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THE ASSESSMENT OF COPING STYLES OF CHILD MOLESTERS AND THEIR RELATIONSHIP TO SPECIFIC COGNITIVE DISTORTIONS, AND LEVELS OF ANXIETY AND DEPRESSION

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

By

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* * * * *

The Ohio State University
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ABSTRACT

The epidemic levels of child sexual abuse in the United States necessitate swift and sure intervention which includes efficient and effective treatment of the perpetrators. The most widely used sexual offender treatment approach, Relapse Prevention, focuses on helping perpetrators develop more appropriate coping strategies so as to preclude any possible return to sexually abusing children. This study focused on identifying the coping styles of convicted child molesters and their relationship to the etiological factors of anxiety, depression and cognitive distortion. A total of 128 convicted child molesters completed 4 different instruments to assess each of these variables. Average scores for anxiety were found to be relatively low and average depression scores were found to fall in the mild range. Item analysis did reveal a considerable amount of cognitive distortions endorsed. Coping style scores were generally average to slightly above average except social diversion which was much below average. The resulting data also reveal that there were significantly large differences in the frequencies of the coping styles with the majority of offenders (68%) endorsing the task oriented style and another fourth (25.4%) choosing the emotion oriented style. For the relationship between coping style and anxiety level, a significant difference was found indicating that as the level of anxiety increased from mild to moderate, the frequency of child molesters having a task oriented
style (64%) decreased to 36% and those with an emotion oriented style (32%) increased to 52%. The avoidance style shows no appreciable correspondence with anxiety level. No significant relationship was detected between coping style and level of depression. Also, while the total cognitive distortion levels were found to be elevated for only two subjects and therefore their relationship to coping style could not be evaluated as a whole score, many subjects still endorsed specific individual cognitive distortions. Multiple regression analyses revealed significant low to moderate coefficients explaining the portion of the variance of each coping style and the predictor variables of anxiety, depression, and cognitive distortion. It was found that anxiety and cognitive distortion levels were inversely related to endorsing a task oriented style and depression was not a significant contributor. Implications for treatment and further research are discussed.
Dedicated to God who called me to do it, my family who supported me through it, and the offenders who contributed to it and hopefully may benefit from it.
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CHAPTER 1

INTRODUCTION

The sexual abuse of children, while not a new problem, has become the focus of a great deal of attention in recent years. Interest in this issue has increased moving it from being a highly taboo subject to being featured regularly in books, magazines, movies, television news and talk shows. Along with this heightened awareness of the sexual abuse of children, and the need to counter its devastating effects, has come a recognition of the need to understand and stop its perpetrators. The question of what to do with child molesters evokes considerable passion when asked and the answer is a hotly debated one. Many vehemently demand that they should be locked up and the key thrown away, or castrated or tortured or killed, while others are open to considering sexual offenders as treatable and in need of intervention. Regardless of one's wishes that the problem be made to disappear, and apart from the intense feelings that raising the issue evokes, the fact is that sexual offending against children is rampant and not stopping on its own. Therefore, while doing so may not be popular, intervention with perpetrators must and is
being attempted. For intervention to be successful, a clear understanding of the variables which contribute to sexually abusing children is essential.

Problem Statement

In general, the problems of concern for this research project revolve around the need to understand the coping styles used by child molesters and what relationship these styles may have with certain variables known to be associated with sexual offending behavior. Specific points of consideration are raised in the following questions:

1) In what ways do child molesters try to cope with stressful situations (as such stress could lead to a relapse into sexually offending again)?

2) Do the ways child molesters try to cope vary according to their offender type?

3) Do their styles of coping differ according to the levels of anxiety, depression and/or cognitive distortion they experience?

4) How much do the factors of anxiety, depression and cognitive distortion (which are considered relevant clinically) contribute to the coping style of child molesters?

5) Do the perpetrators' degree of anxiety or depression vary according to offender type?

6) Do the coping styles used by sex offenders correlate with specific affective states?

Purpose

The purpose of this study is to explore what coping styles are used by child molesters, and whether there is a relationship between levels of anxiety, depression, cognitive distortions held, and those coping styles. In addition, identifying whether the
coping styles used by child molesters vary according to their corresponding offender types is also of interest. The most widely used intervention approach, Relapse Prevention (RP), aims to assist clients "in maintaining behavioral change by anticipating and coping with the problems of relapse." Since it is necessary to develop new coping strategies which interrupt the chain of events leading to relapse, it is critical to be able to identify and understand the offenders' currently held coping strategies which are needing to be modified. In addition, it is crucial to understand what affect is experienced and what cognitive distortions are operating which may influence the coping strategies used by the offenders.

Research Questions

The following research questions are the focus of this study:

Research question # 1  What coping styles are most prevalent among child molesters?

Research question # 2  Do the coping styles used by child molesters vary according to the level cognitive distortion?

Research question # 3  Do the coping styles used by child molesters vary according to the level of the specific affective states of anxiety and depression?

Research question # 4  Do the coping styles of child molesters vary according to their offender type (either situational or preferential)?
Research question # 5 What relative influence do the variables of anxiety, depression, cognitive distortion, and offender type have on the coping styles of child molesters?

Definition of Terms

The following terms are used throughout this writing and defined here for clarity and consistency:

- sexual offender - An individual who has committed one or more sexually deviant acts.
- child molester - An individual who has committed one or more sexually deviant acts with a child (age 0 - 18).
- child molestation - Sexually deviant acts committed against a child.
- sexual deviancy - Inappropriate acts of a sexual nature including (but not limited to):
  - voyeurism
  - exhibitionism
  - obscene phone calls
  - frotteurism
  - fondling
  - rape
- cognitive distortions - A thinking error or irrational thought which distorts reality in order to justify sexually abusive behavior.
- coping style - A general pattern of activities used to deal with a difficult, stressful, or upsetting situation.

Limitations of the Study

This study needs to be viewed with some cautions in mind. As in all studies which attempt to understand the complex phenomenon of human behavior, certain limitations
are present and must be considered in order to interpret the information the studies yield. Because this particular research is directed at the sex offender sub group of child molesters, the results are not necessarily generalizable to all types of sex offenders. In addition, as cultural mores may differ across various geographical regions, the results here may not be found for offenders from another part of the country other than the Midwestern United States. Furthermore, some important aspects involved in the assessment of sex offenders may affect the validity of the information obtained. For example, much of the research reviewed relies on the self-report of the perpetrators. The use of self-report measures carries potential opportunities for a response bias. This is due to the transparency of the instruments used and the higher likelihood for this population which has operated within the hallmark dynamic of secrecy to want to "fake good." They may misrepresent themselves by providing socially acceptable answers in order to avoid or lessen punishment. The possibility that offenders may withhold information or not report accurately, could make the results invalid overall. Second, those who are able to be assessed have usually been caught rather than come forth voluntarily and therefore, their motivations to participate in the assessment may be suspect. Third, those offenders who have been caught (and available to assess) may differ from those offenders who have not been caught. Fourth, few instruments are available which can identify key elements of sexual offending behavior and its underlying etiology. The use of phallometry to assess sexual arousal has shown to yield significant information regarding sexual preferences. However, this author has raised concerns about the potential perception of this method as being highly intrusive and violating and therefore the possibility of harm to the client
would make it unethical to use no matter how useful is the information it yields (not to mention that such intrusion could reinforce the very violation which those in treatment are trying ameliorate!).

Certain methodological issues have surfaced in attempting to do research on the sex offender population. First, the researcher is often the one providing the treatment which can confound the results due to experimenter bias and expectancy effects. Second, adequate control and comparison groups have been lacking in much of the research. Third, the univariate approaches which have set out to find a single defining variable for sex offenders and their subtypes, have been insufficient to account for the complexity and heterogeneity of this phenomenon. More sophisticated multivariate approaches are beginning to be used to account for the high degree of variability within this population and its thoughts, motivations, and behaviors. And last, but certainly not least, the variety of approaches to this subject and the diverse and inconsistent nomenclature used in defining it make comparisons between studies difficult and render more overarching meta-analytic examinations rather inconclusive or weak in their results.

A major factor affecting this study is one of sample size and subject access. To obtain a sample of subjects which would be representative of all child molesters would require both access to and participation of a very large number of offenders. While a large group of offenders does exist across the United States, their number is difficult to determine. Of the 61,000 inmates in state prisons nationwide for crimes against children, 70% (42,700) reported they were in prison for rape or sexual assault (Bureau of Justice Statistics, 1996). While this gives some hint as to the size of this population, it does not
take into account all those such offenders in federal penitentiaries, local jails, and outpatient treatment programs. Also it obviously does not reflect the number of child molesters which have not been prosecuted or even detected. As a result, an accurate number reflecting the actual total of child molesters in this country is very difficult to ascertain and consequently to research in a representative way. In addition, access to those whom are known offenders is extremely difficult to obtain on a large scale due to confidentiality, anonymity, and security concerns. This is made even more difficult due to the fact that they are all accessed through controlled settings for either punishment or treatment. Due to nature of these settings and the bureaucratic systems within which they function, multiple layers of requirements (albeit appropriate ones) must be negotiated in order to make face to face contact. This makes for a cumbersome, time consuming, and often redundant process. Therefore, this research is definitely limited by the size of the pool of subjects with which contact was possible. The small amount of time available to have access to subjects and collect data also effected the scope of what could be assessed and what instruments could be incorporated into the administration sessions.

Despite any such limitations, the following information is the result of an exploratory investigation about the coping styles of sex offenders which have heretofore been assumed rather than assessed.
CHAPTER 2

REVIEW OF THE LITERATURE

Although the significance of the problem of sexually offending against children is apparent, little is fully understood about the motivations, personality, or coping behaviors of the perpetrators. The following review will outline and summarize the major trends in the literature related to the phenomenon of sexual offending in general, and focus specifically on the child molester population including issues related to the hypotheses focused on in this study. Even a cursory review of the relevant literature reveals a smattering of articles spread across several different disciplines such as community mental health, social work, criminal justice and medicine. While the amount of information gleaned from clinical intervention has been steadily growing and expounded upon theoretically, as one would expect from this roughly 30 yr. old field of investigation, the amount of research conducted to test out theoretical constructs and hypotheses is more rudimentary by comparison. The review in this chapter will include the following sections:
Scope of the Problem of Sexual Offending

Sex Offender Characteristics and Classification

Theories of the Etiology of Sexual Offending

Treatment Approaches

State of the Research to Date

Focus of This Study

Summary

The Scope of the Problem of Sexual Offending

Although various investigators concur that the seriousness of sexual offending is great, exactly how widespread sexual offending behavior is depends on what statistics are cited. Based on the reports of an outpatient population of 232 child molesters, Abel, Mittleman, and Becker (1984) concluded that the men had molested an average of 76 victims each (prevalence), had made an average of 238 attempts at molesting children, and on average had carried it out in 167 cases (incidence). Finklehor (1993), examining information from a multitude of resources, stated that "prevalence estimates in community surveys range from 6 to 62% for females and 3 to 16% for males with the better studies generally finding higher rates." Therefore, he believes that at least one in four girls and one in ten boys will suffer sexual victimization (P. 67). Hopper (1997) in his on-line review of child abuse statistics has stated that current estimates indicate that
one in three girls is sexually abused before age 18, and one in four by age 14. while one in six boys are sexually abused before age 16.

It is obvious, then, that the problem of sexual offending demands attention. Fortunately, scholars have begun to investigate the factors related to this deviation and have formulated theoretical explanations which can facilitate intervention and perhaps prevention as well.

Sex Offender Characteristics and Classification

While sex offenders historically have been viewed rather globally, and terminology to describe them has had many broad terms (which would imply that they are a homogeneous group), more current understanding gained through both treatment and research suggests that they are a very heterogeneous population (Ellis, 1989; Groth, 1979).

Many specific characteristics of sex offenders have been postulated. A complete compilation and description of them all is beyond the scope of this writing. However, a summary of those which are most representative of the research is in order. Carich and Adkerson (1995) have outlined 5 categories of lifestyle characteristics of sex offenders which include:

Antisocial - "crooked" and deviant characteristics
Narcissistic - self-centeredness and entitlement
Borderline - instability in emotions, relationships,
and other life areas
Schizoidal - alienation and isolation in relationships

Obsessive - Compulsive - rigid control and compulsions.

Within these 5 categories, a large number of specific characteristics are delineated (See Appendix A for a complete list). Researchers also have found that sex offenders tend to display the defense mechanisms of denial, minimization (Rogers & Dickey, 1991; Hall, 1989; Langevin, 1988), misattribution of responsibility (Marshall & Eccles, 1991; Bennett, 1986), cognitive distortions (Hayashino, Wurtele & Klebe, 1995; Abel, Gore, Holland, Camp, Becker & Rathner, 1989; Marshall & Barbaree, 1989; Stermac & Segal, 1989; Murphy, & Stalgaitis, 1987; Nedoma, Mellan & Pondelickova, 1981), lack of empathy (Marshall & Barbaree, 1989; Williams & Finklehor, 1989), social anxiety, social isolation and poor social skills (Araji & Finklehor, 1986; Overholser & Beck, 1986; Segal & Marshall, 1985) and deviant patterns of arousal (Langevin, 1983; in child molesters - Freund, 1967; Quinsey, 1977).

A host of other specific characteristics have been noted clinically and some have been studied empirically. Those receiving some support in the literature include: victimization (Williams & Finklehor, 1989; Lanyon, 1986), impulsivity (Prentky & Knight, 1986), the use of power and control (Groth, Hobson, & Gary, 1982; Groth, 1979), substance abuse (Langevin, Bain, Wortzman, Hucker, Dickey, & Wright, 1988; Groth et al., 1982), the use of pornography (Murrin & Laws, 1989), and disturbances of affect such as anxiety and depression (Williams & Finklehor, 1989), anger (Pithers, Kashima, Cumming, Beal, & Buell, 1988), and fear of negative evaluation (Overholser & Beck,
1986; Hayashino et al., 1995). Other characteristics which have been postulated but which have yet to be substantiated include psychopathology (Kalichman, Dwyer, Henderson, & Hoffman, 1992; Henderson & Kalichman, 1990; Lanyon, 1986), and personality correlates (Okami & Goldberg, 1992; Valliant & Blasutti, 1992; Lanyon, 1986). Some characteristics appear to be true for only small segments of the sex offender population including endocrine differences, brain anomalies, intellectual deficits (Williams & Finklehor, 1989), and sexual dysfunction (e.g. impotence and premature ejaculation, Marshall & Barbaree, 1988).

Because the number of characteristics that have been attributed to sex offenders is large, it may be more helpful to point out what is not true about them. Many myths or common stereotypes are just that - untrue. Groth, Hobson and Gary (1982) summarize that

> Generally speaking we have not found any social or demographic characteristics that differentiate the child molester from the general population, not his race, religion, intelligence, education, vocation, socio-economic class, or the like. What we have found is that pedophilia cuts across the whole spectrum of diagnostic categories, but for the most part we are not dealing with persons who are mentally ill but who are emotionally troubled. (p. 130)

Okami and Goldberg (1992), in their review of literature related to personality correlates of pedophilia conclude that "little clinically significant pathology was found among either 'pedophiles' or 'sex offenders with minors' (p. 297)." Conte and Berliner (1981) have noted that most molestation is done by men who are not strangers, but who are known to
the victim, and in fact are often related to the victim. So, the common perceptions of a sex offender as someone who is a stranger, a "dirty old man" or deranged or crazy, are not supported by clinical evidence as common truth.

One significant attempt to understand sex offenders and their behavior has been to try to develop characteristic profiles through the use of psychological tests (Ballard et al., 1990). The most widely used instruments in this regard have been the MMPI and more recently the MCMI (Millon Clinical Multiaxial Inventory) and NEO-PI (NEO Personality Inventory). In general, the results have been inconsistent. Kalichman et al. (1992) have summarized that

few consistent results have yielded from univariate (single scale elevations and group comparisons based on single scales) and bivariate (high-point scale pairs) levels of analysis. In fact, the only replicated difference between non-sexual offenders and sex offenders has been the tendency for sex offenders to present higher elevations on the Schizophrenia (Sc) scale of the MMPI. However, even this finding has been inconsistent. (p. 260)

Overall, efforts to identify a typical profile or single explanatory variable for sexual offenders have been unsuccessful. As Kalichman, Dwyer, Henderson, & Hoffman, (1992) conclude: "Sexual violence is a major social malady and little is known about the psychological functioning of sex offenders. Widely agreed upon, however, is that sex offenders comprise a heterogeneous population."

Knowing that sex offenders are very diverse, and being faced with the widespread prevalence and severe impact of sexual offending behavior, corrections personnel, treatment professionals, and researchers have seen the need to identify and understand the
various sub-groupings within this population. This effort has led to the exploration and development of classification systems for sex offenders.

Although the classification of sex offenders is currently in its infancy, its conception has introduced ideas which have remained influential to this day. Karpman (1954) made an important distinction in distinguishing molesters who have a consistent "preference" for children from those who turn to children as "surrogates" for age-appropriate sexual partners. Gebhard et al. (1965), in an extensive research effort, posited several variables which distinguished various sex-offender types. Seven such variables were: 1) sexual preference (heterosexual vs. homosexual), 2) age of victim (minor vs. adult), 3) relationship to the victim (incestuous vs. nonincestuous), 4) offense behavior (e.g. peepers vs. exhibitionists), 5) offense circumstances (setting, offender age and marital status), 6) criminality (number and type of convictions, and recidivism), and 7) impact of addictions (e.g. gambling, drug use, and alcohol use). While these variables described in early classification attempts show striking similarity to other later formulations, they are rarely cited, further suggesting that the literature on sexual offending behavior is disjointed and, consequently, rather inconsistent and imprecise.

A handful of different classifications of sex offenders have emerged in recent years and have focused on a series of variables from which to derive distinctions among this heterogeneous population. These variables have included: age of victim, relationship to victim, type of offense, perpetrator characteristics, perpetrator psychopathology, sexual preference and others. These variables each warrant a brief description as they relate to classifying sex offenders into specific distinct types.
The classification of offenders according to the age of their victim has been one of the earliest and most enduring distinctions. Simply put, the two most basic types - child molester and rapist - are determined by the age of the victim as noted in their definitions stated earlier. The age of the child is further delineated as either prepubescent - generally 13 yrs. of age or younger or pubescent. This distinction is made in the mental health profession to diagnose pedophilia, and in law enforcement, to determine the appropriate legal charges and punishments (in general, the younger the victim the more significant the charge and severe the consequences).

A second dichotomy defining different types of offenders is whether or not they are known by their victim. For child victims the offenses of molesters are often described as incestuous (within their family) vs. nonincestuous (outside their family). For adult victims, distinctions such as stranger rape vs. date rape vs. marital rape exist.

A third variable used for subtyping sex offenders is the nature of the offensive sexual act itself and how intrusive and abusive it is. Nuisance offenders are those who watch others involved in sexual activity or undressing in private (voyeurs) or expose their own genitalia to an unsuspecting onlooker (exhibitionist). Child molesters are those who are involved in fondling of breasts and genitals, fellatio, and cunnilingus (typically without any physical force), whereas child rapists engage in oral, vaginal, and/or anal penetration often using physical force.

Classification of sex offenders has also been done rather pragmatically according to several specific characteristics of the perpetrator. For example, offenders have been separated for treatment by age, gender, and level of intellectual functioning. From early
on, sexual offenders have been divided into subgroups according to sexual preference. Gebhard et al. (1965) subdivided perpetrators into heterosexual and homosexual offenders. More currently, for example, the DSM-IV (1994) distinguishes among pedophiles based on whether they are attracted to males only, females only, or both.

Although a review of the literature reveals many attempts to classify sex offenders, four specific taxonomies stand out, due to their exemplary pioneering efforts and prototypic results, and will be summarized here. The first three describe child molester typologies while the fourth describes different types of sex offenders in general according to an addiction perspective. The first and fourth are the formulation of clinician, the second of law enforcement personnel, and the third of academic researchers. Each is significant and influential in its respective field.

Perhaps the most influential taxonomy was developed by Dr. A Nicholas Groth, a psychologist working with incarcerated sex offenders in Connecticut and Massachusetts, which he expounded in several writings (Burgess, Groth, Holstrom & Sgroi, 1978; Groth & Birnbaum, 1979, and Groth et al., 1982). Through his clinical observations and research, he has identified two major types of child molesters and three types of child rapists. The following diagram (Figure 2.1) illustrates the components of his taxonomy.
In this model, Groth contrasts the approach used toward the victim by the perpetrator as one of "seduction" or "persuasion" in molestation and one of "attack" or "assault" in rape. Groth et al. (1982) also identify two basic types of child molesters based upon their level of socio-sexual maturation: (1) the fixated offender whose primary sexual orientation is towards children, and (2) the regressed offender whose sexual involvement with a child is a clear departure, under stress, from a primary sexual orientation towards agemates. (p. 133)

The child rapist sex offenders differ from each other in terms of the type of attack they use in overpowering their victims. For example, the Anger dominated child rapist uses more physical force than is required to overpower the victim and generally batters the victim. The Power child rapist uses whatever threat or force is necessary to gain
control of the victim and overcome resistance. Often the victim is physically unharmed and whatever physical injury does occur is usually unintentional. For the Sadistic child rapist physical force, power, or anger is eroticized so that the victim is subjected to ritualized acts such as bondage or spanking or to torture and sexual abuse (Burgess et al., 1978; Groth & Birnbaum, 1979).

A second major taxonomy comes directly from the field of law enforcement by one of the most knowledgeable and highly regarded FBI officials, Kenneth V. Lanning, Supervisory Special Agent for the Behavioral Science Unit of the Federal Bureau of Investigation at the FBI Academy in Quantico, Virginia. After consulting on hundreds of cases in his work at the FBI Behavioral Science Unit and not finding a typology that fit law enforcement needs, he decided to develop his own. He expanded on the two broad categories posited by Dietz (1983) of situational vs. preferential sex offenders, the former being similar to Groth's regressed offender and the latter being similar to Groth's fixated offender.

Agent Lanning outlines seven sub-types of child molesters as follows:
He describes a situational child molester as not having a true sexual preference for children, but engages in sex with children for varied and sometimes complex reasons ... sex with children may range from a 'once-in-a-lifetime' act to a long-term pattern of behavior. The more long-term the pattern is, the harder it is to distinguish from preferential molesting. (p. 6)

The situational subtypes follow four different patterns. The regressed offender "usually has low self-esteem and poor coping skills; he turns to children as a sexual substitute for the preferred peer partner (p. 6)." For the morally indiscriminate offender, "the sexual abuse of children is part of a general pattern of abuse in his life. He is a user and abuser of people (p. 6)." The sexually indiscriminate offender "differs in that he appears to be discriminating in his behavior except when it comes to sex. He is the
'trysexual' - willing to try anything sexual (p. 7)." Finally, the inadequate offender "includes those suffering from psychoses, eccentric personality disorders, mental retardation, and senility. In layman's terms he is a social misfit, the withdrawn, the unusual (p. 7)."

 Preferential child molesters differ in that they do have a definite sexual preference for children (clinically they would fit the criteria for pedophiles). Lanning (1992) states

They have sex with children not because of some situational stress or insecurity but because they are sexually attracted to and prefer children ... their problem is not only the nature of the sex drive (attraction to children) but also the quantity (need for frequent and repeated sex with children). (p. 8)

The preferential sub-types follow three different patterns. The seduction offender "engages children in sexuality by 'seducing' them - courting them with attention, affection, and gifts (p. 8)." The introverted offender, is described as having "a preference for children but lacks the interpersonal skills necessary to seduce them ... he typically engages in a minimal amount of verbal communication with his victims and usually molests strangers or very young children (p. 8)." The sadistic offender is one who "has a sexual preference for children but who, in order to be aroused or gratified, must inflict psychological or physical pain or suffering on the child victim (p. 9)."

The third major taxonomy - The Child Molester Typology - comes out of a classification research program conducted at the Massachusetts Treatment Center in Bridgewater, Massachusetts by Raymond Knight and Robert Prentky from the Department of Psychology of Brandeis University in Waltham, Massachusetts. A diagram
(Knight & Prentky, 1990, fig. 2) (shown here as Figure 2.3) can illustrate the key elements of their taxonomy.
Figure 2.3: The child molester typology of Knight and Prentky
Their resulting multidimensional typology arranges the empirically derived types according to four factors. These include 1) the degree of fixation and 2) level of social competence (Axis I), as well as 3) the amount of contact with the child victim and 4) its meaning to the perpetrator (Axis II).

The fourth major taxonomy stands distinctly apart from others because it is based on the addiction model of behavior. Its originator, Patrick Carnes, has described four possible subpopulation parameters based on findings from his clinical work and the results of a nationwide survey of sex addicts. His groupings are summarized in the following figure (Carnes in Horton, 1990, p. 139):

![Venn Diagram](image)

1. the sexually addicted offender
2. the sexually addicted incest perpetrator
3. the incest perpetrator/ sex offender
4. the sexually addicted incest perpetrator/ sex offender

Figure 2.4: The sexual addiction model of Patrick Carnes
Carnes (in Horton, 1990) has identified the extent of physical and emotional abuse involved in the sexually addicted behavior as key factors in delineating between those individuals who are sexually addicted and either do or do not perpetrate sexual abuse. According to Carnes, those who are sexually addicted and who do perpetrate physical and emotional abuse tend to hold stronger dysfunctional beliefs and thought patterns, have more deeply rooted core beliefs of unworthiness and unlovability, use patterns of force in sexual compulsivity, and feel more despair and shame about their behavior.

Attempts to describe and classify sexual offenders are many and diverse. Each draws from and contributes its own view of the etiology of such behavior. A summary follows of the various theories of the etiology of sexual offending.

Theories of the Etiology of Sexual Offending

Not only is it crucial to know about the nature of the sexual offender, but it is equally important to understand how and why the abusive acts are committed. In reviewing models of sexual offending behavior and corresponding typologies, an intriguing trend becomes quite apparent. The formulation of models and typologies have developed somewhat independently depending on whether those involved have taken what could be called a "top down" or "bottom up" approach to understanding sex offenders and their behavior.

Top down models utilize pre-existing theoretical views of human behavior from the fields of counseling and psychology to explain the act of sexual offending in a
deductive fashion. Models emphasizing irrational thinking and cognitive distortions held by the sexual offender as being critical for the act to occur follow this path. Bottom up approaches have arisen in a more inductive fashion as the sexual offending behavior itself has been focused on and categorized according to variables that define an individual case, such as, age of the victim, the type of physical contact, and relationship of the perpetrator to the victim. Because neither approach alone appears to provide a comprehensive picture of the etiology of sexual offending behavior, researchers recently have called for the need to develop a more integrated and unifying theory to both explain sexual offending behavior and guide its research and treatment (Schwartz & Cellini, 1995; Marshall & Barbaree, 1989). This section will describe several of these models and their underlying theories in greater detail.

Biological Theories. Several theories suggest that sexually deviant behavior occurs due to genetic, instinctual, hormonal, physiological or neurological biological influences. A cluster of researchers have approached sexually aberrant behavior from the perspective of biological determination yet their postulations have taken many different forms. Aspects of such behavior have been attributed to various physiological factors including: a more primitive species (Caesare Lombroso as noted in Schwartz & Cellini, 1995), epilepsy or head injuries (Radzinowicz, 1957; Selling, 1942), various neurological disorders (Rosen, 1964), a psychosomatic disturbance resulting from a lack of early touching (Tauber 1975), Klinefelter's Syndrome and the XXY chromosome pattern (Schwartz & Cellini, 1995), familial history of pedophilia (Gaffney, Lurie & Berlin, 1984), and a hormonal imbalance (Rada, 1978). For example, the physiological model
(Abel et al., 1977; Quinsey et al., 1984) is based on greater levels of sexual arousal for sex offenders to rape stimuli than to consenting stimuli. Because of its greater emphasis on the physical aspects of arousal (e.g. increased testosterone levels), this model has led to the exploration of medical interventions such as hormonal treatments with the progestogen medication, Depo-Provera, and a greater assessment of the levels of arousal and their corresponding stimuli through the use of penile plethysmography.

Other biologically oriented views are based on the notion of natural selection claiming that deviant sexual behavior may result from adaptive attempts of the human species to survive. The sociobiological model (Ellis, 1989; Thornhill & Thornhill, 1983) views sexual aggression as an adaptive strategy of some males to ensure that their genetic heritage would survive and be passed on to ever-evolving generations. Clifford Allen (1940) and later Pinkava (1971) were proponents of "instinct theory" which is evolutionary in nature and based on animal research. This theory suggests that instincts can be altered by the environment. Sexual behavior is seen as the manifestation of sexual instincts trying to be satisfied. The frustration or mischanneling of these instincts is assumed to underlie sexual offending behavior.

Finally, sexually aggressive behavior is attributed by some as being the result of an underlying brain dysfunction. Langevin has summarized the literature related to sexual anomalies and the brain and concluded that sexually anomalous behavior appears linked to temporal lobe impairment.
Psychoanalytic Theories. Sigmund Freud (1938), in formulating his theory of psychosexual development with its delineation of stages, established the first comprehensive, psychological explanation of sexuality in humans. Fixation at any of these steps is considered to be the basis of sexual deviation as it results in the distortion of a sexual desire or sexual object. The psychoanalytic view of the structure of personality including three parts - the id, ego, and superego - has also been applied to the understanding of sexual deviancy. When the sexual impulses of the id are not able to be controlled by the poorly developed superego, sexually deviant thoughts are more easily manifested in behavior. Various specific psychoanalytic notions have been hypothesized as underlying sexual deviancy. Schwartz and Cellini (1995, p. 2-11) list these theoretical concepts and their proponents which include castration anxiety, reaction to a seductive mother, inadequate ego/ superego, reenactment of sexual trauma, confusion of aggressive and libidinal drives, and a narcissistic representation of self as child.

Ego psychology suggests that sexual deviations are produced by "an impairment of one of the ego functions (Schwartz & Cellini, 1995, p. 2-11)." These functions are seen as inborn processes and include: perception, thinking, recall, language, object comprehension, motor development and learning. These basic cognitive functions of the ego are important concepts relevant to understanding the behavior of sex offenders and providing for their effective treatment. For when these processing abilities are impaired, sexual deviancy may ensue. Ego psychology also provides the basic theory of object relations. Sex offending is an "interpersonal disorder" (Schwartz & Cellini. p. 2-12) and as such, treatment must take this into account.
Neurosis theory suggests that sexually deviant acts are part of a neurotic process in which personality development is disturbed in ways that leave the individual with intrapsychic conflicts and feelings of insecurity and inferiority. This is exemplified by Torbert's (1959) description of a pedophile as one who, "because of a sense of weakness, inadequacy, and low self-regard ... finds a solution for his tensions in identification with the physically weaker and emotionally less sophisticated child (p.278)."

**Interactional Theories.** Both relational theories and family theories consider the interactions between individuals as key to the development of sexually deviant behavior. Relational theories emphasize the critical role of relationships and their impact on individuals. Each person is changed by the contacts he or she has with others. The work of such theorists as Fromm, Kernberg, Khan, and Lichtenstein (Mitchell, 1988) has led to a consideration of sexual deviance from an interactional point of view.

Family theorists approach pathology in general and sexual deviancy specifically from an interactional perspective as well. Sexual offending behavior is considered as occurring within the context of a dysfunctional family system. The two major variations which have been posited differ according to whom the psychopathology is assigned. One camp represented by authors such as Bradshaw (1988), Miller (1990), Middleton-Moz and Dwinell (1986) see problems developing within the individual who ineffectively responds to a dysfunctional family system. The Family Systems theorists, on the other hand, take an opposing view. Prominent proponents Minuchin (1974), Haley (1980) and Satir (1983) conceptualize problems as occurring within the dynamic interactions of the family network rather than within individual members of the family. Incestuous
relationships are accounted for in this way.

*Cultural Theories.* The whole idea of what constitutes sexual deviance is highly variable across cultural groups. An anthropological approach reveals that a variety of sexual activities such as homosexual relations between adults and male children, marriage with prepubescent brides, or the use of senile men to enlarge the genitals of prepubescent females (Schwartz, 1995) are accepted and practiced in various different people groups around the world. Societal theories contend that sexual deviance is defined by the cultural environment and mores. Society plays a role in the learning of sexual deviance by fostering "certain beliefs (e.g., women want to be raped) or present material through the media (e.g., pornography, "slasher" films) that desensitizes or sexually arouses the audience to rape (Schwartz, 1995, p. 2-19)." Political theories further emphasize the importance of cultural roles and gender stereotypes in contributing to sexual deviance.

For example, Susan Brownmiller (1975) stated a feminist perspective on rape as a sexist act, saying, "men who commit rape have served in effect as front line terror guerrillas in the largest sustained battle the world has ever known" (p. 210). Gilgun (1988) summarized the essence of the cultural theories stating that

The sexual socialization of the female which connects love and commitment to sexual behavior discourages the self-centered drive for sexual conquest and gratification that male sexual socialization encourages. Thus socialization practices such as sexual socialization, socialization for parenting, and socialization for experiencing and expressing feelings inadvertently may be factors in the development of sexually abusive behaviors. (p. 228)
Behavioral Theories. Sexual deviation from the behavioral perspective is characterized by reinforced inappropriate arousal patterns which are the result of the operations of classical conditioning, operant conditioning and/or modeling. Each acquisition process can contribute to the learning of sexually deviant behavior just as it can to the learning of any other behavior. Laws and Marshall (1990) have discussed in great detail how these conditioning processes occur in the development of deviant sexual arousal. The simultaneous repeated pairing of two stimuli such as pornography with sexual arousal (classical conditioning) which becomes reinforced through masturbation (operant conditioning) constitutes learning. The more deviant the content of the pornography and the fantasies about it, the more sexually deviant the responses become. Modeling of sexually deviant behavior occurs when an individual witnesses others (whom he would tend to trust, follow and emulate) engaged in sexually deviant acts. These processes all act to reinforce the response to sexually deviant stimuli.

Cognitive-Behavioral Theory. The cognitive-behavioral view (Murphy, 1990; Pithers, 1990) moves its emphasis beyond simple arousal patterns and places it on the importance of individual cognitions within the temporal sequence of affect ➔ fantasy ➔ conscious plan ➔ behavior. This model considers thinking errors (Yochelson & Samenow, 1977) or cognitive distortions (Abel et al., 1984) as paramount to the establishing and promoting of sexual offending behavior. These cognitive-behavioral variations draw heavily on Bandura's (1977) social learning theory. Each deals with "the way individuals perceive (or misperceive) and attend to environmental cues, as well as the way they process information and the way each individual evaluates or misevaluates the consequences of
the behavior (Murphy, 1990, p.332)."

Addictions Theory. Deviant sexuality has also been accounted for from the perspective of an addictions oriented approach borrowed from the substance abuse field. Carnes (1991), in his 10-point definition of sexual addiction (see Appendix C), has applied such addiction theory to sexually deviant behavior. Sexually addicted behavior is seen as a pattern that is cyclical, compulsive and progressive. It becomes increasingly destructive moving from the use of pornography to misdemeanor crimes such as exhibitionism and obscene phone calls to the felony sex offenses of rape, child molestation, and incest. This pattern has its roots in a set of distorted beliefs arising from a dysfunctional family pattern. For example, sex addicts view sexual gratification as their most important need. Schwartz (1995) has summarized that it is "their only source of nurturance, the origin of their excitement, the remedy for pain, and their reason for being (p. 2-16)."

Multivariate Models. Multivariate models are characterized as "population-specific and multicausal (p.663)." This approach to describing sexual offending behavior is illustrated by the clinical classification system derived statistically which subtypes offenders on the basis of the levels of sexual and aggressive motivation as researched by Knight and Prentky (1990, see characteristics and classification section, pp. 20-22).

Integrative Models. The most recent theoretical developments in regard to sexual deviancy have attempted to provide a comprehensive understanding of its multiple factors through an integrational approach. Certain views have described the nature and etiology of sexual offenses from the vantage point of those precursors which predispose and/or
precipitate such behavior. Two key examples include the Quadripartite Model (Hall & Hirschman, 1991) and the theory based on specific preconditions (Finklehor, 1984). Hall & Hirschman (1991) in their pursuits of a theoretical description of sexual aggression toward women have accounted for the heterogeneity of sexual aggressors by the prominence of each of four etiological factors - physiological sexual arousal, cognitions that justify sexual aggression, affective dyscontrol, and personality problems. Subtypes of sexually aggressive offenders are defined according to the relative prominence of these motivational precursors. The authors also purport that the absence of any one of the four precursors would likely reduce the probability of such sexual offending behavior. They suggest that the assessment of these precursors would not only identify population subtypes, but give information that would contribute to making treatment more effective.

The extensive research of David Finklehor (1984) into the nature and extent of child sexual abuse led him to formulate the Preconditions Theory, a theoretical description, based on account histories, of the preconditions which "set the stage" for a sexual offense to occur. Each precondition or set of preexisting set of circumstances leaves every perpetrator with an unmet need. The sexual offending results in certain typical "payoffs" for the perpetrators. For example, the individual who is experiencing severe marital disturbance may turn to a minor to engage in sexual contact in order to receive a payoff of emotional acceptance, sexual gratification and/or tension release not currently being received within the marital relationship. The four preconditions include: 1) a motivation to abuse (e.g., symbolic mastery of a traumatic childhood sexual
experience), 2) justification for committing abuse (e.g., cognitive distortions such as "Most children would enjoy having sex with an adult, and it wouldn't harm the child in the future."), 3) little likelihood of getting caught (e.g., opportunities for an adult to be alone together with a child), and 4) the means to control the victim (e.g., trust between the victim and the offender or the use of threats).

A Cognitive - Affective - Behavioral description of the sexual offending pattern of child molesters has been developed by this present author based on clinical experience in conducting sex offender treatment. The following diagram (Figure 2.5) illustrates the various elements in the pattern. As the individual is presented with various challenges [Offense Antecedents] such as past victimization, low self-esteem, feelings of powerlessness and current stressors (e.g. financial difficulties or marital discord), they then experience emotional distress [Felt Need] such as anxiety and/or depression. This Felt Need against the backdrop of Offense Antecedents presents the individual with the Need for a Coping Response and a state of Tension results. In order to release this Tension, the offender follows the Path of Least Resistance - namely, external inhibitors are low, internal inhibitors are overshadowed by the Felt Need and a victim is available. Under these conditions the Sexual Offense takes place and a Tension Release is experienced. However, once the tension is released, the internal inhibitors are no longer overshadowed and the offender participates in Self-Denigration for the haneous acts he has just committed. This creates Reinforcement of the Offense Antecedents (e.g. low self-esteem and powerlessness) and sets the stage for the pattern to repeat itself.
Marshall and Barbaree (1990) have formulated an integrated theory of sexual deviancy which takes into account a wide range of contributing factors. These major components include: biological influences (e.g., an inherited capacity to sexually aggress, variations in hormonal functioning), negative childhood experiences (e.g., poor parenting), general cultural features (e.g., acceptance of interpersonal violence), availability of pornography, and transitory situational factors (e.g., intoxication, stressful circumstances).
Finally, Schwartz (1995) has developed an integrated theory of the dynamics of a sexual assault. It is based on the fundamental assumption (based on the author's extensive clinical experience) that any criminal act has two components: "a motive and a releasor that allows the motive to transcend personal and societal sanctions and be expressed" (p. 2-24). This theory is illustrated using the analogy of a dam (see Appendix D). The "motivational reservoir" is held back by "floodgates" or control factors. Several influences including stress, substance abuse, mental retardation, psychosis, brain damage, cognitive distortions, lack of empathy, pornography, and peer pressure can impair the individual's self-control. Once this dam has opened, some degree of motivation is unleashed. If the motivation is strong, the environmental barriers are weak (e.g., easy access to a potential victim) and the attributes of the victim are those desired and targeted, a sexual assault is able to be carried out. Situational and patterned offenders differ according the degree of impairment of their control systems. Situational offenders have an intact control system which has cracked or eroded under stress. However, patterned offenders have either extremely vulnerable controls, poorly developed controls, or controls which have been destroyed.

The wide array of theoretical views describing the nature and etiology of sexual offending has lead to an equally broad spectrum of treatment approaches. The following section will describe the variety of approaches which are used to treat sexual offenders.
Treatment Approaches

A recent national survey (Freeman-Longo et al., 1995) of treatment programs and models for sex offenders outlines 8 different treatment approaches which tend to have their moorings in preexisting theoretical expositions of human behavior. The survey outlines them as follows:

- Bio-Medical
- Cognitive/Behavioral
- Family Systems
- Psychoanalytic
- Psycho-Socio-Educational
- Psychotherapeutic (Sexual Trauma)
- Relapse Prevention (RP)
- Sexual Addiction

This alphabetical listing is comprehensive and each approach warrants a brief description of its own.

*Bio-Medical.* The survey (Freeman-Longo et al., 1995) defines this approach as "The primary emphasis is on the medical model, disease processes, with a major emphasis on treatment with medication (p. 27)." For example, antiandrogens (e.g., Depo Provera) are used for the suppression of sexual drive. This approach obviously requires the
involvement of a physician to prescribe the medications, hence it is not an overall psychotherapeutic treatment approach but rather an adjunct to other models. As a result, 0% of the survey respondents indicated that this approach (ranked 8th of 8) best defines the work they do.

Cognitive/Behavioral. The survey (Freeman-Longo et al., 1995) defines this approach as

A comprehensive structured treatment approach based on sexual learning theory using cognitive restructuring methods and behavioral techniques. Behavioral methods are primarily directed at reducing arousal and increasing pro-social skills. Peer groups and educational classes are employed. Draws from a variety of counseling theories. (p. 27)

About .5% of the survey respondents indicated that this approach (ranked 6th of 8) best defines the work they do. Three major approaches to cognitive factors (summarized by Murphy, 1989) which describe the role of cognitions in sexual abuse emphasize 1) cognitive distortions (drawn from the cognitive behavioral literature: see Abel et al., 1984, Murphy & Stalgaitis, 1987; Stermac & Segal, 1987), 2) attitudes supportive of rape (drawn from a more feminist perspective; see Herman, 1989), and 3) thinking errors (drawn from the criminological literature; see Yochelson & Samenow, 1977). In general, the cognitive processes as described by Bandura (1977) in his social learning theory underlie the cognitive/behavioral approach. Interventions used in this approach include: exploration of the cognitive-behavioral chain to identify high risk factors for reoffending, developing coping strategies for high risk situations, and cognitive restructuring of relevant cognitive distortions.
Family Systems. The survey (Freeman-Longo et al., 1995) defines this approach as "The primary emphasis is on family therapy and the inclusion of family members in the treatment process. Draws from a variety of counseling theories (p. 27)." 2% of the survey respondents indicated that this approach (ranked 8th of 8) best defines the work they do. This particular approach has obvious implications for use within incestuous families in particular and is based on the various family systems theories. Such theories include, among others, Structural Family Therapy (Minuchin, 1974) which places a heavy emphasis on interpersonal boundaries, or Strategic Family Therapy (e.g. Haley, 1963) which addresses power and control, for example, within the context of the client's conceptual framework. According to Haley, people inevitably engage in attempts to control the nature of their relationships. Sexual offending behavior is seen as such an attempt.

Psychoanalytic. The survey (Freeman-Longo et al., 1995) defines this approach as "The primary emphasis is on client understanding of the psychodynamics of sexually offending, usually through individual treatment sessions using traditional psychoanalytic principles (p. 27)." About .5% of the survey respondents indicated that this approach (ranked 7th of 8) best defines the work they do. Dissociative state therapy and hypnosis are examples of interventions used to address the unconscious motivations of the offender.

Psycho-Socio-Educational. The survey (Freeman-Longo et al., 1995) defines this approach as "A structured program utilizing peer groups, educational classes, and social skills development. Does not use behavioral methods. Draws from a variety of counseling theories..."
theories (p. 27)." 13% of the survey respondents indicated that this approach (ranked 2nd of 8) best defines the work they do. This approach retains a didactic emphasis, to address those areas deemed to be deficient (such as deficits in social skills, deviant or ignorant understanding of human sexuality, etc.). Assertiveness training, social skills training, and sex education are examples of interventions used in this approach.

**Psychotherapeutic (Sexual Trauma).** The survey (Freeman-Longo et al., 1995) defines this approach as

> The primary emphasis is on individual and/or group therapy sessions addressing the client's own history as a sexual abuse victim and its relationship to subsequent perpetration of others. Draws from a variety of counseling theories (p. 27)."

About 6% of the survey respondents indicated that this approach (ranked 3rd of 8) best defines the work they do. This approach attempts to reckon with the high prevalence, for sex offenders, of a history of sexual victimization against themselves by treating this underlying trauma such that perpetration is no longer necessary to gain control over what was lost in their own abuse.

**Relapse Prevention (RP).** The survey (Freeman-Longo et al., 1995) defines this approach as

> A three dimensional, multimodal approach specifically designed to help clients maintain behavioral changes by anticipating and coping with the problem of relapse. Relapse Prevention 1) teaches clients internal self-management skills, 2) plans for an external supervisory component, and 3) provides a framework within which a variety of behavioral, cognitive, educational and skill training approaches are prescribed in order to teach the sexual offender how to recognize and interrupt the chain of events leading to relapse. The focus of both assessment and treatment procedures is on the specification and modification of the steps in this chain,
The relapse prevention approach is by far the most used treatment approach. About 37% of the survey respondents indicated that this approach (ranked 1st of 8) best defines the work they do. It has its roots in social learning theory (Bandura, 1977) which established the constructs of social learning, the importance of appraisal (Lazarus, 1966) and the contribution of cognitions to behavior (Beck, 1976) and in the treatment of addictive disorders (Marlatt & Gordon, 1980). As outlined by George and Marlatt (1989), it focuses on 1) the determinants of relapse, 2) the covert antecedents of a relapse situation, 3) specific intervention techniques for high-risk situations, and 4) global lifestyle intervention techniques. The emphasis on specific changes being maintained is particularly important in light of the high reoffense rates of both untreated and treated sexual offenders (Furby et al, 1989). Written autobiographies are used to assess the relapse cycle. A relapse prevention plan including specific coping strategies for high risk situations and relapse contracts is developed.

Sexual Addiction. The survey (Freeman-Longo et al., 1995) defines this approach as "A structured program using peer groups and an addiction model. It often includes 12-Step and Sexual Addiction groups (p. 27)." About 1% of the survey respondents indicated that this approach (ranked 5th of 8) best defines the work they do. Its originator, Patrick Carnes (in Horton, 1990), describes it as

a model building on a common definition of alcoholism or drug dependency that states that a chemically dependent person has a pathological relationship with a mood-altering
chemical. In a similar manner, the sexual addict substitutes a sick relationship to sexual behavior for a healthy relationship with others ... (p. 128)

He goes on to outline the four core beliefs which are the foundation of sexual addiction:

- **Self-image** - I am worthless.
- **Relationship** - I cannot trust or rely on others to meet my needs.
- **Needs** - My needs can only be filled by sexual behavior.
- **Sexuality** - Sex is my most important need. (p. 130)

The addictive cycle includes various behaviors that form a pattern which includes different levels of addiction. Nuisance offenses (exhibitionism and voyeurism) comprise the second level of addiction (beyond socially acceptable behaviors such as masturbation). Incest, child molestation, and rape characterize the third and most severe degree of sexual addiction. Intervention focuses on dismantling the addictive cycle and utilizes involvement in groups such as SA (Sexaholics Anonymous) and AA (Alcoholics Anonymous).

As one can see, many theoretical formulations have been posited to explain (and treat) sexual offending behavior, and they cover a wide range of notions describing its nature and etiology which in and of itself gives testimony to the heterogeneous nature of the sex-offender population.

The diversity of these various approaches also gives rise to a host of treatment interventions. Freeman-Longo (1995), in his most recent survey of treatment programs and models, has listed 55 different treatment modalities (for adult offenders) ranging from victim empathy (the most used intervention - carried out by 94.5 % of the 1086 treatment
professionals, for adults, surveyed) to bodywork/massage therapy (the least used intervention - carried out by 2.5% of those who treat adult sex offenders). He has also listed 8 different psychopharmacological agents used in adult sex offender treatment. The most widely used drug is Prozac (utilized by 31.5% of treatment providers) and the Serotonin reuptake blockers rank lowest in usage at 12%.

Of the 8 treatment approaches used in the treatment of sex offenders, Relapse Prevention is the approach used most frequently by providers of child, juvenile, and adult sex offender treatment (Freeman-Longo et al., 1995, Table 4). Specific treatment modalities related to the RP approach are used very frequently (Freeman-Longo et al., 1995, Table 5C). These focus on victim empathy (94.5% of programs working with adult offenders address this), cognitive distortions (91%), relapse cycle (88%), relapse prevention plan (83.5%), and relapse contract (53.5%)

It is clear that treatment operating from the Relapse Prevention (RP) approach is the most widely used intervention for sex offenders. With its key components 1) the cognitive-behavioral chain, 2) lifestyle factors, 3) cognitive distortions, 4) skill deficits, and 5) deviant arousal patterns, the RP approach is widely applicable. Miner et al. (1990) in describing RP state that

intervention takes the form of aiding the offender in identifying situations that put him at risk, teaching more effective decision-making, challenging self-serving cognitions, and teaching more effective coping skills. (p. 167,168)

They add that the Sex Offender Treatment And Evaluation Project (SOTEP), a leading program for sex offenders based on the RP approach, involves treatment that is
multifaceted, focusing on such issues as deviant sexual arousal, social skills, sexual knowledge and attitudes, stress and anger management, and substance abuse. These issues are integrated within the context of high risk elements, coping skills and cognitive set. (p. 168) Relapse Prevention posits that offending is the result of risk factors that can be classified in three major categories: Cognitive distortions that allow the offender to deny responsibility for his offending and non-offending behaviors; deviant sexual arousal; and a lack of adequate coping skills. (p. 170)

State of the Research to Date

Research up to this point in time has encompassed a wide variety of emphases reaching more broadly than they do deeply. Nearly all the major theoretical schools of thought have been applied to the understanding of sexual offending, yet relatively few consistent findings have emerged from the research studies which have been conducted.

Highlights from the research to date reveal the following key findings. In a very extensive review of the research on incestuous fathers, Williams and Finklehor (1989) draw several noteworthy conclusions regarding incestuous fathers. They frequently have difficulties in empathy, nurturance and caretaking. Many lack social skills and experience social isolation. Approximately one fifth of the incest offenders have histories of themselves being sexually abused, and even more have a history of physical abuse. Also, quite common is other parental maltreatment, particularly rejection by fathers. General sexual arousal to children is seen in a fifth to a third of these perpetrators, and a pattern of low sexual arousal to, or even disgust with, normal adult sexual partners is even more
In the area of child molestation, in general, while the research efforts are broad in scope, the findings are not yet as well synthesized as for the subgroup of incestuous fathers. Lanyon (1986) in his review of the state of current knowledge on child molestation shares several key conclusions. The research has disproved three widely held beliefs about child sexual abusers. First, he has noted that molesters are not typically "dirty old men" stating "Indeed, the molester is most commonly a respectable, otherwise law-abiding person, who may escape detection for that very reason. Furthermore, the median age of first offense is reported to be as young as 16 (p. 177)." Second, he has pointed out that most molestation is done by adult men who are not strangers, known and often related to the victim. Third, he has concluded that allegations of sexual abuse are rarely fabricated. He also added that plasma testosterone levels were within normal limits, and mental retardation, senility, and other brain pathology have not been determined to be relevant factors.

With regard to the frequency of child molestation occurring, Lanyon has noted that "in view of the definitional problems and the secrecy surrounding this disorder, estimates of frequency from direct reports are generally believed to be serious underestimates (p. 177)." The best estimates to date suggest that sexual abuse is likely to occur for 1 in 3 females and 1 in 6 males by the age of 18 (Hopper, 1997).
Lanyon (1986) has also summarized what is known about the personality and psychopathology of child molesters and concluded that the current extensive clinical psychoanalytic literature has generated many ideas to explore about the etiology of child molestation, however "No consistent findings emerge... except to support the view that molesters' sexual identification is not significantly feminine and that they tend to be somewhat more shy, passive, and unassertive than average (pp. 178-179)." They are frequently found to have some degree of social difficulty. However, this may simply be due to the fact that those molesters studied have been caught and perhaps the more socially skilled ones have eluded detection.

The most widely used RP model among others supports the importance of cognitions in sexual offending behavior. While cognitive distortions are heavily focused on in treatment, they have received relatively little attention in research on sex offenders (Lanyon, 1986). Abel et al. (1989) noted that by 1989 only one experimental investigation of child molesters' cognitive distortions had been completed. However, in that same article they report on an investigation of their own into the measurement of the cognitive distortions of child molesters. They developed the Abel and Becker Cognition Scale (Abel, Becker, et al., 1984), one of the first scales made to measure distortions in child molesters. The 29-item questionnaire assesses the acceptance or rejection of common cognitive distortions of child molesters which the authors derived from their clinical experience evaluating hundreds of child molesters. Items are scored on a 5-point Likert scale according to the client's indication of their degree of agreement with the statements. Following are sample items from that scale:
2. A man (or woman) is justified in having sex with his (her) children or step-children, if his wife (husband) doesn't like sex.

10. Most children 13 (or younger) would enjoy having sex with an adult, and it wouldn't harm the child in the future.

25. The only way I could do harm to a child when having sex with her (him) would be to use physical force to get her (him) to have sex with me.

They assessed the cognitive distortions of 240 child molester paraphiliacs, 48 non-child molesting paraphiliacs, and 86 non-paraphiliacs. It was concluded that child molesters do report beliefs and attitudes that are dramatically different from those of non-child molesters, suggesting that the normalization of these faulty cognitions may be an integral part of the successful treatment of child molesters. (p. 147)

Overall, several weaknesses exist in the literature about child molesters. First, the lack of clear and universal definitions (those which are not limited by differences between those disciplines involved which include: medicine, psychiatry, psychology, social work, forensics, law, criminal justice, corrections and rehabilitation) has made communication about these problems somewhat confusing and inconsistent. For example, the legal nomenclature applied to sexually deviant behavior varies greatly from that of a clinical orientation (e.g., gross sexual imposition vs. incest). Likewise, little collaboration among the various disciplines involved in dealing with the perpetration of sexual abuse has occurred. This has resulted in a rather disjointed literature base which suggests that "the
right hand doesn't know what the left hand is doing" at times. Third, and perhaps in
response to the fragmented information base, only one review article has been written
regarding child molestation. Fourth, many of the available research studies have been
criticized for their lack of sound methodology. Examples include: small sample sizes,
unchecked response bias, and the tendency to view sexually deviant behavior as a
univariate phenomenon. The "single lens" views offered by the purist theoretical
orientations have led much of the research to be narrow and limited in its focus. This has
often resulted in a homogenous treatment and consideration of a heterogeneous
population. Fifth, whether subjects participate on a voluntary or involuntary basis is not
always well considered or documented. Sixth, a lack of reliable and valid assessments
aimed specifically at evaluating sexual offenders is yet to be overcome. Seventh, few
replication studies have been undertaken in this area and are needed in order to verify and
establish the truth of what is involved in sexual offending from a research rather than
clinical standpoint. This leads to an eighth weakness which is that treatment accordingly
is nearly exclusively theory based rather than research based.

These weaknesses give rise to a multitude of important questions needing further
investigation. Of relevance to this present study, it is clear that there is a need to assess
and identify the coping strategies (or their deficits) used by sex offenders. The importance
of cognitive distortions and their restructuring are well documented and critical to the
treatment process. However, virtually no research has been done in the area of the
specific coping strategies used by sex offenders which would likely be the target of
modification. Specific questions to explore include
1) In what ways do child molesters try to cope with stressful situations (as such stress could lead to a relapse into sexually offending again)?

2) Do the ways child molesters try to cope vary according to their offender type?

3) Do their styles of coping vary according to the levels of anxiety, depression and/or cognitive distortion they experience?

4) How much do the factors of anxiety, depression and cognitive distortion (which are considered relevant clinically) contribute to the coping style of child molesters?

5) Do the perpetrators' degree of anxiety or depression vary according to offender type?

Such questions direct the focus of this study.

The Focus of This Study

The intent of this study is to focus on identifying descriptive information about the coping styles utilized by child molesters and the interactive effects of these styles with 1) the cognitive distortions, and 2) the affective state (anxiety or depression, in this case) of those offenders. Each of these could be considered critical variables in sexual offending. In order to achieve this end, two samples of known child molesters (including both situational and preferential offenders in each) will be evaluated. The assessment will objectively identify their dominant coping styles, specific cognitive distortions, and levels of anxiety and depression and explore possible significant relationships among these variables. Findings of this nature would contribute to the base of knowledge about sex offenders (child molesters in particular) and aid treatment professionals in isolating and addressing some key variables, which when captured and responded to could improve
both the efficiency and effectiveness of intervention with this population. Such an effect
could result in reducing offending and reoffending and thereby help check this tragic
epidemic.

Summary

Despite an inclination to view sex offenders as all alike, a host of characteristics
of various types of offenders have been suggested clinically and many have been explored
through various types of research. These pursuits have led to the need for and exploration
of classification systems to delineate various subgroupings of this heterogeneous
population.

Several theories have been put forth to explain the etiology of sexual offending. However, not until recently has their synthesis or integration been attempted in order to
establish a unified theory based on all that is known about sex offenders to date.

Treatment approaches for sexual offenders are many and varied according to their
corresponding theoretical (or in some cases, atheoretical) underpinnings. By far the most
widely espoused approach is Relapse Prevention which exemplifies a cognitive-
behavioral orientation to intervention.

In reviewing the literature on sexual offenders, it quickly becomes clear that
much is not certain about sexual offenders and their behavior. A great number of
hypotheses regarding sexual offending behavior have been posited but relatively few have
been investigated to any large degree and virtually no replication studies have been
undertaken. So what is concluded at the present time as this field is in its infancy needs to
be viewed cautiously and tentatively, reviewed carefully, and researched more fully. All of the variables noted previously need be tested out with sufficient methodological techniques and scientific rigor to identify more precisely what we know about this broad population and its critical need to be understood and treated. As stated by Quinsey (1995) "Because sex offenders are heterogeneous even within categories defined by offense history, sex offender treatment programs should be organized so as to take account of these differences (p. 6)." A full understanding of the etiology of sexual offending is essential for the establishment of effective treatment so as to be able to reduce, if not ameliorate sexual offending behavior and the devastation it causes in the lives of the victims, the perpetrators, and those closely associated with each of them as well as society at large.
CHAPTER 3

METHODOLOGY

Research Approach

This chapter describes the research methodology and corresponding statistical procedures used in this study. First, the instruments used and the rationale for their selection are described. Second, the process of obtaining the data from the sample is explained. Finally, the procedures for analyzing the data are reported.

The type of research conducted was correlational-predictive thereby exploring the extent of significant relationships between the relevant variables which were examined.

Selection of Instruments

This study sought out descriptive information regarding the coping styles and corresponding affect (anxiety and depression) and cognitions of both situational and preferential convicted child molesters. The specific coping style (dependent variable) was identified as were the anxiety level, depression level, cognitive distortions held and...
offender type (independent variables). In order to assess each of these variables, the following instruments were selected:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>anxiety ( (X_1) )</td>
<td>State-Trait Anxiety Inventory</td>
</tr>
<tr>
<td>depression ( (X_2) )</td>
<td>Beck Depression Inventory</td>
</tr>
<tr>
<td>cognitive distortions ( (X_3) )</td>
<td>Abel and Becker Cognitions Scale</td>
</tr>
<tr>
<td>coping styles ( (Y) )</td>
<td>Coping Inventory for Stressful Situations</td>
</tr>
</tbody>
</table>

Each of the instruments and the rationales for their use are described below.

*State-Trait Anxiety Inventory - Form Y* (Spielberger, 1983). The State-Trait Anxiety Inventory - Form Y (STAI) is a 40-item self-report measure of anxiety. It is comprised of two subtests (20 items each) one of which assesses state-anxiety and the other trait-anxiety. Responses to its multiple choice items indicate the degree and frequency of specific feelings held. The STAI is by far the most widely used measure of anxiety. It was normed on a variety of groups including prisoners. The technical merit of the STAI is sound as it rates highly for reliability and validity. The reported alpha coefficients for reliability among the normative samples described in the manual range from .86 to .95 (median = .93) for state anxiety, and from .89 to .91 (median = .90) for trait anxiety. The manual also reports research findings which provide evidence to support the concurrent, convergent, divergent, and construct validity of the STAI scales.
The STAI is scored by summing the responses across the two subsections (state and trait) to arrive at one total score for anxiety. The level of severity for these scores was assigned using the following cutoffs:

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 - 80</td>
<td>MILD</td>
</tr>
<tr>
<td>81 - 120</td>
<td>MODERATE</td>
</tr>
<tr>
<td>121 - 160</td>
<td>HIGH</td>
</tr>
</tbody>
</table>

These ranges correspond with the response intervals established in the questionnaire. For example, answering with a 1 (the indicator of the lowest level of anxiety) on all items would result in a total score of 40. Answering with a 2 on all items would result in a total score of 80. Hence the first range, from 40 - 80 would constitute a mild level of anxiety. The second and third ranges are delineated in the same way according to the higher responses of a 3 or a 4.

*Beck Depression Inventory - Second Edition* (Beck, 1996). The Beck Depression Inventory - Second Edition (BDI-II) is a 21-item multiple choice self-report measure for the assessment of depression. Each of the items corresponds to a specific category of depressive symptom and/ or attitude. The BDI-II has a proven history of usefulness in both clinical work and in research. Its sound reliability and validity as well as its ease of use and applicability across a wide variety of situations have made it the inventory of choice for the assessment of depression. The reported alpha coefficients for reliability among the normative samples described in the manual were .92 and .93, and the test-retest correlation based on a subsample was .93 as well. The manual also reports research
findings which provide evidence to support the content, construct, and factorial validity of the BDI-II scale.

The BDI-II is scored by summing the individual responses into one total score for depression. The level of severity for these scores is predetermined using criteria from the test manual as follows:

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 13</td>
<td>MINIMAL</td>
</tr>
<tr>
<td>14 - 19</td>
<td>MILD</td>
</tr>
<tr>
<td>20 - 28</td>
<td>MODERATE</td>
</tr>
<tr>
<td>29 - 63</td>
<td>SEVERE</td>
</tr>
</tbody>
</table>

Abel and Becker Cognitions Scale (Abel, Becker, et al., 1984). The Abel and Becker Cognitions Scale (ABCS), one of the first scales made to measure distortions in child molesters, is a 29 - item self-report questionnaire which assesses the degree of acceptance or rejection of common cognitive distortions of child molesters which the authors derived from their clinical experience evaluating hundreds of child molesters. Items are scored on a 5 - point Likert scale according to the client's indication of their degree of agreement with the statements. Answers are given for two conditions: 1) the offenders' current thinking, and 2) the offenders' thoughts before others became aware of their deviant sexual behavior. As it is not a standardized instrument, but rather a clinical questionnaire, no investigation into its reliability or validity has been done.

This measure as used in the field and reported in the literature has no scoring procedure but rather is used descriptively. The results are used on an item by item basis to
inform clients about their thinking errors and confront them about what they need to change. However, for this study, individual scores were summed to obtain one total score. Distortion level cutoffs were established by collapsing the responses into one of two possible categories -either distorted (responding with a “1” for strongly agree or “2” for agree) or not distorted (responding with a “3” for neutral, a “4” for disagree or a “5” for strongly disagree.

*Coping Inventory for Stressful Situations - Adult Version* (Endler & Parker, 1990). The Coping Inventory for Stressful Situations - Adult Version (CISS) is a 48-item retrospective self-report measure of multidimensional coping designed to identify one of four facets: task-oriented, emotion-oriented and two avoidance-oriented: distraction and social diversion coping styles. Unlike many other coping measures, it has been demonstrated to be both reliable and valid. The reported alpha coefficients for reliability among the normative samples described in the manual range from .87 to .92 on the Task scale, .82 to .90 on the Emotion scale, .76 to .85 on the Avoidance scale, .69 to .79 on the Distraction subscale, and .74 to .84 on the Social Diversion subscale test-retest correlations conducted over a six-week period with an additional sample ranged from .51 to .73 across the subscales. The manual also reports research findings which provide strong evidence to support the multidimensionality and construct validity of the CISS scales.

The CISS is scored by totaling the responses on the self-scoring answer sheet according to the 4 subsets they are divided into which delineate the 4 separate coping styles and arriving at a single score for each style. The scale with the highest score was 55.
determined to be the predominant coping style. In the event of a tie, the scale deemed more dysfunctional (Emotion or Avoidance over Task or Emotion over Avoidance) was selected since the more dysfunctional aspects would be the important focus in treatment.

Setting

The settings, from which subjects were obtained, included both a state correctional institution and an outpatient public community mental health center each located in small Midwestern cities.

Sample

The sample for this study included two groups of convicted child molesters. One group (n=135) was comprised of subjects who were inmates in a medium security state correctional institution with a population of slightly more than 2200 inmates. Approximately 500 of them had convictions for sexual crimes. The other group (n=19) consisted of subjects involved in treatment in an outpatient sex offender treatment program at a community mental health center. The incarcerated sample was obtained by the institution’s psychology supervisor (who also directs the sex offender treatment program housed there) posting notices for all inmates to see and also making announcements to inmates currently in the sex offender treatment program which invited anyone who has committed a sexual offense to come and hear about the research and participate in the study if they would like. A total of 175 inmates came to hear about the research and 135 of them (77%) chose to participate.
The outpatient sample was obtained by the therapists for the sex offender treatment program allowing the research to be presented by the investigator in the sex offender treatment groups and making it possible for clients to choose to participate. A total of 25 clients (from a population of approximately 30 clients involved in one of five treatment groups) were present to hear about the study and 19 of them (76%) chose to participate.

Procedure

Meeting with the investigator in groups, subjects were introduced to the research and asked to sign a consent form to insure their voluntary participation in this study. After hearing what the investigation would involve, those who chose to participate were each asked to anonymously complete a Participant Information Form which solicited demographic information as well as information about the nature of their offending. Participants were given verbal instructions and answered questions to help in completing this form. They were then asked to complete the assessment instruments which included the State-Trait Anxiety Inventory - Form Y, the Beck Depression Inventory - Second Edition, the Abel and Becker Cognitions Scale, and the Coping Inventory for Stressful Situations - Adult Version. To ensure consistent administration across the 11 different group sessions and facilitate the understanding of directions and items for those whom reading was difficult, the 4 instruments were administered by audio tape in accordance with oral instructions given in the test manuals. Anonymity was maintained by numerically coding each subject's set of questionnaires with the same number instead of
identifying the protocols by name. Participants were given a card with their corresponding code number on it to refer to in order to find out their results in a follow-up interpretation and feedback session. Responses and scores were compiled in a database and from which statistical analyses were conducted. The SAS (1992) statistical package running on an IBM 3090 Model 600J processor was used to identify descriptive and correlational information about the variables which were assessed.
CHAPTER 4

ANALYSIS OF THE DATA

The following table (Table 4.1) illustrates the elements of analysis for this study and the types of analyses applied to examine these data as well. It includes demographic information, scale scores and potential relationships examined between the dependent variable of the predominant coping style and the dependent variables of offender type, anxiety level, depression level, and the degree of cognitive distortions held.
<table>
<thead>
<tr>
<th>Research domain</th>
<th>Data element</th>
<th>Analysis/ Statistic used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preliminary analysis</td>
<td>- demographic information</td>
<td>N, range, mean, frequency mean, standard deviation</td>
</tr>
<tr>
<td>(descriptive)</td>
<td>- scale scores</td>
<td>mean, standard deviation</td>
</tr>
<tr>
<td></td>
<td>- scale reliabilities</td>
<td>alpha coefficient</td>
</tr>
<tr>
<td></td>
<td>- correlation of 7 scales</td>
<td>intercorrelation matrix</td>
</tr>
<tr>
<td>Primary analysis</td>
<td>distribution of coping styles</td>
<td>frequency distribution, chi square</td>
</tr>
<tr>
<td>(inferential)</td>
<td>(research question #1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>coping style x cognitive distortion</td>
<td>chi square, item analysis</td>
</tr>
<tr>
<td></td>
<td>(research question #2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>coping style x affective states</td>
<td>chi square</td>
</tr>
<tr>
<td></td>
<td>(anxiety and depression)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(research question #3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>coping style x offender type</td>
<td>MANOVA, descriptive data</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>coping style x anxiety, depression,</td>
<td>multiple regression</td>
</tr>
<tr>
<td></td>
<td>cognitive distortion, and offender</td>
<td></td>
</tr>
<tr>
<td></td>
<td>type (research question #5)</td>
<td></td>
</tr>
</tbody>
</table>

Table 4.1 Overview of the analyses conducted as part of this study.

Preliminary Analysis

In examining the demographic characteristics of the subjects, several types of information were obtained. After eliminating those whom had adult victims only, the final sample described here was comprised of 128 subjects. Adjusting for missing data, the final results for each analysis are hereby listed with their corresponding subject counts (n).
Specific findings about the subjects include their age, ethnicity, educational level, marital status at the time of their offending, time served in jail or prison for their sexual offending crimes, length of time in sex offender treatment, the number of types of sexually deviant behaviors they engaged in, the number of offenses they committed, the age of their victims, their number of victims, their relationship to the victims, their sexual preference by age and gender, and the duration of their offending.

The current age of the subjects ranged from 19 to 67 with the average age being approximately 39 (mean(\(\bar{x}\)) = 38.79, n = 120).

The ethnicity of the subjects was slightly more than half Caucasian with the next largest grouping at slightly more than one third being African-American. Table 4.2 illustrates the ethnic distribution.

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Number of subjects</th>
<th>Percentage of sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>70</td>
<td>56%</td>
</tr>
<tr>
<td>Black</td>
<td>44</td>
<td>35.2%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7</td>
<td>5.6%</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>0.8%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>2.4%</td>
</tr>
</tbody>
</table>

Table 4.2: Ethnicity of subjects (n = 125).
The overall educational level of the subjects was relatively high. Only one individual had no formal education and one completed 6th grade. All others completed 7th grade or above (see Table 4.3).

<table>
<thead>
<tr>
<th>Highest level of education completed (# of years)</th>
<th>Number of subjects</th>
<th>Percentage of sample</th>
<th>Cumulative percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>1</td>
<td>0.8%</td>
<td>0.8%</td>
</tr>
<tr>
<td>8</td>
<td>1</td>
<td>0.8%</td>
<td>1.6%</td>
</tr>
<tr>
<td>9</td>
<td>4</td>
<td>3.2%</td>
<td>4.8%</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>4.8%</td>
<td>9.6%</td>
</tr>
<tr>
<td>11</td>
<td>13</td>
<td>10.5%</td>
<td>20.1%</td>
</tr>
<tr>
<td>12</td>
<td>57</td>
<td>46.0%</td>
<td>66.1%</td>
</tr>
<tr>
<td>13</td>
<td>15</td>
<td>12.1%</td>
<td>78.2%</td>
</tr>
<tr>
<td>14</td>
<td>16</td>
<td>12.9%</td>
<td>91.1%</td>
</tr>
<tr>
<td>15</td>
<td>4</td>
<td>3.2%</td>
<td>94.3%</td>
</tr>
<tr>
<td>16</td>
<td>5</td>
<td>4.0%</td>
<td>98.3%</td>
</tr>
<tr>
<td>17</td>
<td>1</td>
<td>0.8%</td>
<td>99.1%</td>
</tr>
<tr>
<td>18</td>
<td>1</td>
<td>0.8%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 4.3: Educational level of the subjects (n = 124).
For the subjects (n = 126) at the time of their offenses, approximately half of them were married (48.4%), slightly more than one third were single (38.1%) and the rest were either divorced (11.1%) or widowers (2.4%).

For the total group of subjects (n = 123) the time served in jail and/or prison for their sexual offenses varied greatly. While some have served no time at all (minimum = 0), others have served many years (maximum = 30 years and 7 months). The average length of time served was just over 5 years (x̄ = 5 years, 1 month and 18 days).

While on average the subjects have received 5 years of punishment, many have received treatment for much less time than that. As illustrated in Table 4.4, the length of time in treatment ranges from none at all up to 10 years with half (49.6%) of subjects (n = 125) being in treatment for 18 months or less.
<table>
<thead>
<tr>
<th>Time in treatment</th>
<th>Number of subjects</th>
<th>Percentage</th>
<th>Cumulative percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>none</td>
<td>4</td>
<td>3.2%</td>
<td>3.2%</td>
</tr>
<tr>
<td>1 - 3 months</td>
<td>12</td>
<td>9.6%</td>
<td>12.8%</td>
</tr>
<tr>
<td>4 - 6 months</td>
<td>13</td>
<td>10.4%</td>
<td>23.2%</td>
</tr>
<tr>
<td>7 - 9 months</td>
<td>9</td>
<td>7.2%</td>
<td>30.4%</td>
</tr>
<tr>
<td>8 - 12 months</td>
<td>14</td>
<td>11.2%</td>
<td>41.6%</td>
</tr>
<tr>
<td>13 - 18 months</td>
<td>10</td>
<td>8.0%</td>
<td>49.6%</td>
</tr>
<tr>
<td>19 - 23 months</td>
<td>16</td>
<td>12.8%</td>
<td>62.4%</td>
</tr>
<tr>
<td>2 - 3 years</td>
<td>28</td>
<td>22.4%</td>
<td>84.8%</td>
</tr>
<tr>
<td>4 - 5 years</td>
<td>16</td>
<td>12.8%</td>
<td>97.6%</td>
</tr>
<tr>
<td>6 - 10 years</td>
<td>3</td>
<td>2.4%</td>
<td>100%</td>
</tr>
<tr>
<td>&gt; 10 years</td>
<td>0</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 4.4: Length of time in treatment (n = 125).

Since sex offenders may participate in a wide range of sexually deviant behaviors, subjects were asked to identify what specific types of these behaviors they have committed. The specific types of behaviors included: voyeurism, exhibitionism, obscene phone calls, fondling the victim outside of the clothing, fondling the victim inside of the clothing, penetrating the victim with an object, having the victim penetrate them with an object, performing oral sex on the victim, having the victim perform oral sex on them, vaginal intercourse, and anal intercourse. It was found that the subjects (n = 126)
admitted to participating in a minimum of one type of behavior and as many as seven
different types with an average being between two and three ($\bar{x} = 2.52$).

The total number of offenses that the subjects ($n = 126$) admitted to committing
was 2,169. This occurred with 187 different victims. The average number of offenses
committed by a single offender was approximately 18 ($\bar{x} = 17.87$) and ranged from 1 to
400. The average number of victims for each offender was between 1 and 2 ($\bar{x} = 1.47$)
and ranged from a single victim for some up to as many as 8 different victims. These
reported numbers are likely to be somewhat less than actual occurrences for two reasons.
First, any tendency towards responding with socially acceptable answers might lead to
the actual number of offenses to be minimized or even denied altogether. Second, a few
subjects responded to the question about how many offenses they committed of each
deviant behavior type with a written response of “many” instead of a number. Since it
could not be determined how many “many” was referring to, the response was coded as a
single offense in order to avoid inflating the data by guessing a larger number.

The age of the subjects ($n = 127$) victims ranged from infants to late adolescents
(see Table 4.5). Just over two thirds of the victims were between the ages of 6 and 13.
<table>
<thead>
<tr>
<th>Age of victim</th>
<th>Number of victims</th>
<th>Percentage of victims</th>
<th>Cumulative percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 12 months</td>
<td>1</td>
<td>.005%</td>
<td>.005%</td>
</tr>
<tr>
<td>1 - 5 years</td>
<td>20</td>
<td>10.70%</td>
<td>10.705%</td>
</tr>
<tr>
<td>6 - 9 years</td>
<td>65</td>
<td>34.80%</td>
<td>45.505%</td>
</tr>
<tr>
<td>10 - 13 years</td>
<td>65</td>
<td>34.80%</td>
<td>80.305%</td>
</tr>
<tr>
<td>14 - 17 years</td>
<td>31</td>
<td>16.58%</td>
<td>96.885%</td>
</tr>
<tr>
<td>18 + years</td>
<td>5</td>
<td>2.67%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>187</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.5: Ages of the victims for all subjects (n = 127).

The relationship between the subjects and their victims are illustrated in Table 4.6. Nearly two thirds of the victims (61.97%) were related to the perpetrator in some way and approximately one third (33.10%) more knew their offenders yet were not related to them. Only approximately 5% of the victims did not know their perpetrators.
<table>
<thead>
<tr>
<th>Relationship</th>
<th>Number of victims</th>
<th>Percentage of victims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Known / related:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>daughter</td>
<td>23</td>
<td>16.20%</td>
</tr>
<tr>
<td>son</td>
<td>3</td>
<td>2.11%</td>
</tr>
<tr>
<td>step-daughter</td>
<td>29</td>
<td>20.42%</td>
</tr>
<tr>
<td>step-son</td>
<td>8</td>
<td>5.63%</td>
</tr>
<tr>
<td>other relative child</td>
<td>25</td>
<td>17.61%</td>
</tr>
<tr>
<td>Known / not related</td>
<td></td>
<td></td>
</tr>
<tr>
<td>child in your care</td>
<td>19</td>
<td>13.38%</td>
</tr>
<tr>
<td>child acquaintance</td>
<td>28</td>
<td>19.72%</td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>child stranger</td>
<td>7</td>
<td>4.93%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>142</strong></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.6: Relationship of the victims to their offenders (n = 127).
The reported sexual preference of the subjects was primarily heterosexual and oriented to adult peers as seen in Table 4.7.

<table>
<thead>
<tr>
<th>Sexual preference</th>
<th>Age / gender of choice</th>
<th>Number of subjects</th>
<th>Percentage of subjects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>by age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>younger children</td>
<td>8</td>
<td>6.35%</td>
</tr>
<tr>
<td></td>
<td>(0 - 13 yrs. old)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>adolescents</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(14 - 17 yrs. old)</td>
<td>8</td>
<td>6.35%</td>
</tr>
<tr>
<td></td>
<td>adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(18 yrs. old and up)</td>
<td>110</td>
<td>87.30%</td>
</tr>
<tr>
<td></td>
<td>by gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>male</td>
<td>8</td>
<td>6.50%</td>
</tr>
<tr>
<td></td>
<td>female</td>
<td>113</td>
<td>91.87%</td>
</tr>
<tr>
<td></td>
<td>male and female</td>
<td>2</td>
<td>1.63%</td>
</tr>
</tbody>
</table>

Table 4.7: The subjects’ sexual preference by age (n = 126) and gender (n = 123).

The extent of the sexual offending by the subjects was also determined by looking at over how long a period of time they engaged in these behaviors. Approximately ¾ (75.7%) committed their offenses for one year or less and ¼ (24.3%) continued to offend for more than one year. The duration of their offending is noted in Table 4.8.
<table>
<thead>
<tr>
<th>Length of time</th>
<th>Number of subjects</th>
<th>Percentage of subjects</th>
<th>Cumulative percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 6 months</td>
<td>64</td>
<td>59.81%</td>
<td>59.81%</td>
</tr>
<tr>
<td>7 - 12 months</td>
<td>17</td>
<td>15.89%</td>
<td>75.70%</td>
</tr>
<tr>
<td>13 - 23 months</td>
<td>13</td>
<td>12.15%</td>
<td>87.85%</td>
</tr>
<tr>
<td>2 - 5 years</td>
<td>13</td>
<td>12.15%</td>
<td>100%</td>
</tr>
<tr>
<td>&gt; 5 years</td>
<td>0</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 4.8: Duration of the offending behaviors occurring (n = 107).

The descriptive statistics related to the scores for each of the scales used in the research were computed on all of the subjects (those with both child and adult victims) whose data set were complete across all elements. The results of these analyses are summarized in Table 4.9. The average anxiety score (STAI \( \bar{x} = 78.16 \)) is relatively low as the possible range is 40 to 160 and a total of 80 would result from endorsing all items as sometimes true overall and somewhat true at the present time. This score is also somewhat less than a prison inmate norm group (total \( \bar{x} = 90.60 \)).

The average depression score (\( \bar{x} = 15.91 \)) falls into the mild level which ranges from 14 to 19. This degree of severity falls in between the averages of the two norm groups listed in the manual (college student sample (\( \bar{x} = 12.56 \)) and outpatient sample (\( \bar{x} = 22.45 \))).
The average cognitive distortion score ($\bar{x} = 129.71$) is an overall total that would result if all items were endorsed between disagree (total would be 116) and strongly disagree (total would be 145). For this study, neutral, disagree and strongly disagree responses were considered as not indicating cognitive distortion. The item scores were considered to constitute distortion only if they answered strongly agree or agree. Endorsing the cognitive distortions would result in a score of 58 or less. Therefore, the total score appears to suggest an absence of cognitive distortion for the offenders. However, further analysis (described in the primary analysis section to follow) at the item level reveals considerable endorsement of cognitive distortion.

The average scores for the CISS scales can be interpreted in terms of T scores and percentile ranks. The average Task score ($\bar{x} = 59.31$) would be equal to a T-score of 50 and place it in the 50th percentile in comparison with the adult male norm group reported in the manual. This score would be considered average. The average Emotion score ($\bar{x} = 48.46$) would be equal to a T-score of 58 and place it in the 79th percentile. This score would be considered slightly above average. The average Avoidance score ($\bar{x} = 47.83$) would be equal to a T-score of 60 and place it in the 84th percentile. This score would also be considered slightly above average. The average Distraction score ($\bar{x} = 21.54$) would be equal to a T-score of 58 and place it in the 79th percentile. This score would also be considered slightly above average. The average social diversion score ($\bar{x} = 7.36$) would be equal to a T-score of 34 and place it at the 6th percentile. This score would be considered much below average.
<table>
<thead>
<tr>
<th>Scale / (Variable measured)</th>
<th>N</th>
<th>Mean</th>
<th>Standard deviation</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAI (Anxiety)</td>
<td>138</td>
<td>78.16</td>
<td>22.49</td>
<td>27</td>
<td>148</td>
</tr>
<tr>
<td>BDI-II (Depression)</td>
<td>138</td>
<td>15.91</td>
<td>9.66</td>
<td>2</td>
<td>47</td>
</tr>
<tr>
<td>ABCS (Cognitive Distortion)</td>
<td>138</td>
<td>129.71</td>
<td>13.94</td>
<td>81</td>
<td>145</td>
</tr>
<tr>
<td>CISS: (Coping Style)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>137</td>
<td>59.31</td>
<td>11.50</td>
<td>26</td>
<td>79</td>
</tr>
<tr>
<td>Emotion</td>
<td>136</td>
<td>48.46</td>
<td>11.50</td>
<td>22</td>
<td>74</td>
</tr>
<tr>
<td>Avoidance</td>
<td>136</td>
<td>47.83</td>
<td>9.96</td>
<td>27</td>
<td>78</td>
</tr>
<tr>
<td>Distraction</td>
<td>136</td>
<td>21.54</td>
<td>6.15</td>
<td>8</td>
<td>40</td>
</tr>
<tr>
<td>Social Diversion</td>
<td>136</td>
<td>7.36</td>
<td>4.66</td>
<td>7</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 4.9: Descriptive statistics for the individual scale scores.

The scale reliabilities computed using Cronbach’s alpha to test for internal consistency are reported in Table 4.10 and indicate that the obtained scale scores are highly reliable. It is particularly worthy to note that the finding of such high reliability for the ABCS (while not the intended focus of this study) provides strong support for this
instrument as a consistent measure - validation which has not previously been established and reported about this assessment tool.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Cronbach coefficient alpha for raw variables</th>
<th>Cronbach coefficient alpha for standardized variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAI</td>
<td>.96</td>
<td>.96</td>
</tr>
<tr>
<td>BDI-II</td>
<td>.88</td>
<td>.89</td>
</tr>
<tr>
<td>ABCS</td>
<td>.92</td>
<td>.94</td>
</tr>
<tr>
<td></td>
<td>.97</td>
<td>.97</td>
</tr>
<tr>
<td>CISS:</td>
<td>.90</td>
<td>.91</td>
</tr>
<tr>
<td>Task</td>
<td>.85</td>
<td>.85</td>
</tr>
<tr>
<td>Emotion</td>
<td>.80</td>
<td>.80</td>
</tr>
<tr>
<td>Avoidance</td>
<td>.75</td>
<td>.75</td>
</tr>
<tr>
<td>Distraction</td>
<td>.78</td>
<td>.78</td>
</tr>
<tr>
<td>Social Diversion</td>
<td>.78</td>
<td>.78</td>
</tr>
</tbody>
</table>

Table 4.10: Actual scale reliabilities testing for internal consistency.

To determine if the instruments used in this study did measure distinct variables, an examination of the intercorrelation matrix for the 7 scales (STAI, BDI-II, ABCS, CISS - task, CISS - emotion, CISS - avoidance (distraction) and CISS - avoidance (social diversion)) was completed. As shown in Table 4.11, the correlations between scales were low to moderate overall. Those correlations closest to redundancy were between anxiety and depression (.78), between avoidance and distraction (.84), and avoidance and social diversion.
diversion (.72). Had the depression and anxiety score exceeded the .80 cutoff they could have been combined as one scale or either one could have been eliminated due to concern for multicollinearity. Some effect of multicollinearity may be occurring but tolerance levels indicate there is not singularity. The higher correlation between avoidance and its two subscales, distraction and social diversion would be expected as they are related concepts by their very design. Overall, the instruments did, in fact, measure distinctly different variables.

<table>
<thead>
<tr>
<th></th>
<th>Anx</th>
<th>Dep</th>
<th>Distor</th>
<th>Task</th>
<th>Emot</th>
<th>Avoid</th>
<th>Distra</th>
<th>S. Div</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Depression</td>
<td>0.777</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Distortion</td>
<td>-0.287</td>
<td>-0.438</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Task</td>
<td>-0.218</td>
<td>-0.115</td>
<td>0.177</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Emotion</td>
<td>0.569</td>
<td>0.581</td>
<td>-0.385</td>
<td>-0.115</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Avoidance</td>
<td>0.089</td>
<td>0.167</td>
<td>-0.270</td>
<td>0.383</td>
<td>0.169</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Distraction</td>
<td>0.209</td>
<td>0.269</td>
<td>-0.398</td>
<td>0.097</td>
<td>0.284</td>
<td>0.845</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social Diversion</td>
<td>-0.129</td>
<td>-0.077</td>
<td>0.062</td>
<td>0.546</td>
<td>-0.104</td>
<td>0.720</td>
<td>0.278</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 4.11: Intercorrelation matrix for the 7 scales used in this study.

Primary Analysis

Research question #1 which asked "what coping styles are most prevalent among child molesters?" was answered by compiling a frequency distribution of the different coping styles and then testing for significance by using the chi square statistic. The resulting data (see Table 4.12) note that there were large differences in the frequencies of
the styles with the majority of offenders (68%) endorsing the task oriented style and another fourth (25.4%) choosing the emotion oriented style. A goodness of fit chi square analysis for a single variable (coping style) indicated that the differences in the frequencies of these coping styles did not occur by chance ($\chi^2 (3) = 137.0164, p< .005$).

<table>
<thead>
<tr>
<th>Coping style</th>
<th>Frequency</th>
<th>Percent</th>
<th>Cumulative frequency</th>
<th>Cumulative percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task oriented</td>
<td>83</td>
<td>68.0</td>
<td>83</td>
<td>68.0</td>
</tr>
<tr>
<td>Emotion oriented</td>
<td>31</td>
<td>25.4</td>
<td>114</td>
<td>93.4</td>
</tr>
<tr>
<td>Avoidance:</td>
<td>7</td>
<td>5.7</td>
<td>121</td>
<td>99.2</td>
</tr>
<tr>
<td>distraction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>social diversion</td>
<td>1</td>
<td>0.8</td>
<td>122</td>
<td>100.0</td>
</tr>
</tbody>
</table>

$\chi^2 (3) = 137.0164, p< .005$

Table 4.12: Frequency distribution of coping styles (n = 122).

Research question #2 which asked "do the coping styles used by child molesters vary according to the level cognitive distortion?" was unable to be tested due to the finding of a substantial lack of different levels of distortion among the data with which comparisons could be made. It was found that only 2 subjects had summed scores on the ABCS which fell into the overall range of dysfunctional cognition (all answers being either a 1 (strongly agree) or 2 (agree) endorsing the cognitive distortions). However, in spite of this lack of an overall finding, further analysis of item frequencies (as noted in Table 4.13) does reveal that specific distortions are still held by many subjects.
<table>
<thead>
<tr>
<th>Item #</th>
<th># (% of subjects endorsing this item)</th>
<th>Item #</th>
<th># (% of subjects endorsing this item)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>43 (35.54)</td>
<td>15</td>
<td>3 (2.48)</td>
</tr>
<tr>
<td>13</td>
<td>31 (25.62)</td>
<td>21</td>
<td>3 (2.48)</td>
</tr>
<tr>
<td>27</td>
<td>21 (17.36)</td>
<td>23</td>
<td>3 (2.48)</td>
</tr>
<tr>
<td>6</td>
<td>11 (9.09)</td>
<td>29</td>
<td>3 (2.48)</td>
</tr>
<tr>
<td>25</td>
<td>10 (8.26)</td>
<td>4</td>
<td>2 (1.65)</td>
</tr>
<tr>
<td>14</td>
<td>9 (7.44)</td>
<td>10</td>
<td>2 (1.65)</td>
</tr>
<tr>
<td>18</td>
<td>9 (7.44)</td>
<td>12</td>
<td>2 (1.65)</td>
</tr>
<tr>
<td>28</td>
<td>8 (6.61)</td>
<td>17</td>
<td>2 (1.65)</td>
</tr>
<tr>
<td>1</td>
<td>5 (4.13)</td>
<td>22</td>
<td>2 (1.65)</td>
</tr>
<tr>
<td>3</td>
<td>4 (3.31)</td>
<td>2</td>
<td>1 (0.83)</td>
</tr>
<tr>
<td>5</td>
<td>4 (3.31)</td>
<td>20</td>
<td>1 (0.83)</td>
</tr>
<tr>
<td>9</td>
<td>3 (2.48)</td>
<td>7, 8, 11, 16, 24, 26</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

Table 4.13: Frequency count of item endorsement on the ABCS (n = 121).

Clinically significant trends appear when the content of the items endorsed at a certain levels is examined. For example, the items endorsed 2nd, 3rd and 4th most often (13, 27 and 6) all indicate either ignorance or more likely denial of potential long term consequences for victims of having been sexually abused. They read as follows:

13. An adult can tell if having sex with a young child will emotionally damage the child in the future.
27. An adult can know just how much sex between him (her) and a child will hurt the child later on.
6. Sex between a 13-year old (or younger child) and an adult causes the child no emotional problems.
This would support the importance of educating offenders about the impact of their deviant behavior on their victims. On the other hand, the lack of any endorsement of items 8, 11 and 24 (which all suggest that the abuse is seen as positive and desirable by the child) raise a concern for cognitive distortion in a different way. They read as follows:

8. If I tell a young child (step-child or close relative) what to do sexually and they do it, that means they will always do it because they really want to.

11. Children don’t tell others about having sex with a parent (or other adult) because they really like it and want it to continue.

24. If a child has sex with an adult, the child will look back at the experience as an adult and see it as a positive experience.

If the offenders do not see their victims as liking the abusive sexual behavior but do it anyway, then they clearly place their desires above the well-being of their victims. Countering this self-serving pattern by instilling empathy for the victim (which is currently the most frequently used treatment intervention) appears to be well worth continuing to emphasize in treatment.

Research question # 3 asked "do the coping styles used by child molesters vary according to the level of the specific affective states of anxiety and depression?" In other words, do the coping styles used by child molesters tend to differ depending on the level of the independent variables of anxiety and depression? This was answered using the chi square test for significance. Tables 4.14 and 4.15 show each of these sets of results respectively.
For the relationship between coping style and anxiety, it was found to be significant ($\chi^2 (4) = 18.938, p < .001$) that as the level of anxiety increases from mild to moderate, the frequency of offenders having a task oriented style (64%) decreases to 36% and those with an emotion oriented style (32%) increases to 52%. The avoidance style shows no appreciable correspondence with anxiety level.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
<th>Row Pct</th>
<th>Col Pct</th>
<th>MILD</th>
<th>MODERATE</th>
<th>HIGH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task</td>
<td></td>
<td></td>
<td></td>
<td>48</td>
<td>27</td>
<td>0</td>
<td>75</td>
</tr>
<tr>
<td>oriented</td>
<td>42.11</td>
<td>23.68</td>
<td>0.00</td>
<td>65.79</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>64.00</td>
<td>36.00</td>
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$\chi^2 (4) = 18.938, p < .001$

Table 4.14: Relationship between coping style and anxiety level.
Table 4.15: Relationship between coping style and depression level.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>MINIMAL</th>
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<th>MODERATE</th>
<th>SEVERE</th>
<th>Total</th>
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<td>7.44</td>
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<td>19.35</td>
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<td>26.09</td>
<td>57.14</td>
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<td>4</td>
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<td>1</td>
<td>2</td>
<td>1</td>
<td>7</td>
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<tr>
<td></td>
<td>2.48</td>
<td>0.83</td>
<td>1.65</td>
<td>.083</td>
<td>5.79</td>
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<tr>
<td></td>
<td>42.86</td>
<td>14.29</td>
<td>28.57</td>
<td>14.29</td>
<td>5.79</td>
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<tr>
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<td>5.45</td>
<td>3.45</td>
<td>8.70</td>
<td>7.14</td>
<td>5.79</td>
</tr>
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<td></td>
<td>45.45</td>
<td>23.97</td>
<td>19.01</td>
<td>11.57</td>
<td>100.00</td>
</tr>
</tbody>
</table>

χ² (6) = 10.963, p< .090

As can be seen, the alpha criterion level of .05 was not met for the relationship between coping style and depression (χ² (6) = 10.963, p< .090). Consequently the null hypothesis must be retained and the observed differences noted in Table 4.15 could be the result of chance for this sample.

Research question # 4 which asked "do the coping styles of child molesters vary according to their offender type (either situational or preferential)?" was unable to be answered due to the fact that the sample included nearly all situational offenders as determined by their self-report. The adult male sample endorsed being very highly oriented towards adults (n = 110) and not younger children (n = 8) or adolescents (n = 8)
in terms of sexual preference by age. The subjects were also reported being far more heterosexual in their orientation with 113 preferring females, 8 preferring males, and 2 preferring both males and females. In addition, slightly more than half engaged in sexual offending behavior for 6 months or less. These factors combined suggest that the sample is comprised of nearly all situational offenders and very few preferential offenders thereby precluding any comparative analysis of the two groups based on the self-report information given.

Research question #5 which asked "what relative influence do the variables of anxiety, depression, cognitive distortion, and offender type have on the coping styles of child molesters?" was answered by using Multiple Regression analysis. The variable of offender type was eliminated from the regression analysis as it was found to have only one level and therefore lacked any variability to measure. The equation for the full model was

\[ Y = \alpha + b_1X_1 + b_2X_2 + b_3X_3 \]

Four multiple regression equations (one for each of the four coping styles) were computed to examine the relationships between the dependent variable of coping style (Y) and the independent variables of anxiety (X₁), depression (X₂) and cognitive distortion (X₃). The resulting data are summarized in Tables 4.16 - 4.19. As the theoretical basis for these analyses was exploratory, the variables had no clear precedence over one another, and therefore were entered simultaneously into the regression equations. In all four equations the residuals were random and therefore did not violate the assumptions necessary to compute a multiple regression analysis.
### Table 4.16: Summary of regression analysis for variables predicting a task-oriented coping style (n = 111).

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>Standard error</th>
<th>T</th>
<th>Prob &gt; T</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>-0.1748</td>
<td>0.0756</td>
<td>-2.311</td>
<td>0.0228*</td>
<td>-0.3327</td>
</tr>
<tr>
<td>Depression</td>
<td>0.3553</td>
<td>0.1850</td>
<td>1.920</td>
<td>0.0575†</td>
<td>0.2979</td>
</tr>
<tr>
<td>Cognitive Distortion</td>
<td>0.1914</td>
<td>0.0872</td>
<td>2.196</td>
<td>0.0302*</td>
<td>0.2278</td>
</tr>
</tbody>
</table>

simultaneous entry of independent variables

$R^2 = 0.0780$  \( \text{Adjusted } R^2 = 0.0524 \) \( df = 3 \)  \( F = 3.047 \)  \( \text{Prob } > F = 0.0319 \)

* = significant (p < .05)
† = approaching significance

For the regression analysis computed on the independent variables to predict a task-oriented coping style, the obtained $R^2$ value was approximately .08. As this statistic was significant ($F = 3.047, p<.03$) it can be said with a 95% chance of being accurate that the variables of anxiety level, depression level, and level of cognitive distortion account for 8% of the variance in predicting a task-oriented coping style. As shown by the Beta coefficients, which indicate the relative effect of each independent variable on the dependent variable, anxiety ($\beta = -0.33$) inversely contributes more to predicting a task-oriented coping style than does cognitive distortion ($\beta = 0.22$).
For the regression analysis computed on the independent variables to predict an emotion oriented coping style, the obtained $R^2$ value was approximately .35. As this statistic was significant ($F = 18.925, p < .0001$), it can be said with a 95% chance of being accurate that the variables of anxiety level, depression level, and level of cognitive distortion account for 35% of the variance in predicting an emotion oriented coping style.

As shown by the Beta coefficients, which indicate the relative effect of each of the independent variables (which are either significant or approaching significance) on the dependent variable, depression ($\beta = .30$) contributes more to predicting an emotion oriented coping style than anxiety ($\beta = 0.24$) and cognitive distortion ($\beta = -0.17$) inversely contributes to a lesser degree.

<table>
<thead>
<tr>
<th>Variable</th>
<th>b</th>
<th>Standard error</th>
<th>T</th>
<th>Prob &gt; T</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>0.1185</td>
<td>0.0603</td>
<td>1.966</td>
<td>0.0519†</td>
<td>0.2396</td>
</tr>
<tr>
<td>Depression</td>
<td>0.3357</td>
<td>0.1476</td>
<td>2.275</td>
<td>0.0249*</td>
<td>0.2990</td>
</tr>
<tr>
<td>Cognitive Distortion</td>
<td>-0.1333</td>
<td>0.0699</td>
<td>-1.906</td>
<td>0.0593†</td>
<td>-0.1676</td>
</tr>
</tbody>
</table>

simultaneous entry of independent variables
$R^2 = 0.3467$   Adjusted $R^2 = 0.3283$   $df = 3$   $F = 18.925$   $\text{Prob} > F = 0.0001$

* = significant ($p < .05$)
† = approaching significance

Table 4.17: Summary of regression analysis for variables predicting an emotion oriented coping style (n = 111).
Table 4.18: Summary of regression analysis for variables predicting an avoidance: distraction coping style (n = 111).

For the regression analysis computed on the independent variables to predict an avoidance: distraction coping style, the obtained $R^2$ value was approximately .19. As this statistic was significant ($F = 8.227$ $p < .0001$), it can be said with a 95% chance of being accurate that the variables of anxiety level, depression level, and level of cognitive distortion account for 19% of the variance in predicting an avoidance: distraction oriented coping style. The Beta coefficients indicate the only cognitive distortion ($\beta = -0.37$) contributes significantly to this variance and does so inversely.
As the $R^2$ value of the regression analysis for variables predicting an avoidance: social diversion coping style was not significant at the .05 level ($F = .842$, $p < .47$), the obtained findings could be the result of chance and therefore no conclusions can be drawn about the independent variables contributing to an avoidance: social diversion coping style.

Table 4.19: Summary of regression analysis for variables predicting an avoidance: social diversion coping style ($n = 111$).
CHAPTER 5

SUMMARY AND RECOMMENDATIONS

The field of sex offender treatment would benefit greatly from knowing the coping styles sex offenders tend to use. This information could help effectively direct treatment by letting providers know what responses need to be changed to other more appropriate options and what responses need to be maintained and reinforced. The results of this study begin to shed some light on this important area for convicted child molesters.

To understand the findings it is critical to put them into the context from which they were obtained. The sample was not selected randomly but rather it was a purposeful sample to which access could be gained. Therefore, the results cannot be generalized to the entire target population of sex offenders (specifically child molesters), but instead can be viewed in an exploratory way.

Access to this population is particularly difficult for several reasons. First, no offenders are likely to come forth in public and volunteer to participate as an offender in research. Therefore, they are only able to be found in the confidential or controlled
settings of treatment facilities and penal institutions. Obtaining data in these settings requires satisfying essential safeguards to insure confidentiality, anonymity, and humane treatment. Such safeguards are repeated among the different systems (mental health and corrections). For this study alone, the protocol had to be approved by the human subjects review committees of this university and the department of rehabilitation and correction and further approved by the prison's warden and the mental health center's executive director. These factors made it prohibitive to collect additional data for this study as these procedures would have to be repeated for each new data site considered. Future research in this area will require coordination of these systems so as to eliminate the duplication of these review processes for each new time and location thereby making it possible to access a greater number of subjects. A second key note regarding access to potential subjects is the fact that sex offenders, once located, may still be reluctant or unwilling to participate for fear of divulging sensitive information and being suspicious of possible legal and emotional repercussions. With these potential deterrents at work, the resulting sample size with its 76% / 77% participation rate of those informed about the study is noteworthy. This appears to have been facilitated by two factors: 1) the trustworthy reputations of the treatment professionals who facilitated the data collection, and 2) the investigator being made known to the subjects. Further facilitating these factors could increase the level of participation in future research. All in all, while this sample is not statistically representative of child molesters as a whole, it is a good approximation under these circumstances and can be considered for preliminary investigation.
This sample was found to be a younger middle-age group with a nearly 2 to 1 ratio of Whites to Blacks included. Approximately 4/5 of them had received education through 12th grade or beyond. At the time of their offenses, nearly one half of the men were married while the other half were single, divorced or widowed. The average length of time served as punishment for their crimes was just over 5 years but ranged widely from none at all to over 30 years. The actual offenses perpetrated included a variety of specific types of behaviors and occurred with alarming frequency ranging from a single offense to as many as 400 offenses for a single subject! On average, each subject had between 1 and 2 victims but up to as many as 8 separate victims were perpetrated by a single child molester. While the ages of the victims ranged from infancy through late adolescence, over 2/3 were between the ages of 6 and 13. Over 95% of the offenders knew their victims and almost 62% of them were related to their victims in some way. The reported sexual preference of these adult male perpetrators was almost totally oriented towards adult females, thereby suggesting that if their responses were truthful, these men were likely to be situational offenders. Further refining the identification of subjects’ sexual preference and not relying solely on their own report would be important in the future. Other instruments such as the Bem Sex-Role Inventory or the MMPI-2 Masculinity - femininity scale as well as clinical records could be utilized to gain a more definite understanding of the sexual orientation of the subjects. Actual abuse of their victims took place over one year or less for over 75% of the offenders.

A look at the preliminary analyses reveals that the results obtained are highly reliable with scale alpha coefficients ranging from .80 to .97 for the full scales and .75 to
.78 for the subscales. These figures indicate that the instruments consistently measured the subjects responses.

A total of 128 convicted child molesters completed 4 different instruments to assess the variables of anxiety, depression, cognitive distortion, and coping style. Average scores for anxiety were found to be relatively low and average depression scores were found to fall in the mild range. Item analysis did reveal a considerable amount of cognitive distortions endorsed. Coping style scores were generally average to slightly above average except social diversion which was much below average.

The resulting data also reveal that there were significantly large differences in the frequencies of the coping styles with the majority of offenders (68%) endorsing the task oriented style and another fourth (25.4%) choosing the emotion oriented style. For the relationship between coping style and anxiety level, a significant difference was found indicating that as the level of anxiety increased from mild to moderate, the frequency of child molesters having a task oriented style (64%) decreased to 36% and those with an emotion oriented style (32%) increased to 52%. This finding however, may be suspect as the chi square analysis had expected counts of less than 5 for 56% of the cells. The avoidance style shows no appreciable correspondence with anxiety level. No significant relationship was detected between coping style and level of depression. Also, while the total cognitive distortion levels were found to be elevated for only two subjects and therefore their relationship to coping style could not be evaluated as a whole score, many subjects still endorsed specific individual cognitive distortions. Multiple regression analyses revealed significant low to moderate coefficients explaining the portion of the
variance of each coping style and the predictor variables of anxiety, depression, and cognitive distortion. It was found that anxiety and cognitive distortion levels were inversely related to endorsing a task oriented style and depression was not a significant contributor.

In viewing some of these key results, it is important to consider their application towards sex offender treatment. First, it could be helpful to assess coping styles as part of a sex offender evaluation. Since it has been noted that a task oriented coping style is more functional and been found that higher anxiety levels tend to be more associated with an emotion oriented style, treatment could be facilitated by knowing which of these two styles is preferred. It could help clients move towards more task oriented coping by reduce their anxiety levels (e.g. through stress reduction, relaxation training, etc.). Focusing on identifying and eliminating specific cognitive distortions, as well, would likely help child molesters such as these move towards a more task oriented style and decrease their potential risk for reoffending. Considering the endorsement of one or a series of ABCS items would provide critical information to address in treatment. Use of the ABCS for identification of cognitive distortions would be advisable for all sex offenders. Simply making the individuals aware of their coping style would better equip them to understand their response tendencies allowing them to know what changes could be made to improve their coping ability. Understanding the relationship between their anxiety level, cognitive distortions and coping style could only add to the arsenal of information for combating the pressures which could set the stage for relapse.
This preliminary information provides both some clues as to how to direct
treatment and points to some important questions to consider for further exploration. For
example, would these same results be found for a more representative sample of
offenders? Would the coping styles of preferential offenders be similar? Do the coping
styles of those convicted child molesters differ from others who have not been caught?
Do the coping styles vary differently with extremely high levels of anxiety or depression?
Do certain styles correspond with specific cognitive distortions? If anxiety levels were to
be changed through treatment could overall coping styles be altered as a result?

These questions and a host of others remain to be explored. Here are some to
consider. Studies to replicate these findings on a larger, more representative sample
would be important. Comparative studies between child molesters, rapists and the normal
population could indicate how similar or different their respective coping styles would be
and facilitate their change. Comparing each style for the child molesters with various
demographic variables such as socioeconomic status to detect any correlations would also
assist treatment providers in tapering the treatment to the clients according to these
different characteristics. Identifying what coping style was used at the time of offending
to see if it differs from the offenders overall tendencies to respond to stressful situations
could be very revealing. Finally, input solicited from the offenders regarding their
recognition and understanding of their coping styles as compared to their assessed results
could give some indication as to their levels of minimization, denial, and self-
understanding - all critical aspects of sex offender treatment.
Other types of analysis of this and/or additional data could possibly shed some further light on the nature of sexual offending. For example, exploring the relationships among pairs of the various scales as illustrated in the intercorrelation matrix might reveal some important connections between these factors which contribute to the occurrence of sexual offending and thereby provide clues as to what aspects of coping need to be emphasized in the treatment of individual offenders. Either continuing with a qualitative trend analysis of the items on the ABCS to determine how the items cluster or computing a factor analysis on these items to see how they would be delineated into distinct categories would also provide much needed insight into the nature of the subjects’ cognitive distortions and point to specific themes to address in treatment.

Perhaps most importantly, further research would need to assess and attempt to minimize any response bias especially one of “fake good” on the part of the offenders in order to substantiate its findings. This could be accomplished by administering instruments such as the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), the Fear of Negative Evaluation Scale (Watson & Friend, 1969), or the MMPI-2 with its lie and “fake good” scales to identify any such manipulative response set.

While this study has barely scratched the surface of the possibilities of inquiry, it appears to have pricked better understanding of some of the key elements of sex offender treatment considered herein, and perhaps begun to build a foundation (albeit rudimentary) upon which to build further research aimed at treating the perpetrators of the traumatic and epidemic reality of the sexual abuse of children.
APPENDIX A

Lifestyle Characteristics*

Lifestyle characteristics are those behaviors which, taken together, comprise an individual lifestyle or pattern of personality. Offenders frequently have personality dysfunction as defined below, although variably in intensity and pervasiveness.

Each category is defined by behavioral characteristics:

- **Antisocial** - "crooked" and deviant characteristics
- **Narcissistic** - self-centeredness and entitlement
- **Borderline** - instability in emotions, relationships, and other life areas
- **Schizoidal** - alienation and isolation in relationships
- **Obsessive - Compulsive** - rigid control and compulsions.

Antisocial behavioral characteristics:

1. exploitive (takes advantage of others)
2. cheats (use of trickery, acts dishonestly)
3. lies (purposefully and wholly untruthful statements)
4. deceives others (deliberate concealing/ hiding the truth; intentionally misleading)
5. distorts information (through omission, adding to facts, or embellishment)
6. secrecy
7. slyness/ slick
8. operates on hidden agendas/ motives
9. history of conning
10. displays phoniness
11. disowns behavior
12. history of cruelty towards others
13. currently displays cruelty
14. history of sadistic behavior
15. current display of sadistic behavior
16. destructive
17. impulsive behavior
18. recklessness
19. victimizes others
20. lacks remorse for victims
21. lacks victim empathy
22. unstable work history
23. nonconforming, breaks rules and/or laws
24. lacks social interest
25. lacks loyalty in relationships
26. lacking in close friendships or manipulates friendships
27. projects blame onto victim for antisocial acts
28. uses religiosity as a cover-up

Narcissistic behavioral characteristics:

1. grandiose fantasies
2. "me first" attitude/ behavior
3. attitude of superiority
4. brags and exaggerates about accomplishments
5. egotistical (inflated sense of self-worth)
6. stuck-up or snobbish
7. exaggerated sense of self-importance
8. distorted sense of entitlement
9. unrealistic expectations
10. displays self-pity ("poor me" attitude)
11. is overly concerned by and overly reactive to criticism
12. inconsiderate of others
13. self-centered
14. grandiose behaviors
15. envious
16. strives for control through power
17. pleasure seeking behaviors
18. demanding
19. fears situations where his/ her deficiencies will become known to others
20. uses religiosity to enhance "good person image"

Borderline behavioral characteristics:

1. unstable lifestyle
2. seeks immediate gratification
3. poor impulse control (especially in sexual behavior and substance abuse)
4. repeated suicidal ideation/ threats/ gestures/ attempts
5. unstable, inconsistent, and/ or intense relationships
6. marked intense moodiness with mood shifts
7. emotionally unstable
8. dependency
9. over-attachment to others
10. enmeshed relationships
11. vacillates between over-idealizing and devaluing others
12. possessiveness
13. jealousy
14. unstable/vacillating self-image and self identity
15. sensitivity to, or fear of, real or imagined abandonment
16. fears situations wherein his/her thinking and behavior will become known and result in shame

Schizoidal behavioral characteristics:

1. displays flat/restricted affect
2. avoids people
3. develops superficial relationships
4. isolates self
5. alienates/distances others
6. emotionally withdrawn
7. unaware of feelings
8. lacks social skills
9. tends to prefer solitary activities
10. strong emotions experienced covertly
11. indifferent to praise
12. is covertly concerned by, and overly reactive to criticism
13. difficulties with reciprocating non-verbal emotional expression
14. few, if any, close friends

Obsessive-compulsive behavioral characteristics:

1. controls passively through feigned capitulation, dependency, or inadequacy
2. controls actively through perfectionism as an evasion
3. insistent and persistent about his/her beliefs and rituals
4. overly fastidious
5. ruminates on matters which are discomforting
6. obsessively engages in fantasy
7. avoids mistakes by perseveration or indecisiveness
8. ambivalent toward feelings of others
9. black-white thinking
10. expects any loss of control to result in extreme embarrassment or foolish appearance
11. behavior used to procrastinate
12. inherent conflicts between goals and methods used for attainment
13. covertly defiant, vindictive, spiteful towards others
14. reacts poorly to constructive criticism
15. repeated engaging in appetitive/addictive behaviors which have caused harm to self or others
16. uses religiosity as a means of self-absolution

## APPENDIX B

### Immediate Precursors to Sexual Aggression*

<table>
<thead>
<tr>
<th>Precursor</th>
<th>Rapists</th>
<th>Pedophiles</th>
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<td>Anger</td>
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<td></td>
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<tr>
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<td>3</td>
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<tr>
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<tr>
<td>Generalized, global</td>
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<td>Anger towards women</td>
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<td>Anxiety</td>
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<td>Assertive skills deficit</td>
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<td>23</td>
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<tr>
<td>Boredom</td>
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<td>Cognitive distortions</td>
<td>72</td>
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<td>Compulsive overworking</td>
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<td>8</td>
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<td>Depression</td>
<td>3</td>
<td>38</td>
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<tr>
<td>Deviant sexual fantasies</td>
<td>17</td>
<td>51</td>
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<tr>
<td>Disordered sexual arousal pattern</td>
<td>69</td>
<td>57</td>
</tr>
<tr>
<td>Divorce</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Driving car alone without destination</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>Emotionally inhibited/ overcontrolled</td>
<td>58</td>
<td>51</td>
</tr>
<tr>
<td>Interpersonal dependence</td>
<td>30</td>
<td>48</td>
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<tr>
<td>Low self-esteem</td>
<td>56</td>
<td>61</td>
</tr>
<tr>
<td>Low victim empathy</td>
<td>61</td>
<td>71</td>
</tr>
<tr>
<td>Opportunity (e.g., finding a hitchhiker)</td>
<td>58</td>
<td>19</td>
</tr>
<tr>
<td>Peer pressure</td>
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<td>3</td>
</tr>
<tr>
<td>Personal loss</td>
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<td>14</td>
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<td>Photography as new hobby</td>
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<tr>
<td>Physical illness</td>
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<td>6</td>
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*Note: Percentage of Sample*
<p>| | | |</p>
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<tr>
<td>Planning of sexual offense</td>
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<td>Pornography use</td>
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<td>Psychiatric hospitalization</td>
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<td>Sexual knowledge deficit</td>
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<tr>
<td>Social skills deficit</td>
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<td>Substance use/ abuse</td>
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<td>Alcohol</td>
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<td>23</td>
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<tr>
<td>Other substances</td>
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APPENDIX C

10-Point Definition of Sexual Addiction*

1. A pattern of out-of-control behavior
2. Severe consequences due to sexual behavior
3. Inability to stop despite adverse consequences
4. Persistent pursuit of self-destructive or high-risk behavior
5. Ongoing desire or effort to limit behavior
6. Sexual obsession and fantasy as a primary coping strategy
7. Increasing amounts of sexual experience because the current level of activity is no longer sufficient
8. Severe mood changes around sexual activity
9. Inordinate amounts of time spent in obtaining sex, being sexual, or recovering from sexual experiences
10. Neglect of important, social, occupational, or recreational activities because of sexual behavior

APPENDIX D

Dynamics of Sexual Assault*

Reservoir of Motivation:
Anger, Lack of Power, Fear of Women, Deviant Arousal, Distorted Attitudes
Floodgates of Inhibitions – May be opened by

| Substance Abuse | Mental Retardation | Brain Damage | Cognitive Distortions | Lack of Empathy | Peer Pressure | Stress | Pornography | Psychosis |

Environmental Opportunities

Attributes of Victim

Sexual Assault


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