Age: __________

Place of Birth: ________________________________

Race: (circle answer)

White Hispanic Black Native American Asian American

Other: ______________________________________

Religion: (circle answer)

Protestant Catholic Jewish Islamic Buddhist Hinduism

Native American Other: ____________________ None

Religious Activities: (please list)

a) As a child _________________________________

b) As an adult _________________________________

Living Arrangement Prior to Incarceration:

With whom were you living immediately prior to your incarceration? (List the people and their relationship to you, e.g., wife, son, daughter, step-child, brother, parent, girlfriend, friend, etc.).

______________________________________________

______________________________________________

Did you live in a house, apartment, hotel, room, trailer, etc.? _____________________________
II. FAMILY-OF-ORIGIN

a) Father's Name: ________________________________
   Living? _______ If alive, his present age? ___
   Deceased? _______ If dead, his age at death? ___
   If deceased, your age at the time of his death? ___
   Cause of death? ________________________________
   If alive, his present health? ____________________
   If alive, his present occupation? __________________

b) Mother's Name: ________________________________
   Living? _______ If alive, her present age? ___
   Deceased? _______ If dead, her age at death? ___
   If deceased, your age at the time of her death? ___
   Cause of death? ________________________________
   If alive, her present health? ____________________
   If alive, her present occupation? __________________

c) If you were not raised by your parents, who did bring you up, and between what ages/years?
   Name/Relationship   Ages/Years
   ________________________________   __________________
   ________________________________   __________________
   ________________________________   __________________

   If you have a step-parent, what was your age when your natural parent remarried? _________

d) Siblings:
   Number of brothers: _______ Brothers' ages: _______
   Number of sisters: _______ Sisters' ages: _______
Number of stepbrothers: ____  Stepbrother's ages: __
Number of stepsisters: ____  Stepsister's ages: __
Other (e.g., cousins): ____  Their ages: _______

e) Relationship with siblings:
   1) Past: __________________________________________
       __________________________________________
   2) Present: __________________________________________
       __________________________________________

f) Give a description of your father's (or father substitute's) personality and attitudes toward you (past and present): ______________________________
       __________________________________________

   g) Give a description of your mother's (or mother substitute's) personality and attitudes toward you (past and present): ______________________________
       __________________________________________

h) In what ways were you disciplined (punished) by your parents as a child? (please list)
   ___________________________________________________________________________________
   ___________________________________________________________________________________

i) Give an impression of your home atmosphere (i.e., the home in which you grew up). Mention state of compatibility between parents and children.
   ___________________________________________________________________________________
   ___________________________________________________________________________________

j) Were you able to confide in your parents?  
   No ____  Yes ____

k) Did your parents understand you?  No ____  Yes ____

l) Basically, did you feel loved and respected by your parents?  No ____  Yes ____
m) To which family member did you feel the closest?  

n) Does any member of your family suffer from a serious, chronic illness (e.g., epilepsy, diabetes, high blood pressure, alcoholism, etc.)?  No ____ Yes ____  If yes, who and what illness? ___________________

o) Does any member of your family suffer a "mental disorder" (e.g., schizophrenia, mental retardation, eating disorders, depression, etc.)?  No ____ Yes ____  If yes, list who and what disorder?

<table>
<thead>
<tr>
<th>Name/Relative</th>
<th>Disorder</th>
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</table>

III. CHILDHOOD AND ADOLESCENCE

a) Mother's condition during pregnancy (as far as you know)? _______________________________________

b) Games and interests as a child (including make-believe). _______________________________________

c) Circle any of the following that applied during your childhood:

Night Terrors  Bedwetting  Sleepwalking
Thumb Sucking  Nail Biting  Stuttering
Fears  School Problems  Family Problems
Happy Childhood  Unhappy Childhood  Chemical Abuse

d) Health during childhood? __________________

List any major illnesses or accidents __________________
e) Did you make friends easily as a child?
No ____ Yes ____

f) Did you make friends easily as a teen?
No ____ Yes ____

g) Were you ever bullied or severely teased?
No ____ Yes ____

h) Were you called names (e.g., stupid, dumb, etc.)?
No ____ Yes ____ If so, what names? ____________

i) Did you date much during high school?
No ____ Yes ____ If so, how often? ____________

j) Interests and hobbies during teenage years ____________

k) Health during teenage years ____________

l) Any accidents and/or surgical operations as a child or teenager? No ____ Yes ____ If yes, please list and give age at the time.

<table>
<thead>
<tr>
<th>Accident/Operation</th>
<th>Age</th>
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m) The following checklist will help you assess any abuse during your childhood or adolescence. Read over each of the three categories and fill in the information which applies to you. Record the information to the best of your memory: Age when it started, who abused you (e.g., father, stepfather, mother, stepmother, aunt, uncle, adult neighbor, brother, sister, stranger, etc.), and how often it happened (e.g., daily, 2 to 3 times a week, weekly, etc.).

<table>
<thead>
<tr>
<th>SEXUAL ABUSE</th>
<th>Age</th>
<th>Abusing Person</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suggestive Flirtations</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Propositioning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEXUAL ABUSE</td>
<td>Age</td>
<td>Abusing Person</td>
<td>Frequency</td>
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<td>--------------------------------------</td>
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<td>-----------</td>
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<tr>
<td>Inappropriate Holding</td>
<td>___</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Inappropriate Kissing</td>
<td>___</td>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>Fondling of Breasts</td>
<td>___</td>
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<tr>
<td>Fondling of Genitals</td>
<td>___</td>
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<tr>
<td>Masturbation</td>
<td>___</td>
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<tr>
<td>Oral Sex</td>
<td>___</td>
<td>___</td>
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</tr>
<tr>
<td>Anal Sex</td>
<td>___</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Other</td>
<td>___</td>
<td>___</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICAL ABUSE</th>
<th>Age</th>
<th>Abusing Person</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoving</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Slapping</td>
<td>___</td>
<td>___</td>
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</tr>
<tr>
<td>Punching</td>
<td>___</td>
<td>___</td>
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</tr>
<tr>
<td>Kicking</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Choking</td>
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<td>___</td>
<td></td>
</tr>
<tr>
<td>Poking</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Whippings</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Scratches</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Bruises</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Burns</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Cuts</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Broken Bones/Fractures</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Damage to Organs</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Permanent Injury</td>
<td>___</td>
<td>___</td>
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<tr>
<td>Other</td>
<td>___</td>
<td>___</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>EMOTIONAL ABUSE</th>
<th>Age</th>
<th>Abusing Person</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belittlement</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Harassment</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Name Calling</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Dirty Tricks</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Blackmail</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
<tr>
<td>Cruel Tasks</td>
<td>___</td>
<td>___</td>
<td></td>
</tr>
</tbody>
</table>
EMOTIONAL ABUSE

<table>
<thead>
<tr>
<th>Age</th>
<th>Abusing Person</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>_____________</td>
<td>________</td>
</tr>
<tr>
<td>Cruel Confinement</td>
<td>___</td>
<td>___________</td>
</tr>
<tr>
<td>Unfair Punishment</td>
<td>___</td>
<td>___________</td>
</tr>
<tr>
<td>Abandonment</td>
<td>___</td>
<td>___________</td>
</tr>
<tr>
<td>Other</td>
<td>___</td>
<td>___________</td>
</tr>
</tbody>
</table>

IV. EDUCATIONAL BACKGROUND

a) Age when you started school __________
b) Age when you finished/left school _____
c) The last grade completed ____________
d) Please circle
   - High School Diploma
   - GED Certificate
   - Associates Degree
   - Bachelor's Degree
   - Master's Degree
   - Doctor's Degree

e) What classes were you good in: _______________
f) What classes were you weak in: _______________
g) What school-related activities were you in (e.g.,
   sports, music, drama, debate, etc.)? ____________

V. MILITARY

a) Are you a veteran? No ____ Yes ____ (If no, go to
   Section VI)
b) What branch of the military were you in. Please
circle.
   - Army
   - Air Force
   - Navy
   - Marines
   - Coast Guard
   - Reserves
   - Merchant Marines
   - National Guard
c) Have you been in combat? No ____ Yes ____
d) What was your highest rank? ________________
e) Type of Discharge. Please circle.
   Honorable  Medical  General  Bed Conduct
   Dishonorable  Other _________________________

f) Have you ever been diagnosed as having Post Traumatic Stress Syndrome?  No _____  Yes  _____

h) Decorations, medals, badges, commendations, citations and campaign ribbons awarded or authorized.
   ____________________________________________
   ____________________________________________

i) Any re-listments?  No _____  Yes  _____  If yes, how many?  _______________________________________

VI. MARRIAGES AND/OR LIVE-IN-PARTNERSHIPS

a) Marital status:  (circle answer)
   Single        Engaged      Married     Separated
   Divorced      Widowed

b) How long did you know your last or current wife or partner before living together?  ______  Before becoming engaged (if you did such)?  _____________

c) If married, how long?  _________________________

d) If married, date you were married?  _______________

e) If divorced, date you were divorced?  _______________

f) If separated, date you separated?  _______________

g) If married, what is your wife's age?  _______________

h) If not married, how long did you live with your last or current partner  _______________

i) What is (was) your wife or partner's occupation?  ___
   ____________________________________________
j) Describe your current or last wife or partner's personality


k) In what areas are the two of you compatible? _____


l) In what areas are the two of you not compatible? ____


m) How do you get along with your in-laws (e.g., parents, brothers, sisters-in-law, etc.)? ________


n) Has anyone like parents, relatives or friends ever interfered in your marriage or partnership(s)?
   No ____ Yes ____ If so, who? __________________


o) How many children do you have? ______ Please give their names, ages, and sex.

   Names                    Ages
   ___________________________   ______
   ___________________________   ______
   ___________________________   ______


p) Do any of your children present special problems (e.g., physical disabilities, hyperactivity, educational problems, etc.)? No ____ Yes ____ If so, what? ____________________________


q) Overall, how many times have you been married? _____

   Spouse's Name     Date Married     Date Divorced
   ___________________________   ______     ______
   ___________________________   ______     ______
   ___________________________   ______     ______
Comments or observations about any previous marriage(s), divorce(s), or partnership(s)?


VII. EMPLOYMENT HISTORY

a) Age when you started your first job? ______________

b) What kinds of jobs have you held in the past?

<table>
<thead>
<tr>
<th>Type of Work/Job Title</th>
<th>Length of Time</th>
<th>Reason You Left</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

c) What type of work were you doing before your incarceration? ________________________________

d) Did this work satisfy you? No    Yes

e) How much did you earn a month? __________________

f) How much did it cost you to live a month? _______

g) What were your past ambitions? __________________

h) What are your current ambitions? __________________

i) What specific skills do you have (e.g., carpentry, plumbing, accounting, computer programming, janitorial, drywall, drill press operator, electrician, etc.)? ________________________________


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j) Has anyone (parents, relatives, spouse, friends) ever interfered while you were working?
   No ____  Yes ____  If yes, explain briefly ______

k) Did you have any problems in your relationships with people at work?  No ____  Yes ____  If so, please describe _______________________________

VIII. FRIENDSHIPS AND OTHER RELATIONSHIPS

a) Do you have one or more friends with whom you feel comfortable sharing your most private thoughts and feelings?  No ____  Yes ____

b) Rate the degree to which you generally feel comfortable and relaxed in social situations:

Very Relaxed ____________________________
Relatively Uncomfortable ________________
Relatively Comfortable _________________
Very Anxious ___________________________

c) Generally, do you express your feelings, opinions, and wishes to others in an open, appropriate manner?
   No ____  Yes ____

d) Describe one relationship that gives you:

Joy _________________________________

Grief _________________________________

e) List those individuals with whom (or those situations in which) you have had trouble asserting yourself:

<table>
<thead>
<tr>
<th>Individuals</th>
<th>Situations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
f) Give a brief description of yourself as you would be described by:

Your spouse/partner ________________________

Your best friend _____________________________

Someone who dislikes you ______________________


g) Are you currently troubled by any past rejections or the loss of a love relationship? No _____ Yes _____

If so, explain briefly _________________________

IX. OFFENSE HISTORY

a) For which offense(s) were you convicted (check all that apply)?

___ Rape
___ Exhibitionism
___ Voyeurism
___ Obscene Calls
___ Indecent Liberties
___ Child Molestation/Male Relative
___ Child Molestation/Female Relative
___ Child Molestation/Male Nonrelative
___ Child Molestation/Female Nonrelative
___ Other __________________

b) Which sexual acts did you commit (check all that apply)?

___ Fondling Only ___ Oral Sex/Male on Female
___ Intercourse ___ Oral Sex/Female on Male
___ Anal Sex ___ Oral Sex/Male on Male
___ Masturbation Other __________________

C) Were you drinking at the time of your crime?

No _____ Yes _____
d) Were you drugging at the time of your crime?
   No ____ Yes ____ If so, what drugs were you using? ______________________________________

e) Was a weapon used? No ____ Yes ____ If so describe the weapon ____________________________

f) How did you get victim cooperation/compliance (if a combination, check all that apply).
   ___ Verbal Persuasion ___ Verbal Threat
   ___ Verbal Intimidation ___ Physical Force
   (Circle Acts of Force Used)
   Shove Slap Poke
   Punch Kick Choke
   Scratch Whip Grab Forcefully
   Pin Down Twist Wrist/Arm Stab
   Cut Bite Pull Hair
   Other _____________________________________________

  g) Number of prior convictions for CSC (please circle):
     ___ 1  ___ 2  ___ 3  ___ 4 or more

  h) Convictions other than CSC:

     Name of Crime         Sentence         Time Served
     ___________________________  ____________  ____________
     ___________________________  ____________  ____________

X. PERSONAL HEALTH

a) Circle any of the following medical conditions that apply to you:

   Thyroid Disease  Kidney Disease  Asthma
   Diabetes         Cancer           Glaucoma
   Epilepsy         Heart Problems   Deafness
   Prostate Problems High Blood Pressure Allergies
   High Cholesterol Other_________________________
b) Circle any of the following physical sensations that apply to you:

- Headaches
- Dizziness
- Palpitation
- Muscle Spasms
- Nausea
- Diarrhea
- Vomiting
- Constipation
- Stomach Trouble
- Tics
- Twitches
- Numbness
- Tingling
- Backaches
- Excessive Sweating
- Other
- Watery Eyes
- Painting
- Skin Problems
- Dry Mouth
- Chest Pains
- Blackouts
- Rapid Heart Beat
- Tremors

---

c) Do you wear glasses? No ____ Yes ____

d) Do you wear a hearing aid? No ____ Yes ____

e) Are you dieting? No ____ Yes ____

f) Do you get regular physical exercise?

No ____ Yes ____ If so, what type and how often?

---

g) Have you ever had any head injuries resulting in a loss of consciousness? No ____ Yes ____ If yes, please give details ____________________________

---

h) Please list any accidents or injuries you have had as an adult:

<table>
<thead>
<tr>
<th>Accident/Injuries</th>
<th>Year/Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
i) Please list any surgeries you have had as an adult:

<table>
<thead>
<tr>
<th>Surgeries</th>
<th>Year/Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

j) Did you abuse alcohol or drugs before coming to prison? No _____ Yes _____

k) Do you have a recommendation for AA, NA, or both? No _____ Yes _____

l) Have you ever attended an inpatient treatment program for chemical dependency? No _____ Yes _____ If yes, how many times? _____

m) If yes, what program(s) did you attend and for how long?

<table>
<thead>
<tr>
<th>Program</th>
<th>Length of Time</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

n) At what age did you begin experimenting with chemicals (alcohol and/or drugs)? _____

o) Which have you used and how often?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Never</th>
<th>Rarely</th>
<th>Frequently</th>
<th>Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Heroin</td>
<td></td>
<td></td>
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<tr>
<td>Speed</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Opium</td>
<td></td>
<td></td>
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<tr>
<td>Marijuana</td>
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<td></td>
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</tr>
<tr>
<td>Coffee</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Never</td>
<td>Rarely</td>
<td>Frequently</td>
<td>Very Often</td>
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<tr>
<td>------------------</td>
<td>-------</td>
<td>--------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>Cigarettes</td>
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<tr>
<td>Tranquilizers</td>
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<tr>
<td>Hallucinogens</td>
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</tr>
<tr>
<td>Pain Killers</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Narcotics</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

p) Please list any medicines you are currently taking:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

q) Has any relative ever attempted or committed suicide?
No ____ Yes ____ If so, who ________________________

________________________________________________________________________

r) Have you ever attempted suicide? No ____ Yes ____

If so, when and how?

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Method Used</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>
MTF LIFE HISTORY QUESTIONNAIRE - PART II

This section of the questionnaire is designed to help MTF psychologists understand you and your treatment needs. It is very easy to complete but does require thought and honesty. It is divided into six simple parts.

I. SENTENCE COMPLETION

(Please complete the following)

I am a person who ________________________________
All of my life ____________________________________
Ever since I was a child ____________________________
If I told you what I'm feeling now ________________
One of the things I feel proud of is ________________
I am happiest when ______________________________
One of the things I feel guilty about is _____________
It's hard for me to admit __________________________
If I didn't have to worry about my image __________
What I needed from mother but didn't get was _______
I get so angry when ______________________________
One of the ways people hurt me is __________________
If I weren't afraid to be myself I would ____________
What I wanted from father but didn't get was ______
I really like _____________________________________
Sex is __________________________________________
I believe in _____________________________________
One of the things I'm angry about is ______________
A way I would help myself is _____________________
What saddens me most is _________________________
Father always was _______________________________
Mother always was ______________________________
If I get angry with you __________________________
I could shock you by ____________________________

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A true friend would __________________________________________

One thing I can't forgive is ____________________________________

What I need and have never received from a woman is ____________________________

_______________________________________________________________

What I need and have never received from a man is ____________________________

_______________________________________________________________

II. BEHAVIOR

(Underline any of the following that apply to you)

<table>
<thead>
<tr>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoke</td>
</tr>
<tr>
<td>Insomnia</td>
</tr>
<tr>
<td>Fetishes</td>
</tr>
<tr>
<td>Can't Concentrate</td>
</tr>
<tr>
<td>Impulsive Reactions</td>
</tr>
<tr>
<td>Crying</td>
</tr>
<tr>
<td>Flashbacks</td>
</tr>
<tr>
<td>Eat &quot;Junk Food&quot;</td>
</tr>
<tr>
<td>Take to Many Risks</td>
</tr>
<tr>
<td>Compulsion</td>
</tr>
<tr>
<td>Fitful Sleep</td>
</tr>
<tr>
<td>Don't Like Weekends</td>
</tr>
<tr>
<td>Unable to Relax</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

a) Are there any specific behaviors, actions or habits you would like to change? ____________________________

b) How is your free time spent? ____________________________

c) Do you practice relaxation or meditation regularly?  
   No ____  Yes ____
III. FEELINGS

(Underline any of the following that apply to you)

Angry  Fearful  Tense  Confused
Annoyed  Relaxed  Contented  Hateful
Sad  Excited  Hopeless  Weak
Depressed  Helpless  Bored  Attractive
Energetic  Regretful  Lonely  Useless
Envious  Hopeful  Optimistic  Joyful
Anxious  Panicky  Restless  Inadequate
Happy  Jealous  Unhappy  Aggressive
Guilty  Conflicted  Incompetent  Resentful
Worthless  Unloved  Misunderstood  Unassertive
Confident  Sympathetic  Tired  Hostile
Evil

a) What situations make you feel calm/relaxed? _______

_____________________________________________________

b) What situations make you lose control? _______

_____________________________________________________

c) List your five biggest fears:

1.

2.

3.

4.

5.
IV. IMAGES

(Underline any of the following that apply to you)

- Pleasant Sexual Images
- Images of Being Loved
- Unpleasant Childhood Images
- Unpleasant Sexual Images
- Helpless Images
- Lonely Images
- Aggressive Images
- Seduction Images
- Images of Being Deformed
- Other ________

(Check which of the following applies to you)

I PICTURE MYSELF AS:

- __ Being Hurt
- __ Being Ugly
- __ Not Coping
- __ Succeeding
- __ Losing Control
- __ Being Followed
- __ Being Talked About
- __ Being Intelligent
- __ BeingNaive
- __ Being Cowardly
- __ Being Honest
- __ Being Loyal
- __ Being Unlovable
- __ Being Hard-Working
- __ Being Undesirable
- __ Being a "Nobody"
- __ Being Stupid
- __ Being in Charge
- __ Failing
- __ Being Laughed At
- __ Being Promiscuous
- __ Being Trapped
- __ Being Considerate
- __ Being Morally Wrong
- __ Being Talented
- __ Being Ambitious
- __ Being Trustworthy
- __ Being Suicidal
- __ Being Humorous/Funny
- __ Being Crazy

a) Which picture comes to your mind most often?

b) Describe a very pleasant image, mental picture, or fantasy:

____________________________________

_____________________________

c) Describe a very unpleasant image, mental picture or fantasy:

____________________________________
d) Describe your image of a completely "safe place."

V. THOUGHTS

(Please circle the number that most accurately reflects your opinions)

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I should not make mistakes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I should be good at everything I do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>When I do not know, I should pretend that I do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I should not disclose personal information.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I am a victim of circumstance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>My life is controlled by outside forces.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Other people are happier than I.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>It is very important to please other people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Play it safe; don't take any risks.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>I don't deserve to be happy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>If I ignore my problems they will disappear.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>It is my responsibility to make other people happy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Strongly Disagree Disagree Neutral Agree Strongly Agree

I should strive for perfection. 1 2 3 4 5
Strong people don't ask for help. 1 2 3 4 5
If I'm not happy, something is wrong with me. 1 2 3 4 5
I'm not responsible for what I do sometimes. 1 2 3 4 5
The world ought to be fair, it's God's will. 1 2 3 4 5
I can't stand being in prison. 1 2 3 4 5
Every problem has a perfect solution. 1 2 3 4 5
Basically, there are two ways of doing things - the right and the wrong way.

a) What do you consider your most illogical idea, thought, belief, or opinion? _____________________________

b) Are you bothered by any thought that occurs over and over again? No ____ Yes ____ If yes, explain briefly ________________________________

VI. TREATMENT EXPECTATIONS

a) In a few words, say what you think therapy is all about? ________________________________

__________________________________________
b) How long do you think your therapy should last (check one).

<table>
<thead>
<tr>
<th>Time Frame</th>
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<tbody>
<tr>
<td>0 to 6 months</td>
</tr>
<tr>
<td>7 to 12 months</td>
</tr>
<tr>
<td>12 to 18 months</td>
</tr>
<tr>
<td>19 to 24 months</td>
</tr>
<tr>
<td>24 to 30 months</td>
</tr>
<tr>
<td>30 months or more</td>
</tr>
</tbody>
</table>


c) What personal qualities do you think a good therapist should possess?

__________________________
__________________________


d) How do you think a therapist should interact with you?

__________________________
__________________________


e) What specific goals or behaviors would you like to work on in group therapy?

1.

2.

3.

4.

5.
Appendix D

Age Ranges of Victims of Child Molesters
by Group (CMn=103)
### Age Ranges of Victims of Child Molesters by Group (CMn=103)

<table>
<thead>
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<td></td>
</tr>
<tr>
<td>Ages 2-4</td>
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<td>5</td>
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</tr>
<tr>
<td>5-7</td>
<td>10</td>
<td>17.9</td>
<td>15</td>
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<td>8-10</td>
<td>17</td>
<td>30.4</td>
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<td>19</td>
<td>33.9</td>
<td>51</td>
<td>91.1</td>
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<td>14-17</td>
<td>4</td>
<td>7.1</td>
<td>55</td>
<td>98.2</td>
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<td>18+</td>
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<td><strong>Control Group</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
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<td>3</td>
<td>6.4</td>
</tr>
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<td>5-7</td>
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<td>12</td>
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<td>12.8</td>
<td>46</td>
<td>97.9</td>
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<td>18+</td>
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<td>2.1</td>
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<td></td>
<td></td>
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<td>8</td>
<td>7.8</td>
</tr>
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<td>26.3</td>
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<td>25.2</td>
<td>53</td>
<td>51.5</td>
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<tr>
<td>18+</td>
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<td>1.9</td>
<td>103</td>
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</table>

Experimental group mean was 9.62 with a standard deviation of 6.55 years. Control group mean was 9.76 years with a standard deviation of 6 years. The mode for the experimental group was 13 and for the control group 11.
Appendix E

Age Ranges of Victims of Rapists
by Group (Rn=30)
Age Ranges of Victims of Rapists by Group (Rn=30)

<table>
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<td>5</td>
<td>31.2</td>
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<td>6.3</td>
<td>6</td>
<td>37.5</td>
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<td>2</td>
<td>12.4</td>
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<td>49.9</td>
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<td>5</td>
<td>31.2</td>
<td>13</td>
<td>81.1</td>
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<tr>
<td>31-35</td>
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<td>6.3</td>
<td>14</td>
<td>87.4</td>
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<tr>
<td>36-40 (none)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41-45 (none)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>46-50</td>
<td>1</td>
<td>6.3</td>
<td>15</td>
<td>93.7</td>
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<tr>
<td>51+</td>
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<td>6.3</td>
<td>16</td>
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<td><strong>Control Group</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ages 16-20</td>
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<td>7</td>
<td>50.0</td>
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<td>57.1</td>
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<td>7.1</td>
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<td>11</td>
<td>78.2</td>
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<tr>
<td>36-40 (none)</td>
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<tr>
<td>41-45 (none)</td>
<td></td>
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<tr>
<td>46-50 (none)</td>
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<td>51+</td>
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<td></td>
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</tr>
<tr>
<td>Ages 11-15</td>
<td>5</td>
<td>16.7</td>
<td>5</td>
<td>16.7</td>
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<td>16-20</td>
<td>8</td>
<td>26.7</td>
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<td>10.0</td>
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<td>36-40 (none)</td>
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<td>41-45 (none)</td>
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<tr>
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<td>51+</td>
<td>3</td>
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<td>30</td>
<td>100.0</td>
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</table>

Experimental group mean was 25.25 with a standard deviation of 10.98 years. Control group mean was 25.35 years with a standard deviation of 12.03 years. The modes for were 15 and 19 respectively.
Appendix F

Age Ranges of Victims of Exhibitionists by Group (EXn=3)
### Ages of Victims of Exhibitionists by Group (EXn=3)

<table>
<thead>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Experimental Group (En=73)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 30</td>
<td>1</td>
<td>100.0</td>
<td>1</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Control Group (Cn=63)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 18</td>
<td>1</td>
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<td>1</td>
<td>50.0</td>
</tr>
<tr>
<td>37</td>
<td>1</td>
<td>50.0</td>
<td>2</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total Sample (N=136)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 18</td>
<td>1</td>
<td>33.3</td>
<td>1</td>
<td>33.3</td>
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<tr>
<td>30</td>
<td>1</td>
<td>33.3</td>
<td>2</td>
<td>66.7</td>
</tr>
<tr>
<td>37</td>
<td>1</td>
<td>33.3</td>
<td>3</td>
<td>100.0</td>
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</tbody>
</table>

The mean for the entire sample of exhibitionists was 28.3 years. No meaningful mode or median because the number of exhibitionists in the study as small.
Appendix G

Frequency of Sexual Abuse Experienced by Subjects
Frequency of Sexual Abuse Experienced by Subjects

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
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<tbody>
<tr>
<td>Frequency of</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>Experienced</td>
<td>ES</td>
<td>CS</td>
</tr>
</tbody>
</table>

Child Molesters (CMn=103)

By a Relative

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>No.</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>2</td>
<td>5</td>
<td>7</td>
<td>5.1</td>
</tr>
<tr>
<td>Monthly</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3.7</td>
</tr>
<tr>
<td>Sporadic</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>4.4</td>
</tr>
<tr>
<td>Once</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>2.9</td>
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</tbody>
</table>

By a Nonrelative

<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>No.</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td>7.4</td>
</tr>
<tr>
<td>Monthly</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1.5</td>
</tr>
<tr>
<td>Sporadic</td>
<td>5</td>
<td>2</td>
<td>7</td>
<td>5.1</td>
</tr>
<tr>
<td>Once</td>
<td>7</td>
<td>2</td>
<td>9</td>
<td>6.6</td>
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</table>

Rapists (Rn=30)

By a Relative

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<thead>
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<th>%</th>
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</thead>
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<td>Weekly</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Sporadic</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
</tbody>
</table>

By a Nonrelative

<table>
<thead>
<tr>
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<th>No.</th>
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<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
<tr>
<td>Monthly</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>.7</td>
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<tr>
<td>Sporadic</td>
<td>1</td>
<td>1</td>
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</tr>
<tr>
<td>Once</td>
<td>1</td>
<td>1</td>
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<td>.7</td>
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### Frequency of Sexual Abuse - Continued

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<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
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<tr>
<td>Frequency of Sexual Abuse Experienced</td>
<td>No.</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>of ES</td>
<td>of CS</td>
<td>of TS</td>
<td>of TS</td>
</tr>
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<tr>
<td>Exhibitionists (EXn=3)</td>
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<tr>
<td>By a Relative</td>
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</tr>
<tr>
<td>Sporadic</td>
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<td>1</td>
<td>.7</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By a Nonrelative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekly</td>
<td>1</td>
<td>1</td>
<td>.7</td>
</tr>
</tbody>
</table>

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.

Columns cannot be totaled because some subjects reported sexual abuse happening more than one relative or nonrelative perpetrator.
Appendix H

Frequency of Physical Abuse Experienced by Subjects
### Frequency of Physical Abuse Experienced by Subjects

<table>
<thead>
<tr>
<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of</td>
<td>No.</td>
<td>No.</td>
</tr>
<tr>
<td>Phys. Abuse</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>Experienced</td>
<td>ES</td>
<td>CS</td>
</tr>
</tbody>
</table>

**Child Molesters (CMn=103)**

**By a Relative**

- **Weekly**
  - 9 11 20 14.7 19.4
- **Monthly**
  - 3 3 2.2 2.9
- **Sporadic**
  - 11 13 23 16.9 22.3

**By a Nonrelative**

- **Weekly**
  - 4 1 5 3.7 4.8
- **Sporadic**
  - 1 1 .7 .9
- **Once**
  - 1 .7 .9

**Rapists (Rn=30)**

**By a Relative**

- **Weekly**
  - 1 3 4 2.9 13.3
- **Sporadic**
  - 7 7 5.1 23.3
- **Once**
  - 2 2 1.5 6.7

**By a Nonrelative**

- **Once**
  - 1 .7 3.3

**Exhibitionists (EXn=3)**

**By a Relative**

- **Sporadic**
  - 2 1.5 66.7
Frequency of Physical Abuse - Continued

<table>
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<th>Groups</th>
<th>Sample</th>
<th>Pattern</th>
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<td>No.</td>
</tr>
<tr>
<td>ES</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>CS</td>
<td>TS</td>
<td>TS</td>
</tr>
</tbody>
</table>

Exhibitionists - Continued

By a Nonrelative

| Weekly | 1 | 1 | .7 | 33.3 |

ES = Experimental Subjects; CS = Control Subjects; TS = Total Subjects; SDP = Sex Deviance Pattern.
Appendix I

Frequency of Emotional Abuse Experienced by Subjects
Frequency of Emotional Abuse Experienced by Subjects

<table>
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<tr>
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<th>Pattern</th>
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<td></td>
<td>No.</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>Frequency of Emot.</td>
<td>of</td>
<td>of</td>
<td>of</td>
</tr>
<tr>
<td>Abuse Experienced</td>
<td>ES</td>
<td>CS</td>
<td>TS</td>
</tr>
</tbody>
</table>

Child Molesters (CMn=103)

By a Relative

- **Weekly**
  - 14 10 24 17.6 23.3
- **Monthly**
  - 2 2 1.5 1.9
- **Sporadic**
  - 5 3 8 5.9 7.8
- **Once**
  - 1 1 .7 .9

By a Nonrelative

- **Weekly**
  - 4 5 9 6.6 8.7
- **Monthly**
  - 1 1 .7 .9
- **Once**
  - 1 1 .7 .9

Rapists (Rn=30)

By a Relative

- **Weekly**
  - 1 4 5 3.7 16.5
- **Sporadic**
  - 2 2 1.5 6.7
- **Once**
  - 2 2 1.5 6.7

By a Nonrelative

- **Sporadic**
  - 1 .7 3.3

Exhibitionists (EXn=3)

By a Relative

- **Weekly**
  - 1 1 .7 33.3
- **Once**
  - 1 1 .7 33.3

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Appendix J

T-Test Comparison of Pretest Means on 20 MSI Scales and the MSI Sex History
T-Test Comparison of Pretest Means on 20 MSI Scales and the MSI Sex History

<table>
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<tr>
<th>MSI Scales</th>
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<th>df</th>
<th>P&gt;T</th>
<th>S/NS</th>
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SSD = Social Sexual Desirability Scale; SO = Sexual Obsessions Scale; Lcm = Child Molest Lie Scale; Lr = Rape Lie Scale; CDI = Cognitive Distortion and Immaturity Scale; Ju = Justification Scale; TA = Treatment Attitudes Scale; CM = Child Molest Scale; R = Rape Scale; Ex = Exhibitionism Scale; F = Fetish Scale; Vo = Voyeurism Scale; OC = Obscene Call Scale; BD = Bondage and Discipline Scale; SM = Sado-masochism Scale; SI = Sexual Inadequacies Scale; PE = Premature Ejaculation Scale; PD = Physical Disabilities Scale; Im = Impotence Scale; SKB = Sex Knowledge and Beliefs Scale; SDD = Sex Deviance Development; MD = Marriage Development; GD = Gender Development; GO = Gender Orientation; SAB = Sexual Assault Behavior.
Appendix K

One-way Analysis of Covariance on 19 MSI Scales
and the MSI Sex History
One-way Analysis of Covariance on 19 MSI Scales and the MSI Sex History

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One-way Analysis of Covariance - Continued

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