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**Child Molester Denial:
Utilizing A Multi-Method Assessment Approach**

By

P. Bruce Malcolm, B.A. (Hons), M.A.

**A dissertation submitted to the
Faculty of Graduate Studies and Research
In partial fulfillment of the requirements for the
Degree of Doctor of Philosophy**

Department of Psychology

Carleton University

Ottawa, Ontario, Canada

November 19, 2001

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Abstract

This study examined the relationship between denial and minimization and a number of assessment factors in a sample of 122 convicted child molesters. All participants had recently begun serving a sentence of federal incarceration in a Canadian penitentiary for a sexual offence involving a child. Denial and minimization was measured according to Barbaree's (1991) Denial and Minimization Checklist. The relationship between these constructs and a number of factors, related to potential outcome, was investigated using a multi-method assessment. These factors include, risk of re-offence (sexual and non-sexual), self-reported measures of sexual deviance including response latencies, social desirability, sexual preference, and readiness for treatment. The results were analyzed to determine if any patterns existed within existing typologies such as age of victim, type of child molester as well as level of denial. As hypothesized, the results found that while pretreatment risk and phallometrically measured sexual preference was associated with age of victim and type of child molester, the relationship with denial was not significant. In contrast, results of the self-report measure (Multiphasic Sex Inventory) were highly related to level of denial but not age of victim or type of child molester. The use of self-report response latencies as a measure of deception/faking was not supported. Only the latencies of the MSI: Social/Sexual Desirability Scale were in

the hypothesized direction (longer). Indeed, MSI: Child Molest Scale latencies were in the opposite direction (shorter) to the predicted direction. Finally, the results of the Treatment Readiness Scale were found to be significantly associated with level of denial but not age of victim or type of child molester.

The results are discussed with respect to alternative intervention strategies, improved risk management, future research, and potential impact on correctional policy.

Acknowledgement

This dissertation is dedicated to Frederick A. Eismont, my father-in-law. Although Fred struggled with serious illness during the final years of this project, he always had time for words of encouragement and it was his strength and will to live that fueled my commitment to see this work completed. Indeed, he thoroughly edited an earlier version making numerous suggestions to improve the final product. While I will always appreciate his belief in my abilities and pride in my success, I am most thankful for the way he modeled principles of family and parenting. I can only hope that these principles will continue to guide me in the future.

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Theme and Relevance of the Present Study

The central theme of this study will be the investigation of the multi-method assessment of denial and minimization in convicted child molesters. Convicted child molesters who deny having sexually inappropriate thoughts and/or behaviour present a unique set of problems to organizations and professionals. These difficulties apply to sentencing, risk assessment/appraisal, treatment and individual risk management. It will be argued that current assessment techniques are of limited clinical value in the identification of offence-specific treatment targets for these offenders. The result is that a significant number of offenders, some of whom are quite dangerous are not provided with services that are expected to decrease the probability of future offending. It will be further argued that an accurate, well-informed assessment must focus on each individual's ability to become involved in any risk management strategy and that this can only be accomplished through a multi-method assessment.

The following introduction will attempt to position child molestation within the criminal justice system through a discussion of the definition, incidence and prevalence, the underlying theories of child molestation and the models of denial and minimization. This will be followed by a brief review of how denial and minimization is managed within the context of a "Comprehensive Sexual Offender Treatment Strategy" and a review of "The Principles

of Effective Correctional Intervention" as applied to sexual offender treatment. Current assessment strategies used in the detection of deception will then be critically examined. From this review, the rationale will be drawn for the current study and a number of testable hypotheses will be presented.

Introduction

The past 20 years has seen a significant growth in the literature focusing on the study of sexual offenders, no doubt reflecting society's alarm about the prevalence and impact of sexual victimization. The consequences of sexual victimization go far beyond the immediate physical and psychological impact on the victim (Briere, 1992). These include the short and long term impact on the victim's family (Manion, Firestone, McIntyre, Ensom & Wells, 1994), the financial costs associated with police investigation, prosecution, defense, and eventual incapacitation including treatment (Russell, 1986) and the costs associated with short and long term health care (Prentky & Burgess, 1990). According to Marquis, Day, Nelson and West (1994), increased prevalence rates have resulted in heightened public awareness about sexual offending which in turn have led to increased reporting, more aggressive prosecution, and more severe sentencing.

In response, there has been a concerted effort by the courts, health care professionals and correctional organizations to develop an effective strategy to deter future re-offending. The recent focus of researchers on the prediction of recidivism is an endeavour to identify those variables that are empirically linked to the behaviour in question, in part so that those variables which are amenable to treatment can be targeted for intervention (Harris, Rice & Quinsey, 1993). Indeed a number of conceptual models have been

developed based on empirically derived predictors of sexual recidivism (Knight & Prentky, 1990; Serin, Barbaree, Seto, Malcolm & Peacock, 1997). Clearly, the increase in specialized sexual offender assessment and treatment programs in Canada is a reflection of the current view that offender rehabilitation, in addition to, or instead of incarceration, is the most promising means of reducing further victimization.

Child Molestation

According to the Law Reform Commission of Canada (1978), sexual offending is the sexual contact with another person without that person's consent. Because children are not able to give informed consent, by this definition, all adult sexual contacts with children are considered sexual offences.

Throughout the sexual offender literature the terms "child molester", "pedophile" and "sexual offenders against children" are often used to describe the same or similar individuals. However, Quinsey and Lalumiere, (1996) suggest the term pedophile (lover of children) be reserved for a more specific group within the sexual offenders against children category, who meet the criteria for diagnosis as defined by the DSM-IV (American Psychiatric Association, 1994). These criteria are as follows:

1. *Over a period of at least 6 months, recurrent,
intense sexually arousing fantasies, sexual*

- urges, or behaviours involving sexual activity with a prepubescent child or children (generally age 13 years or younger).*
2. *The fantasies, sexual urges, or behaviours cause clinically significant distress or impairment in social, occupation, or other important areas of functioning.*
3. *The person is at least age 16 years and at least 5 years older than is the child.*

Clearly, not all men convicted of child molesting meet the criteria for the diagnosis of pedophilia. In addition, men who offend against prepubescent children are routinely distinguished from those who select pubescent children. A further distinction is commonly made between extra-familial (outside the family) and intra-familial (within the family) child molesters. Again, intra-familial child molesters need to be distinguished from incest offenders. The definition of incest offender is usually reserved for "blood relatives", (i.e. fathers, grandfathers, brothers) while intra-familial offenders would include stepfathers and stepbrothers. In the case of intra-familial offenders, the focus is on the offender-victim relationship and the extent to which a parental responsibility exists. For the purpose of this thesis, all adult males who commit a sexual offence against a child or youth including

extra-familial and intra-familial child molesters and incest offenders will be included under the generic term of child molester.

Incidence and Prevalence

Whether we consider official statistics, victimization studies or self-reports, sexual offending is a serious problem. Increases in media attention resulting from offenses committed by paroled sexual offenders have heightened public concern. Increased public concern is at least in part responsible for the increased willingness of victims to report sexual crimes to police. Presumably, victims are more willing to report these crimes because there has been a concerted effort to reduce the stigma of being a victim and the trauma of testifying. Indeed, it has become common for victims to come forward many years after the abuse has taken place and for the courts to convict. We also now know that many sexual offenders occupy positions of prominence, authority and trust.

According to the Canadian Centre for Justice Statistics (1999), sexual offences represent a relatively small proportion of all officially recorded crimes. For example in 1997, sexual offences represented approximately 1% of the total number of incidents and 10% of the violent incidents reported to the police. However, in terms of absolute numbers sexual offences clearly constitute a problem. In fact, there were 30,735 sexual offences reported to the police in 1997 (Canadian Center for Justice Statistics, 1999).

The rate of reported incidents of sexual crimes began to increase from approximately 59 incidents per 100,000 in 1983 before the passage of sexual offence reform legislation. The increase peaked in 1993 at 135 per 100,000 and has gradually declined to the current rate of 101 per 100,000. Interestingly, the 1997 rate of reported incidents still represents a 75% increase from 1983.

Based on these same police data, the majority of sexual crimes were committed by males (98%) against children and adolescents; 62% of victims were less than 18 years of age while 30% were under 12. These same data indicate that the majority of reported sexual offence victims were female (82%), however, 30% of victims in the most vulnerable age group (children under 12) were male. These data are quite revealing when compared with non-sexual violent offences, where 76% of victims are adults with approximately 50% being male. Only 7% of victims of non-sexual violence were children.

Notwithstanding such rates, official statistics tend to underestimate the true prevalence of sexual crimes (Marshall, Laws & Barbaree, 1990). It is clear that some acts defined as sexual assault are considered too trivial by the victim to be reported (frottage, voyeurism). Equally clear, some serious sexual assaults go unreported for a variety of reasons. In some cases the victim is too young, is intimidated by the offender, or the offender is a relative. In other cases, the victim chooses not to report due to a fear of the criminal justice system "blaming the victim". Recent

changes in sexual assault legislation (Canadian Center for Justice Statistics, 1999) and improved training for police officers dealing with survivors of sexual assault, have undoubtedly reduced the impact of the latter issue. Even victimization surveys tend to underestimate the incidence of sexual victimization, since they exclude young children and use disparate sampling techniques and definitions. For example, Finkelhor (1986) reports North American estimates of between 6% and 62% of women having experienced child sexual abuse and between 3% and 31% of men. Canadian statistics indicate that half of all females and 1 in 3 males report some form of sexual abuse (Badgley, Allard, McCormick, Proudfoot, Fortin, Oglivie, Rae-Grant, Gelinas, Pepin, & Sutherland, 1984).

From an offender perspective, studies have found that some offenders have had many victims and a proportion have also been involved in the commission of a variety of other sexually deviant acts (Abel, Becker, Mitelman, Cunningham-Rathner, Rouleau, & Murphy, 1987). Clearly, child molesters present as having quite varied offence histories, including sexual and non-sexual crimes (Simourd & Malcolm, 1998). They also vary based on victim selection features such as gender, age and relationship which in turn influence the level of risk for recidivism (Hanson, 1995).

Theories of Child Molesting

It is important to recognize that any theory of deviant sexual behaviour must account for the origins and persistence of the

behaviour, as well as the conditions under which the behaviour is enacted. Since child molesting takes several forms and is comprised of a multitude of sexually inappropriate activities, it would be unrealistic to think that a single theory could account for all aspects. However, there are a few theoretical perspectives that should be considered and reviewed.

Considering the **biological perspective**, it is a commonly held view that sexually deviant behaviour is the result of a "high sex drive". According to Heim and Hursh (1979), hormones are a necessary component for establishing sexual behaviour in males but hormones are not necessary for sexual behaviour to be maintained. Further, it is generally agreed that sexual identity, sexual performance and sexual arousal are learned from a variety of factors. Quinsey (1986) suggests that some sexual stimuli are much more easily learned as a result of their evolutionary significance. Stimuli that are candidates for this "prepared" status include features such as youthful appearance and primary or secondary sexual characteristics. According to Quinsey (1986), children may become the focus of sexual interest because they possess certain characteristics which enhance the conditioning process in some males.

Alternatively, Herman (1990) has conceptualized sexual deviance from a **feminist perspective**, suggesting that sexual assault is intrinsic to a system that is based on male supremacy. From this

perspective, child molestation is viewed as a crime of violence, which results from an association between masculinity, power, dominance and superiority.

Based on a **conditioning and social learning** paradigm, Laws and Marshall (1990) present a theoretical model of the development of deviant sexual preferences in individuals. The model includes both "acquisition" and "maintenance" processes. A set of "general principles", are first presented based on the mechanisms of learning. These mechanisms include, for example, operant and Pavlovian conditioning as well as social learning processes. From these "general principles" they developed a set of "propositions" regarding the application of the principles to sexual behaviour. Fundamental to their theory is the development of deviant interests, attractions and arousal as preconditions for deviant behaviour. Since not all sexual offenders have deviant sexual preferences, they discourage using this theory as an explanation of all deviant sexual behaviour.

Hall and Hirschman (1991) have attempted to integrate aspects of previous theories into a **"quadripartite model"** of sexual aggression. Using this model sexual aggression is said to be facilitated by the interaction of four motivational components. The first component, labeled physiological, includes deviant sexual interests measured by self-report or by phallometry. The second component, labeled cognitive, refers to cognitions that justify

sexual offending and would include hostile attitudes towards women, justifications that the activity is not harmful to the victim and rationalizations regarding the victim's previous experiences. The third component, labeled affective dyscontrol, involves negative emotional states such as anger and depression. Finally, the fourth component, labeled personality or trait variables, includes learning disabilities, childhood abuse and psychopathy.

Knight and Prentky (1990) present an **empirically driven classification** system of sexual offenders based on data that allow the development of theories specific to offender subtypes. This type of work is essential to the development of precise assessments and treatment programs. Unfortunately, while instrumental in guiding research and describing sexual offender subgroups, the ability of such a classification model to predict sexual re-offending has yet to be systematically tested.

Denial and Minimization

Terms and Definitions

Throughout the sexual offender literature regarding denial and minimization a variety of terms are often used to describe the same or similar individuals. The following definitions are presented in an attempt to distinguish many of these terms.

According to Rodgers, (1988) the general term **dissimulation** is usually used to describe individuals who distort or misrepresent

symptoms. Dissimulation can be further distinguished based on the direction of the distortion. The term **malinger** refers to the intentional fabrication or exaggeration of physical and/or psychological symptoms, while **defensiveness** is the polar opposite of malingering. In this context, defensiveness is the **denial** or **minimization** of physical or psychological symptoms. **Deception** and **duplicit** are terms used to describe any attempt by an individual to distort or misrepresent the truth.

Perhaps the most challenging aspect, in a clinical sense, of working with child molesters is the issue of denial and minimization. It is commonplace for child molesters to deny committing an offence long after they have been convicted and in defiance of overwhelming evidence. Further, those offenders who admit to committing the crime routinely deny any planning of the offence or having deviant sexual fantasizes attitudes or beliefs. According to Marshall (1996), a significant number of sexual offenders minimize the intrusiveness of the sexual acts, the degree of force used with the victim and the duration of the offending. Marshall also suggests that sexual offenders routinely deflect responsibility by blaming victims or third parties. They also tend to blame other related factors such as substance abuse, stress or their own victimization. Although each distortion may represent a legitimate treatment target, the primary goal of denial and minimization appears to be to reduce the offender's own

responsibility and to mask some of the most crucial targets, such as deviant attitudes, beliefs and fantasizes. As such, the reliability of assessment results and the utility of treatment strategies are complicated by distortions in self-reported histories and of the non-acceptance of responsibility for the problematic behaviour (Rodgers & Dickey, 1991).

While most clinicians working with sexual offenders recognize the problem of denial and minimization, few studies have documented the extent of the problem. In a study by Scully and Marolla, (1984) only 41% of 114 rapists admitted committing the offence for which they were convicted. This same study indicated that 25% of these admitting offenders believed the victim had actually consented, while 22% suggested the victim's previous sexual experiences diminished the harm inflicted. Of these admitting offenders, 84% attributed responsibility to alcohol and 33% claimed emotional difficulties as a contributing factor.

More recently, similar findings have been reported for child molesters. In excess of 250 justifications were taken from the records of 86 child molesters referred for psychiatric assessment (Pollock & Hashmall, 1991). In addition, a review of incarcerated sexual offenders by Wormith (1983) found that only 14% reported being remorseful for their offence, suggesting a somewhat diminished sense of responsibility.

In an examination of demographic characteristics, Kennedy and Grubin (1992) identified 4 groups or denial types. Those in Group 1 were referred to as "rationalizers". These offenders were most likely to admit sexual deviance but denied victim harm. Group 2 were described as "externalizers" and were most likely to blame the victim, third parties and the legal system. Group 3, described as "internalizers", were most likely to accept responsibility but blamed an abnormal mental state. Group 4, were described as "absolute deniers". Group comparisons found that absolute deniers were more likely to be non-Caucasians, to have offended against adult women, and to be unmotivated for treatment. However, other researchers have not identified differences between admitters and deniers with respect to age, education or race (Langevin, 1988).

In an attempt to gain a better understanding of the problem, Barbaree (1991) developed a typology and checklist of denial and minimization that is applicable to both sexual aggressors and child molesters. According to Barbaree's typology, offenders deny from three different perspectives. First, offenders may claim to have had no contact or involvement with the victim. Common rationalizations include being framed by police, revenge by the victim, or mistaken identity. Second, they may deny that the sexual contact with the victim was an offence. Typical justifications involve victim consent or lack of resistance and believing the victim was old enough to consent. Finally, offenders may

acknowledge committing the offense but deny having a sexual motivation. In such cases, offenders may insist that the touching of a child had a legitimate purpose or that the offence was a non-sexual assault. Such claims include checking to ensure appropriate cleanliness or to determine if the child was sexually active.

Barbaree (1991) also suggests that minimization can take three forms. These include minimization of harm, extent and responsibility. When offenders minimize harm, they usually do so by citing the absence of any long-term trauma for the victim or by suggesting the victim benefited from the experience. Offenders that minimize the extent of the offence often claim that the offence occurred less frequently, less forcefully, less intrusively or that there were fewer victims. Finally, some offenders minimize their responsibility for the offence by blaming the victim, citing personal and emotional problems, or external factors such as alcohol intoxication.

The results of Barbaree's initial application of his typology with convicted offenders were consistent with previous studies (Pollock & Hashmall, 1991; Scully & Marolla, 1984). Only 2.4% of the subjects actually admitted, without any form of minimization, that they committed the offence for which they were convicted. In addition, 58.5% denied responsibility, while 39% minimized. These results revealed that 66% of child molesters and 54% of rapists presented as denying. Conversely, 33% of the child molesters

minimized compared to 42% of the rapists. Interestingly, none of the child molesters presented as fully admitting.

Malcolm (1995) later replicated these results in a study that focused on assessing general risk of re-offending in sexual offenders using the Level of Supervision Inventory-R. In this study only 5 (2.8%) of a sample of 178 newly incarcerated sexual offenders did not present some form of denial or minimization. Further, 91 (51%) were classified as denying and 82 (46%) were classified as minimizing. Importantly, there was no relationship between the level of denial or minimization and estimated level of general risk for re-offence. This suggests that low-risk sexual offenders are equally prone to denial, as are high-risk offenders. However, resistance to treatment was not investigated. It would be interesting to determine if there were differential recidivism rates for offenders who eventually accepted responsibility and completed treatment compared with those who maintained their denial and did not complete treatment.

According to Wormith (1983), it is important to recognize that while many offenders make conscious and calculated decisions about denial, some offenders may not be as fully aware of their true responsibility. Some offenders may deny for reasons that less clearly reflect deviance. These would include mistaken attribution, selective attention and poor memory or attempts to avoid the consequences of self-identification as an offender.

In light of the considerable attrition of criminal justice cases from complaint to charge and conviction, the proportion of individuals who deny their offence and have been incorrectly convicted is probably quite small (Boydell & Connidis, 1986). Clearly, some that deny are lying. Others may have, however, over time, convinced themselves that they are not guilty and still others may not be able to recall the events. Similarly, those who accept some degree of responsibility but minimize the motive, consequence or responsibility appear to do this for a variety of reasons. According to Kennedy and Grubin (1992), some of these explanations may be a defence against reduced self-esteem. In support of this, Marshall (1996) points to the importance of restoring self-esteem as an initial step in treatment.

No matter the type or reason for denial and minimization, it is routinely taken as a measure of poor motivation for treatment. Hence, it often becomes an obstacle to treatment engagement. However, where the goal of treatment is reduced recidivism, there does not appear to be any evidence that level or type of denial has a negative impact on outcome (Hanson & Bussiere, 1998). Clearly, a more precise knowledge of the personal and criminal characteristics associated with denial in sexual offenders is important. This information could be used to guide decisions regarding the targets of treatment as well as an offender's amenability. In addition, although it is clear that these distortions compromise the accuracy

of assessments there is no evidence that denial influences the effectiveness of treatment (Hanson & Bussiere, 1998). According to Maletzky and McFarland (1995), men in total denial who completed a program of cognitive/behavioural groups and individual treatment were safer to be at large than those who admitted their accountability yet never completed treatment. Although, the degree of denial and minimization may be related to increased dropouts, refusals and expulsions clearly decrease the effectiveness of the intervention.

Models of Denial

According to Rogers and Dickey (1991), denial or defensiveness can be conceptualized as the opposite of malingering. They have proposed three explanatory models based primarily on the malingering literature that may help guide interventions.

Pathogenic Model

According to the pathogenic model, unacceptable impulses, which reflect an oedipal conflict, are overcome by ego functions of repression and suppression. The loss of these functions results in deceptions that are largely beyond the individual's control. The pathogenic model is not popular and is largely untestable (Quinsey, 1984). Surveys of sexual offender programs appear to support the more cognitive-behavioural approach (Borzecki & Wormith, 1987).

Criminogenic Model

The criminogenic model suggests that denial is more likely to occur in antisocial individuals because deception is a central characteristic of the diagnosis. While uncooperativeness is a common complaint by clinicians, it is important to recognize that many offenders are merely following the advice of their legal counsel. Compelling an accused to cooperate might violate the right against self-incrimination, but for convicted offenders this may reflect their version of "faint hope". Rogers and Dickey (1991) argue that non-participation is a legal right of any accused and should not be taken as an acknowledgement of deviance. This position is not transferable to convicted offenders, while they have the same right to refuse intervention, this right is in conflict with the clinician's obligation to protect the public by reducing the probability of re-offence.

Adaptational Model

Based on the adaptational model, sexual offenders are likely responding to the negative attitude of the public to their deviant sexual behaviour by denying responsibility. Obviously social pressures tend to deter offenders from revealing the presence of deviant sexual fantasies or behaviours. The influence of these pressures remains present today, particularly with many homosexuals (Jenks, 1988).

Denial may also be the preferred alternative of two possible choices both which have negative outcomes. Certainly, a declaration of deviance would be perceived no less negatively than denial. According to Rogers and Dickey (1991, p. 57), this is akin to "the best alternative in a difficult situation". With the possible exception of those few cases where the sexual misconduct is an isolated event, most sexual offenders have learned to avoid public condemnation by leading "double lives". For those who eventually experience incarceration, the non-sexual offenders perpetuate this condemnation. Indeed, many incarcerated sexual offenders live in fear of being identified and eventually beaten or killed. Therefore, from the adaptational perspective sexual offenders have much to lose by disclosing and, they believe much to gain from denial.

Treatment Issues

While the theoretical debates continue, most treatment programs for sexual offenders tend to address many of the same targets. Nonetheless, there are unique features associated with each program. Marshall (1996) presents a summary of the "offence specific" targets in a representative cognitive-behavioural treatment program. The targets include victim harm and empathy; offense-supportive attitudes, beliefs and distorted perceptions; offense related fantasies and arousal; relapse prevention and denial and minimization. "Offense-related" targets such as anger management

and substance abuse may be managed within the sexual offender program or as an adjunct.

According to Marshall (1996), many programs refuse to treat offenders who deny responsibility. Indeed, a few programs also exclude those offenders who minimize. Marshall concluded that 60% of the offenders treated in his clinic would have been excluded using these criteria. Support for the exclusionary practice can be found in the Ethical Standards and Principles for the Management of Sexual Abusers published by the Association for the Treatment of Sexual Abusers (1997, p. 19). That document states that "Treatment is unlikely to be effective until a client acknowledges the abusive behavior and accepts responsibility for that behavior.". There is, however, no evidence to support this claim although it does have a common-sense appeal" (Schlank & Shaw, 1996).

There is considerable debate regarding the appropriate management of denial within the context of sexual offender treatment, although few studies have actually targeted denial in treatment. Barbaree (1991) reports considerable success getting deniers to remain in treatment and accept responsibility. However, there is no indication how this transformation was accomplished.

Endorsement of the exclusionary criteria used by many programs is likely to significantly alter the proportion of the population deemed appropriate for treatment. The result is that many dangerous

sexual offenders will not be exposed to the intervention they most require (Maletzky, 1996). In addition, this practice may artificially inflate program effectiveness rates.

Some programs (Barbaree, Seto & Maric, 1996) target denial (through a series of disclosures) in a pretreatment phase where only those willing to acknowledge responsibility can continue. This practice while preferable to exclusionary criteria, often merely delays the inevitable, as pretreatment is the confrontation of information the offender has become quite practiced at denying. No apparent steps are taken to help the offender cope with a sudden acknowledgement of responsibility and the accompanying loss of credibility within the group or more importantly with previous supporters such as a wife, a lawyer, or a friend. Indeed, many of these supporters have also invested considerable energy in supporting the claim of innocence by the offender and may be quite resistant to such an acknowledgement. Under these circumstances, the potential loss of support from these individuals may appear to be more significant than the potential gains offered by completing treatment. This is particularly true if completing treatment does not result in a higher probability of being granted parole.

Alternatively, including individuals who deny responsibility may compromise the potential benefit of treatment for the remaining offenders. These offenders may feel pressured to mask their own deviant thoughts and behaviours in an attempt to appear more

"normal". Psychopathic offenders may actually thrive under such circumstances. These offenders could present themselves to therapists as remorseful, cooperative and accepting responsibility, but without the underlying sincerity or attitude change. Estimates, then, for post-treatment outcome could be quite inaccurate (Seto & Barbaree, 1999)

Clearly, programs that treat convicted sexual offenders are faced with the dilemma of choosing one of two equally unappealing alternatives. That is, to include deniers or not, "damned if you do and damned if you don't". Unlike many other correctional programs, sexual offender programs are mainly geared toward the type of offence. This is quite different from non-sexual offender programs where the target is usually a specific criminogenic need. Only recently, have researchers and clinicians begun to apply general correctional programming models to the management of sexual offenders (Simourd, 1999; Simourd & Malcolm, 1998).

Simourd and Malcolm (1998) have suggested that non-sexual criminogenic needs are often overlooked in the assessment and treatment of sexual offenders because of the emphasis on sexual arousal issues. These authors argue that offence-specific information should be augmented with objective evaluations of non-sexual criminogenic needs, thus offering a comprehensive management and treatment strategy. In a study designed to examine their hypothesis, The Level of Service Inventory- Revised; LSI-R, (Andrews

& Bonta, 1995) was administered to a sample of 216 (74 adult victim sexual aggressors, 54 extra-familial child molesters and 88 familial child molesters) incarcerated sexual offenders. The results supported findings (Maletzky, 1991; Weinrott & Saylor, 1991) that sexual offenders have more extensive and varied criminal histories than is commonly believed. While rapists scored higher on the LSI-R domains than the child molesters, the pattern of LSI-R scores for the adult victim offenders was very similar to the LSI-R scores of violent offenders found by Loza and Simourd (1994). For the child molester groups, the results found familial and extra-familial child molesters also differed in their risk level and need areas.

Familial child molesters were clearly the lowest risk/need of the three sexual offender groups. The overall findings suggested that sexual offenders as a group have deficits in many non-sexual risk/need areas that can be adequately assessed by way of the LSI-R. These results call into question the common practice of excluding sexual offenders from interventions directed at criminogenic needs identified for the general criminal population.

Principles of Effective Intervention

The principles of effective correctional programming described by Andrews, Bonta and Hoge (1990) have become an integral part of the risk management strategy used by most offender management agencies. Recently, these principles have been applied to the management of sexual offenders. An important element of this

framework is the relationship between assessment and intervention. Based on an exhaustive review of program characteristics that were related to reductions in recidivism, four principles were delineated.

The **risk principle** refers to the predictability of criminal behaviour and the matching of intensity of services with offender risk for recidivism. Andrews, et al.(1990) found that treatment services tend to be most effective when delivered to higher risk cases while lower risk cases should receive little or no treatment. Further, providing offenders with higher levels of treatment than is necessary can have the inadvertent effect of increasing risk (Andrews & Friesen, 1987; Baird, Heinz, & Bemus, 1979).

Like most other programs delivered to offenders, there are outpatient programs and institutional programs. However, sexual offenders, regardless of level of risk or criminogenic need, were, until recently, typically exposed to the same level of service. While the issue of how much treatment is necessary remains unanswered, there have been significant advances in the application of this important principle to the treatment of sexual offenders. For example, in the Correctional Service of Canada, the Standards and Guidelines for the Provision of Services to sexual offenders (1996) describes four intensity levels of service. These include high, moderate, low and maintenance levels. Each successive level involves progressively fewer therapy-related hours over a

progressively shorter duration. Although the success or failure of this model needs empirical verification, it provides an appropriate foundation for decisions about differential allocation of sexual offenders to treatment.

According to Andrews et al. (, the **need principle** distinguishes between criminogenic and non-criminogenic needs. Criminogenic needs are dynamic risk factors that when changed through treatment tend to reduce recidivism (Gendreau, 1996). Therefore, non-criminogenic needs are less relevant treatment targets. Clearly, the identification of criminogenic needs for an individual is clinical in nature and may vary based on sexual offence type (Quinsey & Lalumiere, 1996). While Gendreau (1996) cites personal distress and self-esteem as non-criminogenic, Marshall (1996) argues that self-esteem and self-confidence are an integral part of sexual offender treatment. While not necessarily criminogenic, Marshall (1996) insists that failure to measure self-esteem and enhance it when indicated could result in less than optimal participation and treatment benefit. For sexual offenders, then, some personality domains may be ancillary treatment targets that mediate response to treatment and thereby influence future risk.

However, the ability to identify specific criminogenic needs for defensive and denying sexual offenders remains a challenge. Self-report measures for sexual offenders have considerable potential for assessing important information before and during

treatment. Unfortunately, these inventories are notorious for being transparent, easily faked and dependent on reading and comprehension abilities (Marshall & Hall, 1995). Consequently, sexual offender assessments rely heavily on police reports, victim impact statements and, whenever possible, collateral sources of information to estimate offence specific treatment targets. However, many of these targets conflict with the offender's version of the events. The resolution of denial and minimization issues merely allows for increased agreement between therapist and offender regarding the various criminogenic needs.

The third, **responsivity principle**, relates to the matching of service delivery with the individual offender's learning style and ability. While the generally preferred mode and style of service delivery involves a social learning and cognitive behavioural approach, special circumstances deserve consideration. These include offender characteristics such as motivation, anxiety and intelligence level as well as offender features such as psychopathy, ethnicity and mental disorder (Andrews et al. 1990). While it is imperative that a given intervention target criminogenic needs, service providers must also consider the learning styles of the offenders (Serin & Kennedy, 1997).

Unfortunately, the responsivity principle is all too often translated into exclusionary criteria. Sexual offender programs in particular often exclude offenders who are mentally disordered,

psychopathic, unmotivated or intellectually delayed. Most often, this is done without regard for the unique treatment requirements of these offenders. While such exclusions from main stream programs may seem reasonable and clinically justified, the empirical research to support the practice is limited and for federally incarcerated offenders, it is contrary to the Corrections Conditional Release Act. Further, in Canada, such exclusions could be challenged under the Charter of Rights and Freedoms based on limited access to programs necessary for release.

Treatment Readiness

According to Garland and Dougher (1991), sexual offenders are generally unmotivated for treatment and this has implications for treatment selection, attrition and completion and post-treatment outcome. Motivation or treatment readiness, are terms generally used to describe the individual's willingness to engage and his attitude toward treatment.

The construct of treatment readiness has been investigated by Prochaska, DiClemente, and Norcross (1992) from an addictions perspective. Their transtheoretical treatment model identified four stages of change: precontemplation, contemplation, action and maintenance. According to this model of change precontemplation is characterized by individuals who do not perceive the need to change and therefore view treatment as satisfying someone else's need. In the contemplation stage individuals present as ambivalent towards

treatment and they may accept or reject the reasons for change almost simultaneously. In the action stage, individuals have typically made a commitment to change and present actions that validate this commitment. Finally, individuals in the maintenance stage are seen as working towards sustaining gains made in treatment. Prochaska et al. (1992) developed and validated a self-report measure the URICA (University of Rhode Island Change Assessment Scale) to ensure their clients' level of readiness was appropriate for their interventions.

Serin and Kennedy (1997) operationally define motivation as "the probability that a person will enter into, continue and adhere to a specific strategy" (p. 10). These authors suggest that offenders who are resistant to treatment may require pre-treatment interventions designed to increase motivation. Preston and Murphy, (1999) suggest that this type of intervention assists offenders to develop their own "cost benefit analysis" of possible treatment outcomes, thereby overcoming some obstacles.

Based on these observations, Serin and Kennedy (1997) developed an interview-based assessment of treatment readiness (The Treatment Readiness Scale). Preliminary results with sexual offenders found that while readiness and responsivity estimates were negatively correlated with a measure of psychopathy there was no relationship with denial (Serin, R.C., Malcolm, P.B. and Mailloux, D. 1998). However, these authors investigated readiness relative to a measure

of degree of denial and found that readiness and denial had a non-significant negative correlation. Further, using the same correlational analysis they also found that treatment readiness had a non-significant positive correlation with level of minimization. It would have been interesting to investigate a dichotomous measure of admit status (denial vs. minimization. Moreover, their analyses did not control for level of risk. As such, it may be that lower risk offenders in denial are more likely to acknowledge the need for treatment. Based on the suggestions by Preston and Murphy, (1999) these offenders may perform their own "cost benefit analysis" and decide that lower security and early parole are reasonable benefits for acknowledging some level of responsibility. Alternatively, the initial benefit for higher risk offenders may be less easily identified.

Finally, the fourth principle of **professional discretion** refers to the informed judgement of a sensitive professional. Here decisions to "override" these principles are justifiable based on unique conditions.

Dealing with Deception

The primary goal of assessment is to determine level of risk and to identify criminogenic targets. However, this task is significantly complicated with offenders who are predisposed to deceive. There is no generally accepted method of controlling for or detecting deception in child molesters. Therefore, some of the

more common methods will be reviewed and discussed. The first two methodologies to be reviewed (polygraphy and phallometric testing) are clearly controversial. Proponents of each are often passionately convinced of their utility and validity, while opponents seem equally passionate about their limitations and potential abuse. Finally, the use of self-report inventories, social desirability and response latencies will be discussed in terms of the detection of deception and use with offenders who deny.

Polygraphic Testing

Polygraph testing, commonly referred to as lie detection, involves the systematic measurement of physiological changes in heart rate, blood pressure, galvanic skin response and respiration, while the examiner asks questions regarding specific behaviours.

According to Iacono and Patrick (1988), there are two types of polygraph tests. The control question test involves the examinee being asked about offence-related activities as well as neutral unrelated events with known answers. The guilty knowledge test involves questions related to a specific crime.

Polygraph testing has been the center of controversy since it was first introduced at the beginning of the century (Lykken, 1981). The primary problem with the control question test is the number of false positives (e.g. the number of individuals identified as lying who are actually telling the truth). According to Balloun and Homes

(1979), the guilty knowledge test is promising but to-date there have been few studies that have evaluated issues of reliability and validity. Polygraph testing of individuals alleged to have committed crimes is commonly used in many states and can be admissible in courts. Recently, however, Montana's Supreme Court ruled that all information gathered from an interview that used polygraph testing was inadmissible (Peters, 1999). Jensen and Jewell (1988) have suggested that polygraph testing could be helpful in detecting and preventing sexual crimes among child molesters. These authors argue that polygraph testing be used to supplement and verify the information gathered from clinical interviews. Recently, polygraph testing has been used to ensure compliance with conditions of community supervision of sexual offenders (Abrams, 1991).

In conclusion, polygraph testing of child molesters to determine guilt or innocence remains highly controversial. Research is needed to investigate the effects of repeated testing and the number of false positive errors. According to Abrams and Ogard (1986), the few studies of polygraph testing with individuals on parole are methodologically weak.

Polygraph testing is especially controversial in Canada. In a recent review of sexual offender programs funded by the Correctional Service of Canada, none of the over 50 programs used a polygraph for any purpose. Therefore, in light of training requirements, access to the technology and most importantly the ethical impediments from

the Correctional Service of Canada, this technology was not used in the present study. However, depending on the outcome of this study a follow-up study may be proposed with polygraph measurements as a central focus.

Phallometric Testing

Phallometric testing is a procedure for measuring the sexual preferences of males. The procedure involves the measurement of penile tumescence responses to stimuli depicting various sexual behaviors (rape) and objects (children). Male sexual preferences for almost any sexual activity can be assessed using these procedures and use of phallometric testing with child molesters is quite popular (Quinsey & Lalumiere, 1996).

Kurt Freund (1965) authored the first report of a comparison between child molesters and non-child molesters. His results indicated that child molesters displayed greater arousal to children than did the non-child molesters. These results were then replicated and extended to male-victim child molesters (Freund, 1967a, 1967b; Freund & Blanchard, 1989; Freund, Chan, & Coulthard, 1979; Freund, Watson & Dickey, 1991).

Numerous other studies have replicated Freund's results discriminating between extra-familial child molesters and non child molesters (Abel, Becker, Murphy & Flanagan, 1981; Baxter, Marshall, Barbaree, Davidson & Malcolm, 1984; Day, Miner, Sturgeon, & Murphy,

1989; Frenzel & Lang, 1989; Grossman, Cavanaugh & Haywood, 1992; Malcolm, Andrews & Quinsey, 1993; Murphy, Haynes, Stalgaitis, & Flanagan, 1986; Quinsey & Chaplin, 1988; Quinsey, Chaplin & Carrigan, 1979; Quinsey, Steinman, Bergersen & Holmes, 1975; Wormith, 1986).

Most studies have found that familial child molesters cannot be differentiated from non-offenders based on sexual preference testing (Frenzel & Lang, 1989; Freund & Watson, 1991; Grossman et al., 1992; Marshall, Barbaree, & Christophe, (1986); Murphy et al., 1986; Quinsey et al., 1975, 1979). However, two studies, both using audio-taped stimuli, have reported that these offenders produce greater arousal to children than to adults (Abel et al., 1981, Murphy et al., 1986). According to Murphy and Barbaree (1994) it may be that audio-tapes allow familial child molesters to imagine their own victims.

For many years the development of phallometric technologies were thought to overcome the limitation of self-reports. Unfortunately, recent reviews point to significant problems with this technology and practice. Evidence has mounted regarding limitations in reliability and validity due to extraneous emotional states such as anxiety and anger; personal differences such as age, intelligence and hormones; external validity such as low responding and voluntary control (faking) and a lack of standardization (Marshall & Fernandez, in press).

Although there remains considerable controversy regarding the use of phallometric measurements, Quinsey and Lalumiere (1996) suggest that next to criminal history it is the most important component in a comprehensive evaluation of child molesters. However, they caution that clinicians should use only those procedures that have demonstrated validity and reliability. Further, researchers should describe all those variables that might be expected to affect responding.

Phallometric assessments have played an important role in determining treatment requirements, evaluating treatment outcome, predicting risk of re-offence and evaluating theories of sexual offending. However, the most significant obstacle to the improved validity and widespread use of penile plethysmography relates to voluntary control. The ability to voluntarily control sexual response patterns during phallometric assessments has been demonstrated for both sexual offenders and non-offenders (Freund, Watson & Rienzo, 1988; Hall, Proctor & Nelson, 1988; Henson & Rubin, 1971; Laws & Holmen, 1978; Laws & Rubin, 1969; Quinsey, Steinman, Bergersen & Holmes, 1975).

There is no generally accepted method of controlling the possibility of faking. Using sophisticated computer and closed circuit video systems, some faking strategies such as manual manipulation are readily detected. Unfortunately, the more important cognitive strategies of faking are almost impossible to

detect. In the past, it has been sufficient to recognize the problem of faking and to interpret assessment results with caution (Laws & Holman, 1978). Barlow (1977) also suggested arranging the testing environment such that the likelihood of faking is minimized. Some have focused on sophisticated techniques to detect which individual may be exercising control (Frenzel, 1990). One researcher suggested that a measure of each individual's ability to fake should be applied to all assessment and treatment results (Farkas, 1978).

Freund et al., (1988) identified three indicators of faking when testing for age and gender preference: (1) pumping or perineal muscle contractions, (2) preferential responding to sexually neutral stimuli and (3) lack of discrimination between male and female stimuli, where at least one of the stimulus categories was adult.

Clearly, the demand characteristics involved in phallometric evaluations will always motivate some unknown number of offenders to attempt to fake. However, it is important to recognize that faking does not necessarily indicate the presence of an inappropriate sexual preference. Finally and perhaps most importantly, there is no evidence that phallometric results can be used to determine guilt.

Deception in Self-Reports

Self-Report Inventories

Measures of sexual attitudes and sexual functioning are typically part of any comprehensive assessment of sexual offenders (Hanson, Cox & Woszcsyna, 1991). Clearly, self-report measures have the advantage of being relatively inexpensive and convenient to administer. However, the literature regarding self-report estimates of sexual deviance has clearly demonstrated these measures to be of limited utility in the risk appraisal and management of sexual offenders (Hanson, et al. 1991).

As indicated earlier, sexual offender's are not likely to disclose their motivation for offending or to admit to their offences (Haywood & Grossman, 1994). Though sexual offenders are not alone in their propensity for denying or distorting responsibility for their offences, the phenomenon has been very well documented (Barbaree, 1991; Kennedy & Grubin, 1992; Scully & Marolla, 1984). Further, in those cases where responsibility is accepted, sexual offenders rarely acknowledge any underlying psychopathology (Marshall, 1994).

One self-report measure that appears to have promise and utility in this area is the Multiphasic Sex Inventory (MSI). According to Hanson et al. (1991), the MSI is considered one of the most comprehensive self-report measures of sexual attitudes and

sexual preference/interest. The scale attempts to assess a variety of sexual characteristics. Most importantly, the authors devote a considerable amount of attention to the issue of denial and minimization. While Hanson et.al (1991) pointed to problems with scale construction and standardization of the MSI, many of these issues have been addressed in later research. Kalichman, Henderson, Shealy and Dwyer (1992) evaluated a number of psychometric properties of the MSI including internal consistency and convergent validity with promising results. In addition, the MSI was found sensitive to changes in denial as a function of treatment (Barbaree, 1991; Clark & Grier, 1993). Unfortunately, there is little evidence to support the use of this instrument with non-admitting offender populations. The major difficulty in using the MSI to assess honesty versus deception is that convicted persons who report no sexually deviant behaviours or attitudes are automatically labeled as dishonest; thus honest "normals" cannot be separated from dishonest child molesters.

Social Desirability

Socially desirable responding (SDR) is the tendency for individuals to present themselves in an overly positive light. According to Paulhus and Levitt (1987), social desirability involves responding in the affirmative to desirable traits and not endorsing undesirable traits. Paulhus (1991) has convincingly demonstrated that socially desirable responding is not a simple

construct, but rather comprises two types of responding. The first he refers to as "self-deceptive positivity" in which a responder gives an overly positive representation of himself. The second he calls "impression management" in which the responder deliberately tailors his responses to his audience. Differences in impression management were found between admitters and non-admitters with non-admitters scoring significantly higher (Nugent & Kroner, 1996). Further, impression management was found to negatively correlate with degree of victim injury in a sample of rapists (Kroner & Weekes, 1996b). Additionally, Looman, Abracen, Maillet and DiFazio (1998) found high impression management scores to be related to low phallometric responding. These findings lend support to the distinction between impression management and self-deception within social desirability.

While there is considerable evidence indicating the validity of measures of social desirability in identifying who may or may not be presenting in an overly desirable manner (Kroner, 1996), there is currently no evidence indicating how this information can be used to identify existing sexually deviant attitudes which have been associated with risk of future sexual offending.

Response Latency - Item Response Times

Clearly the susceptibility of self-report inventories to demand characteristics and response set is a major problem to researchers and clinicians involved in the assessment of deviant sexual

behaviour and attitudes. In recent years there has been considerable interest in the development of validity indices of self-report measures (Helmes & Holden, 1986). Holden, Fekken and Cotton (1991) have proposed a model of psychopathology test item responding that suggests that differential test item response latencies have construct validity for identifying specific areas of psychopathology. This approach focuses on the process of questionnaire responding rather than simply on the actual responses (Holden, 1995). Holden (1995) has demonstrated that respondents who are denying deviant or negative behaviours or cognitions take longer than honest respondents to endorse items that describe negative characteristics about themselves. In addition to the response latency measures being used to detect fakers, Holden and Hibbs (1995) provide evidence that the use of item response latencies can account for variance not accounted for by standard validity indices and therefore can add incremental validity to the detection of deception. Indeed, psychophysics research has demonstrated that responses, which are meaningful to a respondent, will have a linear relationship between response latency and the probability of endorsement (Petrusic & Jamieson, 1978). In a study that investigated response latencies to a scale measuring criminal attitudes, Mills, (2000) found shorter latencies were associated with items describing anti-social themes.

This work indicates that test respondents who "fake good" on

test items that endorse psychopathology should take longer than subjects who are not faking and their responses to these items should be longer than their responses to items that reject psychopathology. This is because the endorsement of psychopathology represents a state of incongruence with the response set to fake good.

In addition, respondents who "fake bad" on test items that reject psychopathology should take longer than subjects who are not faking and their responses to these items should be longer than their responses to items that endorse psychopathology because the rejection of psychopathology is incongruent with the response set to fake bad.

Holden and Kroner (1992) investigated whether differential response latencies could be used to detect faking in a sample of prison inmates. Equal numbers of inmates were randomly assigned to complete the stimulus material under one of three conditions: standard responding, faking good, or faking bad. Discriminant function analysis indicated that response latencies could significantly differentiate among standard, fake good and fake bad responses.

The use of response latencies has the potential advantage of being unobtrusive, representing an independent source of data and being incorporated into any testing situation providing the use of

appropriate computer technology (Holden & Kroner, 1992). Knight (1999) recently found encouraging results using response latencies to measure dissimulation regarding defensiveness and emotional detachment with sexual offenders. Of course, it remains to be determined if the identification of invalid responding can be used to enhance clinical assessments and potentially aid intervention.

Present Study

Child molesters are notorious for their denial of aberrant sexual behaviours and for projecting responsibility for their past and present behaviours to extraneous factors. Consequently, many child molesters either refuse or are denied access to appropriate treatment services. Many clinicians and organizations would argue the adage, "you can lead a horse to water but you can't make it drink". Nonetheless, the costs associated with this position are far too great to take such a simplistic view. The notion that offenders are the beneficiaries of treatment further compounds the issue. An alternative view is that future or potential victims are the true beneficiaries and they present the primary motive for providing treatment. From this point of view, it is the responsibility of clinicians and the criminal justice system to convince convicted offenders to take necessary treatment services. Any procedure(s) or technology that can facilitate involvement in appropriate interventions to give clinicians and decision makers useful information to better manage an individual's risk would, of

course, be welcomed and valuable.

The purpose of the present study will be the examination of a multi-method approach to the differential assessment of denial in convicted child molesters. Child molestation is a complex social problem with a variety of antecedents that are made even more complex as a result of denial and minimization. These offenders differ in their criminal and personal histories as well as the circumstances and characteristics associated with their offenses. Therefore, a multi-method assessment strategy that incorporates clinical observations, interviews, file reviews, as well as psychological and phallometric testing is most likely to provide information necessary for a differential assessment.

This examination will include those factors that may mediate denial and minimization such as level of pre-treatment risk, phallometrically measured sexual preference, offence-related criminogenic factors and demographic factors such as age, intelligence and degree of intrusiveness and violence in the sexual offence. Issues of validity, with and without the benefit of response latencies, will be investigated for self-report measures of sexual attitudes, behaviours and social desirability. In addition, pre-treatment readiness/motivation will be evaluated relative to level of denial and sexual offence.

Hypotheses

Hypothesis 1

Based on previous research with the Denial and Minimization Checklist (Barbaree, 1991) it is expected that approximately 50% of the participants will present as denying. The remaining participants are predicted to express various forms of minimization. Few participants are expected to acknowledge complete responsibility.

Previous research also suggests that level of pre-treatment risk/need as measured by the LSI-R will not be correlated with level of denial or minimization (Simourd & Malcolm, 1998). High and low risk offenders are expected to be equally likely to deny. In addition, offender demographic factors such as intelligence, sentence length, age, and victim characteristic such as number of victims, gender of victim, degree of intrusiveness, degree of victim injury and victim age should not be related to denial and minimization. Further, research also suggests that extra-familial child molesters are likely to present as a higher risk than familial child molesters (Simourd & Malcolm, 1998). However, extra-familial child molesters are not expected to vary with respect to denial when compared with intra-familial child molesters or incest offenders.

Hypothesis 2

The results of the Multiphasic Sex Inventory, Child Molest

Scale and Child Molest Lie Scale are expected to significantly correlate with the Denial and Minimization CheckList (DMCL). High scores on the Child Molest Scale should be associated with lower levels of denial indicating an acknowledgement of responsibility. The reverse is expected for the Child Molest Lie Scale. It is also expected that offenders who deny responsibility will have high Child Molest Lie scores and low Child Molest Scale score, reflecting the transparency of items and therefore providing little useful information regarding treatability or risk. Social desirability (impression management) as measured by the Balanced Inventory of Desirable Responding is also expected to be highly correlated with denial status, indicating the tendency of offenders who deny responsibility for the offence to attempt to present themselves in a favourable light.

Hypothesis 3

Based on the research of Holden and his colleagues, MSI response latency scores for deniers are expected to be significantly longer than those scores of minimizers and admitters. In addition, response latency scores to the MSI should be highly correlated with social desirability. Finally, response latency scores on the child molest scale of the MSI are expected to be correlated with phallometrically measured sexual preferences.

Hypothesis 4

Phallometrically measured deviant sexual preference is expected to vary by child molester typology but not by level of acknowledged responsibility as measured by the DMCL. However, offenders with response levels less than 20% of full erection are expected to be disproportionately in denial and have higher social desirability scores (Looman et al. 1998).

Hypothesis 5

The results of the Treatment Readiness Scale are expected to be negatively correlated with level of risk/need as measured by the LSI-R, (Serin, et al., 1998) such that higher risk/need offenders will present as less motivated or ready to engage treatment. Additionally, treatment readiness scores are expected to be correlated with scores on the DMCL indicating a positive relationship with minimization and a negative relationship with denial. Further, readiness estimates are not expected to be related to type of child molester (Serin et al. 1998).

Implications

As can be seen from the preceding review, child molesters who deny present a multitude of problems to those charged with managing and making decisions about them. In some cases, these individuals are managed by using the preventative detention legislation, requiring them to serve their entire imposed sentence. Clearly, for

some individuals prolonged incarceration will have little or no effect on eventual outcome. However, for others the effect could be an increase in the risk that detention was designed to reduce, by managing them as higher risk offenders. It is equally clear that low risk offenders are not likely to be significantly affected by any treatment program. In other cases, the level of risk and need may be best mediated by other forms of intervention. These would include generic interventions for offence-related needs such as substance abuse, family violence, anger management and cognitive skills. Alternatively, the more offence-specific areas such as victim empathy and harm, intimacy and attachment and relapse prevention could be addressed without requiring the acknowledgement of responsibility. Finally, for those individuals who present a high risk for re-offence we need to identify the impediments to treatment. Clearly these may be legal (advice from legal counsel), environmental (fear of identification and eventual harm), psychological (fear of being abandoned by a spouse or parent) and finally motivational (what is in it for me).

The present study is designed to investigate the utility of a multi-method assessment of denial in child molesters and to better understand the relative contributions to treatment needs and risk management strategies. Potential results could support the notion that precious resources are being used to keep low risk offenders incarcerated when these resources could be applied to high-risk

offenders in need of intervention. Results could further advance the idea that other non-sexual offender programs should be used to modify the level of risk and needs of some of the lower risk sexual offenders. Finally, significant results could suggest methods for addressing the public safety issues and better managing the offender.

Method

Participants

The participants of this study were 122 adult male child molesters involved in an intake assessment process. All participants were assessed between March 1, 2000 and March 1, 2001. This sample represents approximately 10% of the offender population (1200) admitted to the assessment facility during that period and 61% of the (200) offenders undergoing a psychosexual assessment. These 122 participants represent 92% of the subjects (132) meeting the criteria for inclusion in this study. Ten subjects refused to sign the consent form required for inclusion. Although not recorded, it is likely that most were involved in appeals of their conviction and refused to participate on the advice of their legal counsel.

The mean age for the sample was 46.75 years, with a standard deviation of 13.55 years and a range from 20 to 76 years of age. In terms of education level, 32 participants had completed at least grade 12 while 64 had completed less than grade 10. The mean IQ as measured by the WAIS-R estimate of the Shipley Institute of Living Scale (Zackary, 1986) of the sample (N = 80) was 97.88 (SD = 10.02). Eight participants had incomplete test results that were coded as missing data. 34 participants were administered the Ravens Progressive Matrices due to an estimated reading level less than the sixth grade. The Raven's raw score mean was 32.21 (SD = 9.50).

When scores were converted as recommended by Raven, Court and Raven, (1996) 4 participants scored in the "intellectually average" range, 11 scored in the "definitely below average in intellectual capacity" and 17 scored in the "intellectually impaired" category.

All participants had been convicted and sentenced to a federal term of incarceration for sexually victimizing a child aged 15 years or less. Participants were categorized according to three sets of groups based on their index sexual offence. These groups included age of the victim in their offences, the offender's relationship to the victim(s) and the offender's degree of acknowledged culpability.

Although not included in the formal hypotheses, groups were formed on the bases of victim age. According to research by Baxter, et al. (1984), child molesters that select pubescent victims presented similar to rapists in terms of type of sexual deviance.

Participants were separated into groups based on the age of the youngest victim of their index offence (Victim Age: Prepubescent, Pubescent). Those with prepubescent victims had been convicted of a sexual offence involving a child aged 11 years or younger and those with pubescent victims had been convicted of a sexual offence involving a child between 12 and 15 years of age (see Table 1).

All Participants were further assigned to groups based on their relationship to the victim in the index offence (CM Type: Extra-familial, Intra-familial and Incest offender). Incest offenders

Table 1: Offender Characteristics by Child Molester Victim Age

All Participants							
(n=122)							
	Prepubescent		Pubescent				
	Child		Child				
	Molesters		Molesters				
	(n=74		(n=48)				
Variable	Mean	SD	Mean	SD	F	p	η^2
Victim Age ¹	7.46	2.86	13.38	1.18	184.79	.001	.78
Offender Age	49.57	13.73	42.40	12.17	8.67	.01	.26
# of Victims	3.12	4.18	2.17	2.45	1.96		.13
IQ (SILS)	98.51	10.14	97.14	9.97	0.37		.07
Raven's PM	30.54	9.97	36.20	7.16	2.63		.28
Sentence in Years	5.65	5.27	4.70	4.74	1.03		.09
Degree of Intrusion	3.78	.45	3.79	.54	0.01		.01
Degree of Injury	2.41	1.18	2.88	1.44	3.87		.18
Victim Gender	Female	Male	Female	Male	X ² 8.62	.05	.24
	45	29	40	8			

¹ Victim Age is the grouping variable.

Table 2: Offender Characteristics by Child Molester Type

All Participants									
(n=122)									
Variable	Incest Offenders (n=32)		Intra- familial Child Molesters (n=28)		Extra- familial Child Molesters (n=62)		F	p	r
	Mean	SD	Mean	SD	Mean	SD			
Offender Age	49.63	12.70	48.29	12.28	44.56	14.33	1.73		.16
Victim Age	8.66	4.09	8.75	3.71	10.84	3.27	5.39	.01	-.29
# of Victims	2.31	1.73	1.64	.87	3.48	4.79	2.91		-.21
IQ (SILS)	100.43	9.96	95.78	10.20	97.80	10.00	.92		.01
Raven's FM	29.64	9.54	33.63	6.13	34.25	11.16	.87		-.16
Sentence in Years	4.30	1.89	4.05	1.73	6.33	6.74	2.83		.21
Degree of Intrusion	3.94	.25	3.96	.18	3.63	.61	7.41	.01	.33
Degree of Injury	2.41	1.24	2.61	1.07	2.68	1.43	.46		-.07
Victim Gender	Female	Male	Female	Male	Female	Male	X ²		-.15
	26	6	20	8	39	23	3.42		

Note: A combination of the Incest and Intrafamilial groups vs. the Extrafamilial group is used for correlations.

were those who offended only against their own biological child or a sibling (father, grandfather, brother). Intra-familial child molesters were those who offended only against victims residing in the home and for whom they had a parental role such as a stepfather. Extra-familial child molesters had at least one victim outside the home (see Table 2).

Finally, participants were divided into groups based on level of acknowledged culpability as measured by the Denial and Minimization Checklist (Admitter Status). Deniers were those who did not acknowledge any responsibility for any sexually offending behaviour (absence of minimization). Minimizers acknowledged responsibility but cited various reasons designed to reduce their apparent level of responsibility (this included denying responsibility for some offences). Unfortunately, only six participants could be classified as true admitters, neither denying nor minimizing, therefore, the admitters were combined with the minimizers. The resulting groups were referred to as non-admitting and admitting culpability (see Table 3).

Measures

Self Report Measures.

Multiphasic Sex Inventory (MSI).

The Multiphasic Sex Inventory (Nichols & Molinder, 1984) is a 300-item true/false self report questionnaire developed to assess

Table 3: Offender Characteristics by Admitter Status

All Participants (n=122)							
Variable	Non- admitters (n=33)		Admitters (n=89)		F	p	η ²
	Mean	SD	Mean	SD			
Offender Age	48.58	14.80	46.07	13.08	.82		.08
Victim Age	10.33	3.95	9.58	3.64	.97		.09
# of Victims	2.36	4.52	2.90	3.24	.53		.07
IQ (SILS)	94.77	8.30	99.37	10.50	3.83		.22
Raven's PM	30.60	15.57	32.48	8.43	.16		.07
Sentence in Years	5.47	5.66	5.21	4.87	.07		.02
Degree of Intrusion	3.82	.40	3.78	.52	.19		.04
Degree of Injury	2.67	1.24	2.56	1.33	.16		.04
Victim Gender	Female	Male	Female	Male	X ²	.01	.28
	30	3	55	34	9.66		

a range of sexual characteristics of identified sexual offenders (See Appendix A). The scales assess a variety of attributes related to denial and defensiveness, sexual attitudes, sexual history, sexual knowledge and sexual dysfunction.

The entire questionnaire was administered in accordance with the authors' instructions. However, only the following scales were scored and analyzed.

The *Child Molest Scale* has 35 items (24 true, 11 false). Simkins, Ward, Bowman, and Rinck (1989) found that both familial and extra-familial child molesters scored higher on the scale than non-child molesters. They also found scale scores were negatively correlated with denial and treatment outcome. The test-retest reliability coefficient was $\underline{r} = .78$. Kalichman, Henderson, Shealy, and Dwyer (1992) reported an internal consistency coefficient alpha of $\underline{r} = .90$.

The *Child Molest Lie Scale* has 13 items (3 true, 10 false). This scale is intended to measure the degree of denial/minimization in identified child molesters and is the reverse scoring of 13 of the *Child Molest Scale* items.

The *Incest Lie Scale* has 4 items (2 true, 2 false). This scale is simply the reverse of four items from the *child molest scale*.

The *Sexual Obsessions Scale* is intended to assess level of sexual fantasy and activity, it has 20 items (all true). Nichols

and Molinder (1984) report "alpha $\underline{r}$ = .65" and "stability of $\underline{r}$ = .70". Simkins et al. (1989) found 3-month stability slightly better at $\underline{r}$ = .80 but found no relationship with treatment outcome. Kalichman et al. (1992) reported an internal consistency coefficient alpha of $\underline{r}$ = .86.

The *Justifications Scale* is comprised of 24 items (all true) that address various rationalizations offenders use to explain their offenses. Simkins et al. (1989) found the 3-month stability of the scale to be $\underline{r}$ = .78 and it had weak correlations with treatment outcome. In addition, Miner, Marques, Day, and Nelson (1990) found that scores on the scale tended to decrease with treatment. Kalichman et al. (1992) report an internal consistency coefficient alpha of $\underline{r}$ = .82.

The *Social Sexual Desirability Scale* contains 35 items (15 true, 20 false) that aim to assess denial and minimization of normal sexual interests. Gillis (1991) reported high internal consistency for the 35-item scale ($\underline{r}$ = .87) and Simkins et al. (1989) reported 3-month stability to be $\underline{r}$ = .84. Kalichman et al. (1992) reported an internal consistency coefficient alpha of $\underline{r}$ = .87.

Balanced Inventory of Desirable Responding (BIDR) .

The BIDR (Paulhus, 1991) is a 40-item self-report measure of the tendency to give socially desirable responses on self-reports (See Appendix B). The measure is comprised of two sub-scales; Self-

Deceptive Enhancement (SDE, 20 items) which measures the tendency to give honest (though self-deceived) but inflated self-descriptions and Impression Management (IM 20 items) which measures the tendency to give inflated self-descriptions based on a specific situation. Each statement in the scale is rated, on a 7-point Likherd scale, according to the extent to which the participant agrees with it (1 = not true, 4 = somewhat true, 7= very true). Items that receive a rating of 6 or 7 are given a score of "1" and the remaining ratings are scored as "0". The items belonging to each factor are separately summed for a factor score out of 20 and all 40 items are summed for a total score out of 40. Paulhus (1998) reports a coefficient alpha of $\underline{r} = .83$ for the entire scale. For the impression management factor and for the self-deception factor, coefficient alphas range from $\underline{r} = .68$ to $.80$ and $\underline{r} = .75$ to $.86$ respectively. Test re-test reliability for the impression management factor was estimated at $r = .65$ and for the self - deception factor at $\underline{r} = .69$. Kroner and Weekes (1996a) confirmed the 2-factor structure, reliability and validity within an offender sample.

The most recent version of the BIDR, known as the Paulus Deception Scales (Paulus, 1998) uses a 5 point scale which is then transformed to "true" or "false".

Response Latency Measurements.

Response latencies will be adjusted to account for individual

and item differences using a method recommended by Holden, Fekken and Cotton (1991) and Holden and Kroner (1992). First, all response latencies less than .5 seconds and greater than 40.0 seconds were eliminated. These are considered outliers that result from not reading the item before responding (too fast) and distractions from answering the item (too slow). Second, response latencies are standardized across the items for each subject. This corrects for confounding individual differences such as reading speed. Third, response latencies are standardized within each item. This corrects for the confounding influence of item length, vocabulary levels and order of presentation. Fourth, response times converted to z-scores lower than -3.0 and higher than 3.0 are set to -3.0 and 3.0 respectively which manages statistical outliers. Holden and Kroner (1992) refer to the resulting latency scores as "differential item response latencies that represent the latency of responding in relation to a particular respondent and to a particular test item" (p. 171).

Shipley Institute of Living Scale (SILS) .

The Shipley Institute of Living Scale is designed to assess general intellectual functioning and to aid in the identification of cognitive impairment in individuals with normal intelligence (Shipley, 1940). The scale consists of two subtests - a 40-item vocabulary test and a 20-item test of abstract thinking. Both subtests are self-administered and can be presented individually or in

groups. The total administration time for the test is 20 minutes, 10 minutes for each sub-test. The responses are hand scored to produce six summary scores: (a) a Vocabulary score, (b) an Abstraction score, (c) a Total score, (d) a Conceptual Quotient, (e) an Abstraction Quotient and (f) an estimated full scale IQ based on the Wechsler Adult Intelligence Scale- Revised (Wechsler, 1981). The estimated WAIS-R was taken as the measure of intellectual functioning for this study. (See Appendix D)

Interview Based Measures

Denial and Minimization Checklist (DMCL) .

The Denial/Minimization Checklist (DMCL; Barbaree, 1991) is a 27-item checklist that assesses both denial and minimization. Each item is scored in a binary manner indicating the presence or absence of that form of denial or minimization (See Appendix C).

Denial is measured according to three subtypes: (a) denial of any form of interaction (e.g., never had any contact with victim or victim was out to get him), (b) denial of having a sexual interaction (e.g., the assault was not sexual or the touching was for some legitimate reason) and (c) denial that the sexual interaction was an offense (e.g., victim consented, victim didn't resist or benefited from the experience).

Minimization is also measured according to three subtypes (a) minimizing their responsibility for the offense (e.g., attributing

blame to victim, citing external attributions and citing internal attributions), (b) minimizing the extent of the sexual contact, (e.g., frequency of sexual contact, number of victims, force used, intrusiveness of sexual contact) and (c) minimizing the harm suffered by the victim.

Level of Service Inventory-Revised (LSI-R).

The Level of Service Inventory- Revised (LSI-R; Andrews & Bonta, 1995) is a 54 item scale of 10 different risk/need areas including criminal history, education/employment, finances, family/marital, accommodations, leisure/recreation, companions, alcohol/drug, emotional/personal and attitude/orientation. Following a review of available file information and a semi-structured interview, items are scored in a dichotomous manner indicating the presence or absence of the particular risk/need variable. The LSI-R total score is the sum of all items, with higher scores indicating greater risk of recidivism and need for intervention. (See Appendix E)

Static-99.

The STATIC-99 is a simple screening tool for sexual recidivism (Hanson & Thornton, 1999). The scale consists of 10 items scored from a review of the offender's records. Items include: prior sexual offenses, prior sentencing, current age, non-contact offences, index non-sexual violence, prior non-sexual violence,

unrelated victim, stranger victim, male victim, young, single. (See Appendix F)

Statistical Information on Recidivism - Revised (SIR-2.)

The SIR-2 is an actuarial risk prediction instrument (Nuffield, 1982). The scale consists of 15 items that, when summed, provide a single score associated with 5 levels of risk for recidivism ranging from "poor" to "very good". Items are scored such that lower values reflect higher probability of recidivism. The SIR-2 is a well-researched measure of criminal risk with acceptable reliability and validity (Motiuk & Porporino, 1988; Wormith & Goldstone, 1984). It is worth noting that the recently revised version of the SIR-2 has been validated with sexual offenders (Bonta, Harman, Hann, & Cormier, 1996). (See Appendix G)

Treatment Readiness Scale (TRS).

The Treatment Readiness Scale (Serin & Kennedy, 1997) has 11 items measuring readiness before participating in a correctional treatment program. The items have been developed so that two exemplars represent a particular domain relating to treatment readiness. Individual items are summed to provide a total score that represents an individual's readiness for treatment. Higher scores represent greater readiness for treatment. Serin and Kennedy (1997) report inter-rater reliability with sexual offenders of $r =$

.93 and non-sexual offender $r = .90$. In a sample of 148 offenders readiness scores ranged from 6-59 ($M = 34.42$ and $SD = 11.18$). (See Appendix H).

Degree of Sexual Intrusiveness.

Degree of sexual intrusiveness (DSI) is a rating of the most sexually intrusive assault from the index sexual offense. Sexual intrusiveness was rated on a 4-point scale developed by Quinsey, Khanna and Malcolm (1998), with higher scores indicating greater intrusiveness. (See Appendix I)

Degree of Victim Injury.

Degree of victim injury (DVI) is a rating of the amount of physical injury inflicted on the most seriously injured victim from the index sexual offense. Also developed by Quinsey et al., (1998), it is a 7-point scale with higher scores indicating greater victim harm. (See Appendix J)

Sexual Preference Testing

Sexual arousal was measured circumferentially using a mercury-in-rubber strain gauge (Medical Monitoring Systems, D.M. Davis Inc. - see Davidson, Malcolm, Lanthier, Barbaree and Ho, 1981). Conductance changes in the gauge as a result of changes in penile tumescence, were transduced through a Parks model 240 plethysmograph (Parks Electronics). Data were collected and analyzed on-line through a Hewlett-Packard 75000-control processor linked to a

Hewlett-Packard, Vectra computer.

Participants sat in a reclining chair in a private sound-attenuated room. Participants were visually monitored by a closed circuit video camera to ensure their gaze is in the appropriate direction. An intercom system was used for communication between the participant and the experimenter.

Child Sexual Violence Profile (CSVP).

The assessment of child sexual violence employs audio taped descriptions of both heterosexual and homosexual activity. Descriptions include consensual age appropriate encounters as well as descriptions involving sexual interactions with children. Four categories of sexual interaction are included: passive child, coercive child, sexual violence and non-sexual violence (Quinsey and Chaplin, 1988). A sample profile is presented as Appendix K.

Age/Gender Preference Profile (AGPP).

The Age/gender Preference Profile employed slide transparencies consisting of pictures of 9 nude females and 9 nude males. These transparencies were matched for explicitness of pose and sexual development of the model. Three models from each of the following categories were presented, adult, pubescent and prepubescent (Tanner, 1991). The transparencies were presented using a slide projector (Kodak Model, 860H) with a zoom lens (Kodak Model, Ektanar) onto a 1 m² projection screen located 2 m in front of the

subject (Malcolm, Law, Cantarutti and Zuber, 2000). A sample profile is presented as Appendix L.

Procedure

All participants were drawn from offenders admitted to the Millhaven Assessment Unit for intake assessment purposes. Intake and specialized sexual offender assessments are required by the Correctional Service Canada and the National Parole Board to determine the level of risk and needs and to make recommendations for programming and security classification/placement.

Familiarization

Each offender was interviewed and the purpose and procedures of the assessment were explained. Before any testing began, each offender was asked to read and sign a form indicating informed consent. At this time, offenders were asked if they would consent to participate in this study, agreement was indicated by the offender signing the consent form for this study (see Appendix M). Following the testing and full disclosure of their results, study participants were provided a Debriefing Information Sheet (see Appendix N).

Structured Interviews

Each participant completed a structured interview as part of the intake assessment. Three specially trained Behavioural Science Technologists (BST) conducted this interview under the supervision

of the author. During and after this interview, information was collected to allow for the completion of the interview-based measures. Follow-up interviews were scheduled when additional information was required to complete the measures. Although, inter-rater reliabilities were not calculated for the interview-based measures the author attended 3 interviews with each BST to ensure the measures were applied in accordance with the instructions.

Psychometric Testing

The Multiphasic Sex Inventory and the Balanced Inventory of Desirable Responding were administered by microcomputer. According to Miles and King, (1998), differences between self-report measures administered on computer as compared with paper-pencil administration were sufficiently small so as not to threaten their validity. In addition to the computer recording the item responses, the response latency to each item was also measured. The computer presented the instructions (which included the use of the response alternatives) followed by a command to press a key when the participant was ready to proceed. The item then appeared on the screen accompanied by the response alternatives. When the participants made their response the computer recorded the response, response latency, cleared the screen and presented the next item. Raw scores and response latencies were then downloaded to an SPSS file for scoring.

Sexual Preference Testing

Each participant was explained the purposes and procedures involved in phallometric testing. In an attempt to reduce the anxiety associated with these procedures, subjects toured the lab facilities and questions were answered without deception.

Testing was conducted in one or two sessions lasting approximately 90 minutes with at least 24 hours separating the sessions. Only 1 test was administered during a given session. After a subject fitted the strain gauge, he was instructed to view or listen (depending on the stimulus set) to the stimulus material and to think about the information presented. As recommended by the test developers (Quinsey & Chaplin, 1988), following presentation of warm-up stimuli, the actual test stimuli were presented in pseudo-random order. The only restriction on randomness ensured that stimuli of a given category never followed one another in any order. Stimulus presentation was computer controlled, all slide stimuli were presented for exactly 90 seconds. Audio stimuli were presented for between 80 and 90 seconds. Penile tumescence was recorded at 1-second intervals for 30 seconds prior to stimulus onset, 90 seconds during stimulus presentation and 20 seconds after stimulus offset. Subjects were required to return to baseline prior to successive stimuli being presented and this inter-stimulus interval rarely exceeded 90 seconds. The minimum criterion level of responding necessary for analysis was 5% full erection calculated from

normative data. Subjects' data that did not reach this criterion during any of the presented stimuli were not analysed.

Following suggestions by Harris, Rice, Quinsey, Chaplin and Earls (1992) within session z-scores were calculated for each stimulus. A gender preference differential index was calculated for each subject by subtracting the average response to the male stimuli from the average response to the female stimuli. Therefore, differentials < 0 indicate more responding to males than females.

Each subject's age preference differential index was calculated by subtracting the average response to the child stimuli from the average response to the adult stimuli. The gender of the stimuli used in calculating age preference was determined by the preferred gender according to the gender preference index. Therefore, differentials < 0 indicate more responding to children than adults

Results

Characteristics of the data

Prior to analysis, all data were examined through various SPSS* programs for accuracy of data entry, missing values and fit between their distribution and the assumptions of univariate and multivariate analysis. Six individuals received indeterminate or life sentences by the Courts. These individuals were coded as having sentences equal to 25 years to avoid being coded as missing data. In addition, six individuals did not have SIR-2 scores. Although not coded, these were likely aboriginal subjects. The Correctional Service of Canada has a policy that precludes the SIR-2 from being completed and recorded on Aboriginal Canadians.

An analysis of the Mahalanobis distances ($p < .001$ criterion) revealed no cases of multivariate outliers.

Preliminary Analysis

As described earlier, groups formed on the bases of victim age (pubescent, prepubescent), child molester type (extra-familial, intra-familial, incest) and admitter status (admitters, non-admitters) were compared on demographic variables. The demographic variables considered were offender age, victim age, number of victims, gender of victim, length of sentence, degree of sexual intrusion, degree of victim injury and intelligence.

Using a one-way ANOVA offenders with prepubescent victims were

found to be significantly older than those with pubescent victims, $F(1,120) = 8.67, p < .01$, and were more likely to have a male victim $\chi^2(1) = 8.62, p < .05$. None of the other comparisons reached statistical significance (see Table 1).

A second one-way ANOVA revealed a significant main effect for child molester type and victim age, $F(2,119) = 5.39, p < .01$ and degree of sexual intrusion $F(2,113) = 6.55, p < .01$. A planned comparison of the combined intra-familial and incest groups versus the extra-familial group indicated that the extra-familial offenders had significantly older victims, $t(119) = 3.27, p < .01$ and were significantly less sexually intrusive $t(119) = 3.85, p < .001$. A second planned comparison between the incest offenders and the intra-familial offenders failed to reach statistical significance for victim age $t(119) < 1$ or sexual intrusiveness, $t(119) < 1$. The remaining comparisons did not reach statistical significance (see Table 2).

Finally, a third one-way ANOVA found that non-admitting offenders scored lower on the Shipley's Institute of Living Scale than those who admitted responsibility, this difference approached but did not reach statistical significance $F(1,78) = 3.83, p = .054$. Further, low power of .49 and effect size of .05 suggests that increased power would not have rendered the result meaningful. In addition, group differences in scores on the Raven's Progressive

Matrices failed to reach statistical significance (see Table 3).

Experimental Analyses

Pre-Treatment Risk (Hypothesis 1).

A three-way MANOVA was used to investigate differences on the STATIC-99, SIR-2 and the LSI-R total and sub-component scores across three different groups: (i) Victim/Age; (ii) Admitter Status; and (iii) Child Molester Type (CM Type). An examination of the main effects using Wilks's Lambda as a test statistic indicated that the combined risk measures were significantly affected by victim/age, $F(12,94) = 2.48$, $p < .01$, $\eta^2 = .24$; CM type, $F(24,188) = 2.79$, $p < .001$, $\eta^2 = .26$, and admitter status $F(12,94) = 2.67$, $p < .01$, $\eta^2 = .25$. However, none of the two-way interactions or the three-way interaction reached statistical significance.

The tests of the between-subject effects indicated that offenders with prepubescent victims did not differ from those with pubescent victims with respect to the STATIC-99, SIR-2 or LSI-R total score. However, offenders with prepubescent victims scored significantly higher on the Emotional/Personal sub-component of the LSI-R than did offenders with pubescent victims, $F(1,105) = 13.06$, $p < .001$, $\eta^2 = .11$. Differences on the remaining LSI-R sub-component scales between offenders with pubescent victims and those with prepubescent victims were not found to reach statistical significance (see Table 4). Finally, an analysis of power suggests

Table 4: Pre-Treatment Risk by Child Molester Victim Age

All Participants (n=122)							
	Prepubescent		Pubescent				
	Child		Child				
	Molesters		Molesters				
Variable	Mean	SD	Mean	SD	F	p	η^2
STATIC-99	3.03	2.51	3.48	2.45	0.30		.09
SIR-2-R	8.87	10.26	5.31	10.42	3.43		-.17
LSI-R Total Score	23.69	9.35	23.71	11.64	0.35		.01
Criminal History	5.05	2.37	5.54	2.65	1.14		.10
Family/marital	2.39	1.08	2.13	1.25	1.80		.10
Companions	1.32	1.40	1.52	1.40	0.17		.07
Emotional/personal	2.19	1.07	1.88	1.16	13.06	.001	-.14
Education/employment	4.96	2.91	5.52	3.25	0.00		.09
Accommodations	0.68	0.95	0.79	0.97	0.00		.06
Alcohol/drugs	2.93	2.80	2.69	2.53	0.02		-.05
Financial	1.35	0.77	1.23	0.81	0.67		-.70
Leisure/recreation	1.49	0.76	1.27	0.84	1.77		-.70
Attitudes/orientation	1.32	1.22	1.15	1.37	1.71		-.70

that given the low power estimates, all below .45, and effect sizes, all less than .04, increased power would not have rendered the results meaningful.

According to the tests of the between-subject effects, CM type groups differed with respect to the STATIC-99 $F(2,105) = 14.81$, $p < .001$, $\eta^2 = .22$, and the LSI-R total score $F(1,105) = 3.16$, $p < .05$, $\eta^2 = .06$. Post Hoc comparisons (Bonferroni with alpha set at $p < .05$) revealed that the extra-familial child molesters scored significantly higher than the incest offenders and intra-familial offenders on the STATIC-99. As well, the extra-familial offenders scored significantly higher than the incest offenders on the LSI-R total score (see Table 5).

In addition, CM type groups also differed on the Criminal History [$F(2,105) = 4.02$, $p < .05$, $\eta^2 = .07$], Emotional/personal [$F(2,105) = 10.62$, $p < .001$, $\eta^2 = .17$], and the Financial [$F(2,105) = 3.34$, $p < .05$, $\eta^2 = .06$], sub-components of the LSI-R. Further Post Hoc comparisons (Bonferroni with alpha set at $p < .05$) found that the extra-familial child molesters scored significantly higher than incest offenders did on the Criminal History sub-component of the LSI-R.

Finally, the tests of the between-subject effects indicated that non-admitters did not differ from admitters with respect to the STATIC-99, SIR-2 or LSI-R total score. An analysis of power

Table 5: Pre-Treatment Risk by Child Molester Type

All Participants (n=122)									
Variable	Incest (n=32)		Intra- familial (n=28)		Extra- familial (n=62)		F	p	z
	Mean	SD	Mean	SD	Mean	SD			
STATIC-99	1.53	1.41	2.18	1.98	4.53	2.40	14.81	.001	-.55
SIR-2-R	12.17	8.73	8.42	10.38	4.75	10.46	2.46		.27
LSI-R Total Score	20.22	8.02	23.36	10.27	25.65	10.93	3.16	.05	-.19
Criminal History	4.00	2.05	4.71	2.46	6.13	2.39	4.02	.05	-.36
Family/marital	2.00	1.08	2.46	1.26	2.35	1.13	0.55		-.06
Companions	1.19	1.15	1.29	1.33	1.56	1.53	1.99		-.12
Emotional/personal	1.84	1.25	1.71	0.98	2.34	1.04	10.62	.001	-.25
Education/employment	4.50	2.91	5.07	3.07	5.58	3.09	1.24		-.13
Accommodations	0.53	0.80	0.86	0.97	0.76	1.02	1.11		-.04
Alcohol/drugs	2.88	2.59	2.96	2.67	2.76	2.79	0.38		.03
Financial	1.19	0.78	1.39	0.83	1.32	0.76	3.34	.05	-.03
Leisure/recreation	1.50	0.72	1.36	0.83	1.37	0.83	0.80		.04
Attitudes/orientation	0.59	0.76	1.54	1.43	1.47	1.31	2.12		-.17

Note: Note: A combination of the Incest and Intrafamilial groups vs. the Extrafamilial group is used for correlations.

suggests that given the low power estimates, all below .40, and effect sizes, all less than .03, increased power would not have rendered any of the results meaningful. However, non-admitters scored significantly higher than did admitters on the Attitude/Orientation sub-component of the LSI-R, $F(1, 105) = 12.07$, $p < .01$, $\eta^2 = .10$. Differences between admitters and non-admitters on the remaining LSI-R sub-component scales were not found to reach statistical significance (see Table 6).

In order to examine the relationship between these measures, correlation analyses were completed and are presented as Table 7. Inspection of the matrix indicates strong correlations between the LSI-R total score and both the Static99 ($r = .53$, $p < .001$) and SIR-2 ($r = -.73$, $p < .001$). Similarly, the Static99 was significantly related to the SIR-2 ($r = -.53$, $p < .001$). Further, the correlations between the LSI-R sub-components and the Static-99 and the SIR-2 were predominantly modest ($p < .01$). Correlations between the Static-99 and the Alcohol/Drugs and Leisure/Recreation sub-components were exceptions, as was the Emotional/Personal sub-component and the SIR-2 ($p < .05$).

Phallometric Measured Sexual Preference (Hypothesis 4).

Of the 122 participants involved in the present study, only 70 produced interpretable phallometric results. Of the 52 subjects without phallometric results, the majority refused testing on the

Table 6: Pre-Treatment Risk by Admitter Status

All Participants (n=122)							
Variable	Admitters (n=33)		Non- admitters (n=89)		F	p	z
	Mean	SD	Mean	SD			
STATIC-99	3.22	2.59	3.15	2.21	0.01		.01
SIR-2-R	7.39	9.98	7.77	11.72	0.73		-.02
LSI-R Total Score	23.29	9.77	24.79	11.58	0.16		-.07
Criminal History	5.19	2.42	5.39	2.67	0.17		-.04
Family/marital	2.31	1.13	2.21	1.22	0.11		.04
Companions	1.38	1.38	1.45	1.46	0.40		-.02
Emotional/personal	2.13	1.15	1.88	0.99	2.20		.10
Education/employment	5.02	3.06	5.61	3.00	2.11		-.09
Accommodations	0.69	0.94	0.82	1.01	0.01		-.06
Alcohol/drugs	2.87	2.71	2.76	2.66	0.09		.02
Financial	1.33	0.77	1.24	0.83	2.97		.05
Leisure/recreation	1.42	0.78	1.36	0.86	1.35		.03
Attitudes/orientation	0.96	1.15	2.06	1.27	12.07	.01	-.39

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Table 7: Correlation between Pre-treatment Measures of Risk

	1	2	3	4	5	6	7	8	9	10	11	12
1. STATIC-99												
2. SIR-2-R	-.53											
3. LSI-R Total Score	.53	-.73										
4. Criminal History	.63	-.79	.78									
5. Family/marital	.48	-.40	.62	.48								
6. Companions	.38	-.52	.68	.46	.41							
7. Emotional/personal	.19	-.11	.33	.20	.26	.06						
8. Education/employment	.32	-.46	.78	.43	.36	.51	.21					
9. Accommodations	.30	-.35	.53	.26	.37	.48	.10	.43				
10. Alcohol/drugs	.17	-.54	.66	.49	.30	.31	.11	.34	.09			
11. Financial	.26	-.48	.70	.49	.42	.39	.16	.52	.42	.45		
12. Leisure/recreation	.17	-.30	.56	.30	.35	.40	.22	.39	.41	.21	.60	
13. Attitudes/orientation	.38	-.37	.54	.44	.25	.34	.08	.35	.30	.22	.25	.30

Note: Correlations above .18 are significant beyond the .05 level; correlations above .23 are significant beyond the .01 level; correlations above .30 are significant beyond the .001.

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advice of their legal counsel, while a few failed to reach the minimum criterion response level (5% Full Erection) thus rendering the results uninterpretable. Importantly, while non-admitters (51%) were more likely to refuse phallometric testing than admitters (39%) this trend was not significantly different $\chi^2 (1) = 1.46, p > .10$.

Correlational analyses were performed to investigate the relationship between the BIDR sub-scales (social desirability) with phallometrically measured age preference and maximum peak response during phallometric testing. As can be seen in Table 8, the correlations between the BIDR sub-scales and phallometric age preference were negative and non-significant. This was also the case for the BIDR sub-scales and maximum peak response.

A univariate ANOVA found that child molesters with female victims (n=46) had significantly different gender preference differentials compared with child molesters with a male victim (n=24), $F(1,68) = 13.94, p .001, \eta^2 = .17$ (see Figure 1). The mean gender preference differential for the sample was .18 (SD = .79).

A three-way MANOVA was used to explore differences in age preference differentials and peak response magnitude across the three different offender groups: (i) Victim/Age; (ii) Admitter Status; and (iii) Child Molester Type (CM Type). An examination of the main effects using Wilks's Lambda as the test statistic indicated that the combined measures were significantly affected by

Table 8: Relationship between Age Preference, Peak Response and BIDR Scales

	Phallometric Age Preference	Maximum Peak Response
Self Deceptive Enhancement	-.11	-.25
Impression Management	-.02	-.22

Figure Caption

Figure 1: Mean Gender Preference Differential by Victim Gender.

Mean Gender Preference Differential
based on Victim Gender

having a prepubescent versus a pubescent victim, $F(2,58) = 7.11$, $p < .01$, $\eta^2 = .20$, and CM type, $F(4,116) = 2.74$, $p < .05$, $\eta^2 = .09$ but not admitter status $F(2,58) = 0.41$, $p > .10$, $\eta^2 = .01$. In addition, none of the two-way interactions or the three-way interaction reached statistical significance.

The tests of the between-subject effects indicated that age preference indices were significantly more deviant for offenders with a prepubescent victim than those with a pubescent victim, $F(1,59) = 13.59$, $p < .001$, $\eta^2 = .19$ (see Figure 2). In addition, the three child molest groups also differed with respect to age preference indices, $F(2,59) = 3.81$, $p < .05$, $\eta^2 = .11$ (see Figure 3). However, Post Hoc comparisons failed to reveal any significant differences between the CM types.

Finally, the tests of the between-subject effects indicated that group differences based on peak response magnitude did not reach statistical significance.

Multiphasic Sex Inventory (Hypothesis 2).

Of the 122 participants involved in the present study, only 75 completed the MSI. Of the 47 subjects who did not complete the MSI, 34 did not have the requisite reading skills, while 13 subjects were administered the MSI but failed to complete all the items.

A three-way MANOVA was used to investigate differences on the 6 MSI scales (Child Molest, Child Molest Lie, Incest Lie,

Figure Caption

**Figure 2: Mean Age Preference Differential by Child Molester Victim
Age**

Mean Age Preference Differential
based on Victim Age

Figure Caption

Figure 3: Mean Age Preference Differential by Child Molester Type

**Mean Age Preference Differential
based on Child Molester Type**

Justifications, Obsessions and Social/Sexual Desirability) across the three different groups: (i) Victim/Age; (ii) Admitter Status; and (iii) Child Molester Type (CM Type). None of the interaction effects reached statistical significance. An examination of the main effects using Wilks's Lambda as the test statistic indicated that the combined effects of the MSI scales were significantly affected by admitter status, $F(6,59) = 2.72$, $p < .05$, $\eta^2 = .22$ but not victim/age, $F(6,59) = 1.17$, $p > .10$ or CM type, $F(12,118) = .99$, $p > .10$.

The tests of the between-subject effects indicated that admitting offenders scored significantly higher than non-admitters on the Child Molest Scale, [$F(1,64) = 11.32$, $p < .01$, $\eta^2 = .15$] and the Justifications Scale, [$F(1,64) = 5.73$, $p < .05$, $\eta^2 = .08$]. In addition, admitting offenders scored significantly lower than non-admitters on the Child Molest Lie Scale, [$F(1,64) = 8.06$, $p < .01$, $\eta^2 = .11$] and the Incest Lie Scale, [$F(1,64) = 4.34$, $p < .05$, $\eta^2 = .06$] (see Table 9).

MSI - Response Latencies (Hypothesis 3)

A three-way MANOVA was used to investigate differences in response latencies on the 6 MSI scales (Child Molest, Child Molest Lie, Incest Lie, Justifications, Obsessions and Social/Sexual Desirability) across the three different groups: (i) Victim/Age; (ii) Admitter Status; and (iii) Child Molester Type (CM Type). None

Table 9: Multiphasic Sex Inventory Scales by Admitter Status

All Participants (n=76)							
MSI Scale	Admitters (n=49)		Non- admitters (n=27)		F	p	ξ
	Mean	SD	Mean	SD			
Child Molest Scale	12.64	8.51	2.11	1.91	11.32	.01	.60
Child Molest Lie Scale	8.11	4.26	12.32	.77	8.08	.01	-.52
Incest Lie Scale	2.70	1.25	3.64	.49	4.34	.05	-.41
Justifications Scale	4.43	3.77	1.50	1.07	5.73	.05	.42
Obsessions Scale	3.19	3.97	.61	1.10	.62		.37
Social/Sexual Desirability	23.89	5.71	19.25	6.05	.02		.36

of the interaction effects were found to reach statistical significance. An examination of the main effects using Wilks's Lambda as the test statistic indicated that the combined effects of the scale response latencies were significantly affected by admitter status, $F(6,59) = 2.60$, $p < .05$, $\eta^2 = .21$ but not victim/age, $F(6,59) = .73$, $p > .10$ or CM type, $F(12,118) = .59$, $p > .10$.

The tests of the between-subject effects indicated that admitting offenders took significantly longer than non-admitters to respond to items on the Child Molest Scale, [$F(1,64) = 6.61$, $p < .05$, $\eta^2 = .09$] and the Justifications Scale, [$F(1,64) = 5.27$, $p < .05$, $\eta^2 = .08$]. However, non-admitters took significantly longer than admitters to respond to items on the social/sexual desirability [$F(1,64) = 6.77$, $p < .05$, $\eta^2 = .10$] (see Table 10).

Balanced Inventory of Desirable Responding

(BIDR) .

Regarding the relationship between the BIDR scales and the MSI scales, scores on the Self Deceptive Enhancement Scale were found to be positively correlated with scores on the Child Molest Lie Scale ($r = .45$, $p < .01$) and the Incest Lie Scale ($r = .40$, $p < .01$). In addition, there was a significant negative relationship between Self Deceptive Enhancement and the Child Molest Scale ($r = -.42$, $p < .01$), and Obsessions Scale ($r = -.41$, $p < .01$) and the Social Sexual Desirability Scale ($r = -.25$, $p < .05$). Further, Impression

Table 10: Response Latencies for MSI Scales by Admitter Status

All Participants (n=76)							
Variable	Admitters		Non-admitters		F	p	r
	(n=49)		(n=27)				
	Mean	SD	Mean	SD			
Child Molest Scale	1.61	7.35	-2.10	8.67	6.61	.05	.23
Child Molest Lie Scale	.70	5.06	-.97	4.00	3.43	.05	.17
Incest Lie Scale	-.10	2.31	.12	2.22	.95		-.05
Justifications Scale	2.98	8.50	-4.69	6.13	5.27	.05	.44
Obsessions Scale	.74	5.04	-1.15	6.75	.09		.16
Social/Sexual Desirability	-3.41	9.11	5.60	9.22	6.77	.05	-.44

Management scores were found to be significantly related to the Child Molest Lie Scale ($\underline{r} = .28, p < .05$) and negatively correlated with the Child Molest Scale ($\underline{r} = -.26, p < .05$) the Obsessions Scale ($\underline{r} = -.26, p < .05$). Finally, there was a significant correlation between Impression Management and the response latencies for the Social Sexual Desirability Scale ($\underline{r} = .25, p < .05$).

Treatment Readiness Scale(Hypothesis 5).

Internal Consistency.

Treatment Readiness Scale internal consistency information is presented in Table 11. Inspection of the correlation matrix indicates modest to high inter-scale correlations among all the components. Cronbach's Alpha for the 11 sub-scales was .77.

Treatment readiness total score was found to be negatively related to the LSI-R total score ($\underline{r} = -.27, p < .01$) and the Static99 ($\underline{r} = -.18, p < .05$) but not the SIR-2. (see Table 12)

A three-way MANOVA was used to investigate differences on the Treatment Readiness Scale and sub-scale scores across the three different groups: (i) Victim/Age; (ii) Admitter Status; and (iii) Child Molester Type (CM Type). None of the interaction effects were found to reach statistical significance. An examination of the main effects using Wilks's Lambda as the test statistic indicated that scores on the Treatment Readiness Scale varied significantly by admitter status, $F(11,98) = 5.80, p < .001, \eta^2 = .39$ but not by

Table 11: Treatment Readiness Scale Intercorrelations, Means and SDs

Treatment Readiness Scale	1	2	3	4	5	6	7	8	9	10	11	12
1. Problem Recognition	1.00											
2. Goal Setting	.62	1.00										
3. Motivation	.77	.68	1.00									
4. Self Appraisal	.69	.56	.66	1.00								
5. Expectations	.60	.63	.69	.52	1.00							
6. Behavioural Consistency	.46	.66	.57	.47	.43	1.00						
7. Views About Treatment	.59	.62	.69	.55	.62	.64	1.00					
8. Self Efficacy	.42	.47	.48	.46	.49	.63	.55	1.00				
9. Dissonance	.53	.47	.48	.65	.47	.45	.51	.53	1.00			
10. External Supports	.33	.47	.45	.44	.39	.47	.53	.39	.38	1.00		
11. Affective Component	.44	.58	.47	.51	.49	.60	.59	.59	.57	.47	1.00	
12. TRS Total Score	.76	.81	.83	.78	.75	.77	.82	.73	.73	.64	.75	1.00
Mean	1.72	1.82	2.17	2.31	1.89	2.52	2.67	3.20	2.51	1.56	2.33	24.72
Standard Deviation	1.44	1.61	1.74	1.60	1.36	1.56	1.61	1.93	1.73	1.70	1.50	13.49

Note: All correlations were significant at the .01 level Alpha = .77

Table 12: Correlation Matrix for all Measures

Measures	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.
1. LSI(total)																		
2. Static99 .53*																		
3. SIR-2	-	-																
4. TRS	-	-	.04															
5. Phallo	.02	-.05	-.05	.13														
6. BIDR(SDE)	.04	.02	-.17	-.23	-.11													
7. BIDR(IM)	-.12	.01	.01	-.09	-.02	.51*												
8. MSI(CM)	-.02	.06	.05	.53*	.13	-	-											
9. MSI(CML)	.01	-.09	-.09	-	-.10	.45*	.28*	-										
10. MSI(INL)	.09	.14	-.19	-	-.27	.40*	.18	-.60*										
11. MSI(JUS)	.04	-.04	.04	.34*	.02	-.06	-.09	.38*	-	-.08								
12. MSI(OBS)	.10	.19	-.02	.31*	-.08	-	-.47*	-	-.22	.43*								
13. MSI(SSD)	-.10	-.03	.06	.14	.05	-	-.17	.29*	-	.12	.29*							
14. MSI(CM)	-	-.07	.01	.10	.04	.07	-.11	.20	-.16	-.12	.19	-.11	-.04					
15. MSI(CML)	.02	.08	-.09	.11	-.03	.19	-.00	.24*	-	-.07	.23*	-.02	-.08	.72*				
16. MSI(INL)	-	-.03	.08	.03	-.05	.12	.10	-.12	.07	-.03	-.10	-.20	-.23	.40*	.33*			
17. MSI(JUS)	-	.01	.02	.32*	-.02	-.05	-.04	.45*	-	-.21	.63*	.45*	.21	.05	.10	-.06		
18. MSI(OBS)	.11	-.05	.06	-.04	.09	-.12	-.04	.06	-.02	-.08	.08	.10	.08	.03	-.05	-	.03	
19. MSI(SSD)	.03	.05	-.06	-	-.13	.19	.25*	-.37*	.36*	-	-	-.19	-	-.03	-	-.16		

*p < .05. **p < .01. ***p < .001

victim/age, $F(11,98) = 1.21$, $p > .10$, $\eta^2 = .12$ or CM type, $F(22,196) = .73$, $p > .10$, $\eta^2 = .08$.

The tests of the between-subject effects indicated that admitting offenders scored significantly higher on problem recognition [$F(1,108) = 40.12$, $p < .001$, $\eta^2 = .27$], goal setting [$F(1,108) = 18.55$, $p < .001$, $\eta^2 = .15$], motivation [$F(1,108) = 36.35$, $p < .001$, $\eta^2 = .25$], self-appraisal [$F(1,108) = 39.20$, $p < .001$, $\eta^2 = .27$], expectations [$F(1,108) = 19.47$, $p < .001$, $\eta^2 = .15$], behavioural consistency [$F(1,108) = 5.10$, $p < .05$, $\eta^2 = .05$], views about treatment [$F(1,108) = 13.43$, $p < .001$, $\eta^2 = .11$], dissonance [$F(1,108) = 6.21$, $p < .05$, $\eta^2 = .05$], external supports [$F(1,108) = 4.39$, $p < .05$, $\eta^2 = .04$] and affective component [$F(1,108) = 7.12$, $p < .01$, $\eta^2 = .06$]. However, groups did not differ significantly with respect to self efficacy [$F(1,108) = 2.72$, $p > .10$, $\eta^2 = .03$] (see Table 13).

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Table 13: Treatment Readiness Scale by Admitter Status

All Participants (n=119)							
Variable	Admitters (n=87)		Non- Admitters (n=32)		F	p	ξ
	Mean	SD	Mean	SD			
Treatment Readiness Total	28.36	12.93	14.84	9.57	24.71	.001	.45
Problem Recognition	2.23	1.30	0.34	0.70	40.16	.001	.58
Goal Setting	2.17	1.58	0.88	1.31	18.55	.001	.36
Motivation	2.72	1.65	0.66	0.83	36.35	.001	.53
Self Appraisal	2.85	1.39	0.84	1.17	39.20	.001	.56
Expectations	2.23	1.33	0.97	1.00	19.47	.001	.41
Behaviour Consistency	2.71	1.49	2.00	1.65	5.10	.05	.20
Views about Treatment	3.02	1.53	1.72	1.44	13.43	.001	.36
Self Efficacy	3.37	1.80	2.75	2.21	2.72		.14
Dissonance	2.78	1.73	1.78	1.54	6.21	.05	.26
External Supports	1.73	1.71	1.09	1.59	4.39	.01	.17
Affective Component	2.53	1.44	1.81	1.55	7.12	.05	.21

Discussion

The present study was designed to investigate the utility of a multi-method assessment of denial in child molesters and to gain a better understanding of the relative contributions of these methods to identifying treatment needs and developing risk management strategies. Following a brief discussion regarding the study sample, the results will be discussed in accordance with each of the presented hypotheses. Table 14 summarizes the various measures as a function of admitter status.

General Findings

The use of consecutive admissions of convicted child molesters to federal custody in the present study produced a unique sample in comparison to samples used in previous research. In this way, a more representative sample was utilized than if it had been drawn from a particular institution/facility. In general, the proportion of offenders with prepubescent victims relative to those with pubescent victims was consistent with previous research (Baxter, et al., 1984; Simourd & Malcolm, 1998). Similarly, the relative proportions of extra-familial, intra-familial and incest offenders approximated the proportions reported in previous studies (Hanson, Scott, & Steffy 1995; Simourd & Malcolm, 1998). The proportion of individuals identified as non-admitters (deniers) was somewhat less than the expected 50% based on previous research (Barbaree, 1991; Scully & Marolla, 1984). In the present study, 27% of the sample

Table 14: Summary Of Measure Outcome By Admitter Status

MEASURES	Admitter Status		F	p	z
	Admitters	Non-Admitters			
PRE-TREATMENT RISK:					
	Mean	Mean			
Static99:	3.22	3.15	.005	ns	.01
SIR-2:	7.39	7.77	.157	ns	-.02
LSI-R:	23.29	24.79	.730	ns	-.07
PHALLOMETRIC TESTING:					
Age Preference Differential:	-.75	-.60	.437	ns	-.05
BIDR:					
Impression Management:	87.51	91.78	1.61	ns	-.08
Self Deception:	90.00	97.96	1.55	ns	-.26
TREATMENT READINESS:					
Total Score:	28.36	14.84	29.05	.001	.45
MULTIPHASIC SEX INVENTORY:					
	12.64	2.11	11.32	.01	.60
Child Molest:	4.43	1.50	5.73	.05	.42
Justifications:	3.19	.61	.624	ns	.37
Obsessions:	23.89	19.25	.017	ns	.36
Social/Sexual Desirability:					
MSI-RESPONSE LATENCIES:					
Child Molest:	1.61	-2.10	6.61	.05	.23
Justifications:	2.98	-4.69	5.27	.05	.44
Obsessions:	.74	-1.15	.09	ns	.16
Social/Sexual Desirability:	-3.41	5.60	6.77	.05	-.44

were considered non-admitters which was closer to the proportion (31%) reported by Marshall (1994). This finding was likely due to the dichotomous definition used to assign subjects to the admitter and non-admitter groups. Some researchers such as Barbaree (1991) tended to define non-admitters based on the presence of some level of denial (denial seeking). As such, subjects who denied any aspect of their offence(s) were classified as deniers. For example, if an offender was convicted of molesting two children and acknowledged responsibility for one offence but not the other offence he would be classified as a denier. The present study however, followed Marshall (1994), non-admitters were defined as those who expressed no acknowledgment of responsibility (responsibility seeking). Therefore, because the offender in the above example accepted responsibility for molesting one of the victims he would be classified as an admitter. Stated differently, subjects who accepted any form of culpability for sexual misconduct were considered admitters.

Pre-treatment Risk (Hypothesis 1)

The significant correlations between the three measures of risk (LSI-R, Static-99, SIR-2) were in-line with results presented in previous studies (Barbaree, Seto, Langton, & Peacock, 2000; Glover, Nicholson, Hemmati, Bernfeld, & Quinsey 1999; Simourd & Malcolm, 1998).

It was hypothesized based on previous research by Serin et al.

(1999) and Simourd & Malcolm (1998) that pre-treatment risk would not be related to admit status. Further, it was hypothesized that extra-familial child molesters would present as a higher risk for re-offence than would intra-familial child molesters and incest offenders. The results support both of these hypotheses.

Only the Attitude/Orientation subcomponent of the LSI-R was found to vary based on admit status. According to Simourd and Malcolm (1998) high scores on Attitude/Orientation are consistent with offenders who have a propensity towards response bias and self-deception. Clearly, knowing that an offender denies committing an offence for which he has been convicted does not accurately reflect his level of pre-treatment risk.

Further and as expected, these results indicate that extra-familial child molesters present a significantly higher level of risk for re-offence than do familial child molesters. These results are in agreement with previous studies (Marshall & Barbaree, 1988; Malcolm & Simourd, 1999; Rice, Quinsey & Harris 1991).

Multiphasic Sex Inventory (Hypothesis 2)

Interestingly, a substantial proportion of the subjects (38%) could not or did not complete the MSI. Most were unable to complete the test due to limited reading skills. Others began the test but failed to complete enough items for scoring purposes.

In general, the results were as hypothesized, scores on the

MSI were highly associated with admitter status. Admitters scored significantly higher on the Child Molest Scale and lower on the lie scales than did non-admitters. In addition, these self-report findings were significantly correlated with Impression Management scores on the BIDR scale.

Therefore, because minimization of responsibility is commonplace among child molesters, the potential for significant response bias needs to be investigated beyond the use of self-report measures such as the MSI. This is especially true when the offender categorically denies involvement. It is clear that the transparency of items on the MSI prompts subjects inclined to deception to reflect a non-admitter status. As such, little useful information is obtained regarding past sexual behaviour or the need for intervention for non-admitting offenders. Thus while transparency of items makes response bias a relatively simple task, transparency remains a necessary feature of such inventories. Items on self-report inventories need to clearly represent the behaviour they are designed to measure. What is at issue is whether such inventories should be administered to, or are useful with offenders who deny culpability.

Response Latencies (Hypothesis 3)

In contrast to the predicted outcome, response latencies were longer for admitters than non-admitters on both the Child Molest Scale and the Justifications Scale. However, the Social Sexual

Desirability Scale latencies were as predicted with non-admitters taking significantly longer to respond. Previous research involving response latencies has typically used inventories that address attitudinal issues (Holden & Kroner, 1992; Mills, 2000). In such cases, subjects are required to assess the applicability of the items to their attitude, value or belief. This is the situation with respect to the Social Sexual Desirability Scale where latencies were consistent with the predicted outcome. Indeed Holden and Kroner (1992), suggest that the effect of response latencies can be enhanced when the reference point of the material is less familiar such as a non-self-referent response set. This is not the case with the Child Molest Scale or the Justifications scale where items tend to question past behaviour. Moreover, the majority of child molesters are quite practiced at responding to this type of question. Consequently, they require little thought to respond to the question in their intended direction, hence, the almost reflex reaction times.

Phallometrics (Hypothesis 4)

Phallometric results replicated previous findings in terms of gender and age preference results as well as proportion of subjects tested (Malcolm Andrews & Quinsey, 1994; Malcolm, et al. 2000). All offender groups differed in the expected direction. Offenders with prepubescent victims were more sexually deviant than were offenders with pubescent victims. Similarly, extra-familial child

molesters were more deviant than intra-familial child molesters and incest offenders. Most importantly, there were no significant differences between admitters and non-admitters.

Based on the work of Looman et al, (1998) it was expected that the non-admitter group would have a disproportionate number of non-responders and have higher social desirability scores. Indeed slightly more admitters than non-admitters consented to and completed phallometric assessment however, this difference was not statistically significant. Further, although group differences were in the expected direction, non-admitters did not have statistically significant higher social desirability scores than admitters.

Therefore, while phallometric testing has a well-documented problem with voluntary control or faking as cited by Marshall and Fernandez (in press) not all non-admitters are necessarily motivated or have the ability to control their deviant responding. Finally, these results indicate that non-admitters failed to employ the simple strategy of refusing to be tested or failing to respond to interpretable levels in order to avoid the potential of being viewed as sexually deviant.

Treatment Readiness (Hypothesis 5)

According to these results, groups based on offence characteristics such victim age and CM type did not differ with respect to treatment readiness. This finding replicates the

earlier work reported by Serin, et al. (1998). However, while Serin et al. (1998) found that treatment readiness was not correlated with denial and minimization, the present study, using a larger sample, found highly significant results. The significant relationship between admitter status and treatment readiness may suggest that not acknowledging responsibility is worthy of specifically targeted interventions. In the present study, non-admitters were rated lower than admitters on most readiness subscales. Not surprisingly, admitters were rated as better able to recognize the existence of problems, set appropriate goals and have positive expectations about treatment than did non-admitters. Further, non-admitters were less motivated and had less positive views about treatment. Although it could be argued that these results could be expected based solely on the denial of responsibility, these observations allow clinicians to generate intermediate treatment targets. Early interventions might focus on setting appropriate long and short-term goals, establishing external supports, facilitating problem recognition and establishing a therapeutic alliance. Fernandez, Kunic and Marshall (1999) have reported preliminary results of such a program. Offenders were offered admission to a pre-treatment sensitization program within the first month of admission to federal custody. The program focused on victim awareness/problem recognition, personal dissonance/distress and the development of therapeutic alliances. Although no statistical comparisons were made, feed

back from subsequent treatment programs suggested that these offenders were better prepared to address the challenges of treatment (Fernandez, personal communication, October 1999). Follow-up studies will determine if such interventions are associated with improved short-term goals such as program completion and support for release and long-term goals such as re-offence.

Implications

Child molesters who deny present a multitude of problems to those charged with managing them and making decisions about them. Many of these individuals are managed by way of the preventative detention legislation and accordingly are required to serve the totality of their imposed sentence. Clearly, this is a reasonable outcome for high-risk offenders who will not comply with program recommendations and are not likely to comply with the requirements of supervision. However, this practice does nothing to mitigate the risk of future offending. The results of this study strengthen the view of denial as a responsivity factor and lend support to the argument in favour of "motivational", "treatment readiness", or "sensitization" programs. For those individuals who present a high risk for re-offence we need to identify and manage the impediments (legal, environmental, psychological, motivational) to treatment such that optimal behaviour change is realized. Such programs could focus on the process of problem recognition and therapeutic

alliance before the more traditional program syllabus is introduced.

Additionally, these data lend support to the evolving practice of not imposing such stringent criteria when managing low-risk sexual offenders including those who do not accept responsibility. These offenders may be better managed using offence-related programs to address related criminogenic factors that influence offending such as substance abuse or anger management. In this way precious resources would be available and more appropriately used to manage high-risk offenders regardless of their admitter status.

Limitations of Findings

This current study is comprised solely of child molesters, therefore, it would be inappropriate to generalize these results to other types of sexual offenders such as rapists. Further, these results only apply to federally incarcerated child molesters. Typically, these offenders have offences that are more serious or they have a more extensive criminal history than do those offenders who are not federally incarcerated. As such, the extent to which these results can be generalized to child molesters not in federal custody remains unclear. A final limitation relates to one of the studies strengths. The present sample was collected approximately 2 months following the participants being sentenced for their offences. Many potential non-admitter subjects planned a legal appeal of their convictions and some had been cautioned by their

legal counsel to not participate in assessment and research procedures. Thus, somewhat fewer non-admitters participated than may be the case had the study occurred later in their sentence.

Suggestions for Future Research

There is a need for long term follow-up of sexual offenders who do not complete sexual offender specific programs but do complete other non-sex offender programs while controlling for level of pre-treatment risk. Further, the issue of managing low risk sexual offenders should be addressed empirically. In light of the low recidivism rates associated with these offenders, should they undergo sexual offender specific intervention and how much?

The results of this study suggest that future research should investigate the use of response latencies with a measure of cognitive distortions such as Bumby's Cognitive Distortion Scale (Bumby, 1996) and/or Hanson's Sexual Attitude Scale (Hanson, Gizzarelli, & Scott 1994).

The use of dynamic factor rating measures such as Violence Risk Scale : Sex Offender Version (Gordon, Nicholaichuk, Gordon & Wong, 1999), and SONAR (Hanson & Harris, 2000) should be investigated with admitting and non-admitting offenders. Although it is likely that the raters of these measures will continue to be influenced by the presumption of guilt, these scales should be sensitive to proximal offence factors that offenders may be willing to address in treatment.

Based on these findings separate norms for the Multiphasic Sex Inventory should be provided for admitter and non-admitter offenders.

Conclusions

Contingent on the limitations expressed, the results of this study lend continued support for the use of a multi-method assessment procedure with child molesters who do not accept responsibility.

As with previous studies, level of acknowledged responsibility was unrelated to actuarially measured pre-treatment risk for re-offence (Kennedy & Grubin, 1992; Simourd & Malcolm, 1998; Hanson & Bussiere, 1998). Further, this result was found true for all three measures of risk, the STATIC99, LSI-R and SIR-2. This finding provides further evidence that untreated non-admitting child molesters present no greater risk for re-offence than untreated admitting child molesters.

The continued use of phallometric testing as part of a multi-method assessment strategy is supported. While faking and voluntary control are ongoing threats to the external validity of phallometric testing, these data support the notion that not all potentially motivated subjects have the ability to hide their deviant response profiles.

The use of self-report inventories with child molesters other than those already acknowledging responsibility is not supported.

Although such measures provide considerable information the reliability and validity of the information remains questionable. Similarly, the potential benefit of response latencies with self-report measures of sexual deviance requires considerable research before it could be used to inform clinical decisions.

Although treatment readiness is not a criminogenic factor, it might be characterized as a mediating factor. According to Bonta, (1995), successful interventions need to consider those factors which influence the impact of the intervention. In this context, interventions could be developed to enhance motivation and improve program performance. In light of the significant correlation between treatment readiness and risk as measured by the LSI-R and the Static-99, such interventions may actually reduce the required intensity level of subsequent programs.

References

Abel, G.G., Becker, J.V., Mittelman, M., Cunningham-rathner, J., Rouleau, J.L., & Murphy, W.D. (1987). Self-reported sex crimes of non-incarcerated paraphiliacs. Journal of Interpersonal Violence, 2, 3-25.

Abel, G.G., Becker, J.V., Murphy, W.D., & Flanagan, B. (1981). Identifying dangerous child molesters. In J.R. Stuart (Ed). Violent behavior: Social learning approaches to prediction, management and treatment. (pp. II 6-13 7). New York: Brunner/Mazel.

Abrams, S. (1991). The use of polygraphy with sex offenders. Sexual Abuse: A Journal of Research and Treatment, 4, 239-263.

Abrams, S., & Ogard, E. (1986) Polygraph surveillance of probationers. Polygraph, 15, 174-182.

American Psychiatric Association. (1994) Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Andrews, D. A., & Bonta, J. L. (1995). The Level of Service Inventory-Revised. Toronto, Canada: Multi-Health Systems.

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

Andrews, D.A., & Friesen, W. (1987) Assessments of anticriminal plans and the prediction of criminal futures: A research note. Criminal Justice and Behavior, 14, 33-37.

Association for the Treatment of Sexual Abusers (1997) Ethical Standards and Principles for the Management of Sexual Abusers.

Beaverton, Oregon: Author.

Badgley, R., Allard, H., McCormick, N., Proudfoot, P., Fortin, D., Oglivie, D., Rae-Grant, Q., Gelinas, P., Pepin, L. & Sutherland, S. (1984). Sexual offences against children. (Vol. 1). Ottawa: Canadian Government Publishing Centre.

Baird, S.C., Heinz, R.C. & Bemus, B.J. (1979). The Wisconsin case classification and staff development project: A two-year follow-up report. Wisconsin: Division of Corrections

Balloun, D., & Homes, D.S. (1979) Effects of repeated examinations on the ability to detect guilt with a polygraphic examination: A laboratory experiment with a real crime. Journal of Applied Psychology, 64, 316-322.

Barbaree, H.E. (1991). Denial and minimization among sex offenders: Assessment and treatment outcome. Forum on Corrections Research, 3, 300-333.

Barbaree, H.E., Seto, M.C., Langton, C.M. & Peacock, E.J. (2000). Six risk assessment instruments for adult sex offenders, a paper submitted for publication.

Barbaree, H.E., Seto, M.C. & Maric, A. (1996), Sex offender characteristics, response to treatment and correctional release decisions at the Warkworth Sexual Behaviour Clinic. Forensic Division, Clarke Institute of Psychiatry.

Barlow, D.H. (1977) Assessment of sexual behavior. In A.R. Ciminero, K.S. Calhoun, and H.E. Adams (Eds) Handbook of Behavior Assessment. New York: John Wiley.

Baxter, D.J., Marshall, W.L., Barbaree, H.E., Davidson, P.R., & Malcolm, P.B. (1984). Deviant sexual behavior: Differentiating sex offenders by criminal and personal history, psychometric measures, and sexual responses. Criminal Justice and Behavior, 11, 477-501.

Bonta, J., Harman, W. G., Hann, R. G., & Cormier, R. B. (1996). The prediction of recidivism among federally sentenced offenders: A re-validation of the SIR scale. Canadian Journal of Criminology, 38, 61-79.

Borzecki, M. & Wormith, J.S. (1987) A survey of treatment programmes for sex offenders in North America. Canadian Psychology, 28, 30-44.

Boydell, C.L. & Connidis, I.A., (1986) A social systems approach to criminal justice research: An overview. In C.L. Boydell & I.A. Connidis (Eds.) The Canadian Criminal Justice System. Canada: Holt, Reinhart and Winston.

Briere, J.N. (1992) Child abuse trauma: Theory and treatment of the lasting effects. Newbury Park: Sage.

Bumby, K.M. (1996) Assessing the cognitive distortions of child molesters and rapists: Development and validation of the molest ,and rape scales Sexual Abuse: A Journal of Research and Treatment, 8, 37-54.

Canadian Centre for Justice Statistics (1999), Juristat: Sex Offenders. Statistics Canada

Clark, M. & Grier, P.E. (1993, August). Using the multiphasic sex inventory with child molesters. Paper presented at the meeting of the American Psychological Association, Toronto, Canada.

Correctional Service of Canada. "Standards and Guidelines for the Provision of Services to Sex Offenders", 1996.

Davidson, P. R., Malcolm, P. B., Lanthier, R. D., Barbaree, H. E., & Ho, T.P. (1981). Penile response measurement: Operating characteristics of Parks plethysmograph. Behavioral Assessment, 3, 137-143.

Day, D., Miner, M., Sturgeon, V., & Murphy, J. (1989). Assessment of sexual arousal by means of physiological and self-report measures. In D.R. Laws (Ed.), Relapse prevention with sex offenders (pp. 115-123). New York: Guilford Publications.

Farkas, G.M. (1978). Comments on Levin et al. and Rosen and Kopel: Internal and external validity issues. Journal of Clinical and Consulting Psychology, 46, 1515-1516.

Fernandez, Y., Kunic, D. & Marshall, W.L. (1998, October) Treatment at intake: The benefits of early intervention. A paper presented at the association for the treatment of sexual abusers conference, Vancouver, Canada.

Finkelhor, D. (1986) A Sourcebook on Child Sex Abuse. Newbury Park, Ca: Sage.

Frenzel, R. (1990) Generalization gradients in the erotic preference profiles of normal and pedophilic men. Unpublished Masters Thesis University of Alberta, Edmonton Alberta.

Frenzel, R.R., & Lang, R.A. (1989). Identifying sexual preferences in intrafamilial and extrafamilial child sexual abusers. *Annals of Sex Research*, 2. 255-275.

Freund, K. (1965). Diagnosing heterosexual pedophilia by means of a test for sexual interest. *Behaviour Research and Therapy*. 3. 229-234.

Freund, K. (1967a). Diagnosing homo- and heterosexuality and erotic age-preference by means of a psychophysiological test. *Behaviour Research and Therapy*, 5, 209-228.

Freund, K. (1967b). Erotic preference in pedophilia. *Behaviour Research and Therapy*, 5, 339-348.

Freund, K., & Blanchard, R. (1989). Phallometric diagnosis of pedophilia. *Journal of Consulting and Clinical Psychology*, 57, 1-6.

Freund, K., Chan, S., & Coulthard, R. (1979). Phallometric diagnoses with "nonadmitters". *Behaviour Research and Therapy*, 17, 451-457.

Freund, K., & Watson, R.J. (1991). Assessment of the sensitivity and specificity of a phallometric test: An update of phallometric diagnosis of pedophilia. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 3, 254-260.

Freund, K., Watson, R.J., & Dickey, R. (1991). Sex offenses against female children perpetrated by men who are not pedophiles. Journal of Sex Research, 28, 409-423.

Freund, K., Watson, R.J., & Rienzo, D. (1988). Signs of feigning in the phallometric test. Behaviour Research and Therapy, 26, 105-112.

Garland, R.J., & Dougher, M.J. (1991). Motivational Intervention in the treatment of sex offenders. In W.R. Miller & S. Rollnick (Eds.), Motivational interviewing: Preparing people to change addictive behaviour (pp. 303-313). New York: Guilford.

Gendreau, P. (1996). Offender Rehabilitation: What we know and what needs to be done. Criminal Justice and Behaviour, 23, 144-161.

Gillis, J.R. (1991) The rapist as a sexually deviant offender. Unpublished doctoral dissertation, Queens University, Kingston.

Glover, A.J., Nicholson, D.E., Hemmati, T., Bernfeld, G.A. & Quinsey, V.L. (2001). A comparison of predictors of general and violent recidivism among high risk federal offenders. A paper submitted for publication.

Grossman, L.S., Cavanaugh, J.L., & Haywood, T.W. (1992). Deviant sexual responsiveness on penile plethysmography using visual stimuli: Alleged child molesters vs. normal control subjects. Journal of Nervous and Mental Disease, 180, 207-208.

Hall, G.C.N., & Hirschman, R. (1991) Towards a theory of sexual aggression: A quadripartite model. Journal of Consulting and Clinical Psychology, 59, 662-669.

Hall, G.C.N., Proctor, W.C., & Nelson, G.M. (1988). Validity of physiological measures of pedophilic sexual arousal in a sexual offender population. Journal of Consulting and Clinical Psychology, 56, 118-122.

Hanson, R.K. (1995) The development of a brief actuarial risk scale for sexual offense recidivism. User Report No. 1997-04. Ottawa: Department of the Solicitor General of Canada.

Hanson, R.K., & Bussiere, M.T. (1998). Predicting Relapse: A meta- analysis of sexual recidivism studies. Journal of Consulting and Clinical Psychology, 66, 348-362.

Hanson, R. K., Cox, B. & Woszczyzna, C. (1991). Sexuality, personality and attitude questionnaires: A review. Programs Branch User Report, Vol. 13. Ottawa: Corrections Branch, Ministry of the Solicitor General.

Hanson, R. K., Gizzarelli, R. & Scott, H. (1994). The attitudes of incest offenders: Sexual entitlement and acceptance of sex with children. Criminal Justice and Behavior, 21, 187-202.

Hanson, R. K. & Harris, A.J.R. (2000). The Sex Offender Need Assessment Rating (SONAR): A method for measuring change in risk levels. Ottawa: Department of the Solicitor General of Canada.

Hanson, R. K., Scott, H., & Steffy, R.A. (1995). A comparison of child molesters and non-sexual criminals: Risk predictors and long-term recidivism. Journal of Research in Crime and Delinquency, 32, 325-337.

Hanson, R.K., & Thornton, D. (1999). Static-99: Improving actuarial risk assessments for sex offenders. User Report 99-02. Ottawa: Department of the Solicitor General of Canada.

Harris, G.T., Rice, M.E., & Quinsey, V.L. (1993) Violent recidivism of mentally disordered offenders. The development of a statistical prediction instrument. Criminal Justice and Behaviour, 20, 315-335.

Harris, G. T., Rice, M. E., Quinsey, V. L., Chaplin, T. C., & Earls, C. M. (1992). Maximizing the discriminant validity of phallometric data. Psychological Assessment, 4, 502-511.

Haywood, T.W., & Grossman, L.S. (1994). Denial of deviant sexual arousal and psychopathology in child molesters. Behavior Therapy, 25, 327-340.

Heim, N. & Hursch, C.J. (1979) Casteration for sex offenders: Treatment or punishment? A review and critquic of recent european literature. Archives of Sexual Behavior, 8, 281-304.

Helmes, E. & Holden, R.R. (1986) Response styles and faking on the Basic Personality Inventory. Journal of Consulting and Clinical Psychology, 54, 853-859.

Henson, D.E., & Rubin, H.B. (1971). Voluntary control of eroticism. Journal of Applied Behavior Analysis, 4, 37-44.

Herman, J. L. (1990) Sex Offenders: A feminist perspective. In W.L. Marshall, D.R. Laws & H.E. Barbaree (Eds.) Handbook of sexual assault: Issues, theories and treatment of the offender. New York: Plenum Press.

Holden, R.R. (1995) Faking and its detection on the Holden Psychological Screening Inventory. Psychological Reports, 76, 1235-1240.

Holden, R. R., Fekken, G. C., & Cotton, D. H. G. (1991). Assessing psychopathology using structured test-item response latencies. Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3, 111-118.

Holden, R. R., & Hibbs, N. (1995). Incremental validity of response latencies for detecting fakers on a personality test. Journal of Research in Personality, 29, 362-372.

Holden, R. R., & Kroner, D. G. (1992). Relative efficacy of differential response latencies for detecting faking on a self-report measure of psychopathology. Psychological Assessment, 4, 170-173.

Iacono, W.G. & Patrick, C.J. (1988) Assessing deception: Polygraph techniques. In R. Rogers (Eds.), *Clinical Assessment of Malingering and Deception*. New York: The Guilford Press.

Jenks, R.J. (1988) Nongays' perceptions of gays. Annals of Sex Research, 1, 139-150

Jensen, S.H., & Jewell, C.A. (1988) The sex offender expects. The Prosecutors, 21, 13-20

Kalichman, S.C., Henderson, M.C., Shealy, L.S., & Dwyer, M. (1992). Psychometric properties of the multiphasic sex inventory in assessing sex offenders. Criminal Justice and Behaviour, 19, 384-396.

Kennedy, H.G., & Grubin, D.H. (1992). Patterns of denial in sex offenders. Psychological Medicine, 22, 191-196.

Knight, R. (1999, October) Assessing duplicity in the self report of sexual offenders. A paper presented at the Annual Association for the Treatment of Sexual Abusers, Orlando Florida.

Knight, R.A. & Prentkey, R.A. (1990) Classifying sexual offenders: The development and corroboration of taxonomic models. In W.L. Marshall, D.R. Laws & H.E. Barbaree (Eds.) Handbook of sexual assault: Issues, theories and treatment of the offender. New York: Plenum Press.

Kroner, D. (1996). Socially Desireable Responding: A Review. Unpublished manuscript.

Kroner, D. G., & Weekes, J. R. (1996a). Balanced Inventory of Desirable Responding: Factor structure, reliability, and validity with an offender sample. *Personality and Individual Differences*, 21, 323-333.

Kroner, D. G., & Weekes, J. R. (1996b). Socially desirable responding and offence characteristics among rapists. *Violence and Victims*, 11, 263-270.

Knight, R.A., & Prentky, R.A. (1990). Classifying sexual offenders: The development and corroboration of taxonomic models. In W.L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), Handbook of sexual assault: Issues, theories, and treatment of the offender (pp. 23-52). New York: Plenum Press.

Langevin, R. (1988). Defensiveness in sex offenders. In R. Rogers (Ed.), Clinical assessment of malingering and deception (pp. 269-290). New York: Guilford Press.

Law Reform Commission of Canada. (1978) Sexual offenses (Working Paper No. 22). Ottawa: Author.

Laws, D.R., & Holmen, M.L. (1978). Sexual response faking by pedophiles. Criminal Justice and Behavior, 5, 343-356.

Laws, D.R. & Marshall, W.L. (1990) A conditioning theory of the etiology and maintenance of deviant sexual preference and behaviour. In W.L. Marshall, D.R. Laws & H.E. Barbaree (Eds.) Handbook of sexual assault: Issues, theories and treatment of the offender. New York: Plenum Press.

Laws, D.R., & Rubin, H.B. (1969). Instructional control of an autonomic response. Journal of Applied Behavior Analysis, 2, 93-99.

Looman, Abracen, Maillet, & DiFazio, (1998). Phallometric Nonresponding in Sexual Offenders. Sexual Abuse: A Journal of Research and Treatment, 10, 325-336.

Loza, W. & Simourd, D., (1994) Psychometric evaluation of The Level of Supervision Inventory (LSI) among male Canadian federal Offenders. Criminal Justice and Behaviour, 21, 468-480.

Lykken, D.T. (1981) A tremor in the blood: Uses and abuses of the lie detector. New York: McGraw-Hill.

Malcolm, P.B. (1995). Sex Offender Denial and Minimization. Unpublished Manuscript. Carleton University.

Malcolm, P.B., Andrews, D.A., & Quinsey, V.L. (1993). Discriminant and predictive validity of phallometrically measured sexual age and gender preference. Journal of Interpersonal Violence, 8, 486-501.

Malcolm, P.B., Law, K., Cantarutti, D.G. and Zuber, B.G. (2000, November). Phallometrically measured age and gender preference: A comparison of audio and visual stimuli. A paper presented at the association for the treatment of sexual abusers conference, San Diego California.

Malcolm, P.B. & Simourd, D.J. (1999, October). The Level of Service Inventory - Revised: Discriminant and predictive validity with incarcerated sex Offender. A paper presented at the association for the treatment of sexual abusers conference, Orlando Florida.

Maletzky, B. W. (1991). Treating the Sex Offender. Newbury Park, CA: Sage.

Maletzky, B. W. (1996). Denial of treatment or treatment of denial. Sexual Abuse: A Journal of Research and Treatment, 8, 1-5.

Maletzky, B. W. & McFarland, B. (1995). Treatment results in offenders who deny their crimes. Manuscript submitted for publication.

Manion, I.G., Firestone, P., McIntyre, J., Ensom, R. & Wells, G. (1994) Parent and child reactions to extrafamilial sexual abuse. Final Report to NHRDP. Ottawa

Marques, J. K., Day, D. M., Nelson, C., & West, M. (1994). Effects of cognitive-behavioral treatment on sex offender recidivism: Preliminary results of a longitudinal study. Criminal Justice and Behavior, 21, 28-54.

Marshall, W. L. (1994). Treatment effects on denial and minimization in incarcerated sex offenders. Behaviour Research and Therapy, 32, 559-564.

Marshall, W. L. (1996). Assessment, treatment, and theorizing about sex offenders: Developments during the past twenty years and future directions. Criminal Justice and Behavior, 23, 162-199.

Marshall, W.L. & Barbaree, H.E. (1988). The long-term evaluation of a behavioral treatment program for child molesters. Behavior Research and Therapy, 26, 499-511.

Marshall, W.L., Barbaree, H.E., & Christophe, D. (1986). Sexual offenders against female children: Sexual preferences for age of victims and type of behaviour. Canadian Journal of Behavioural Science, 18, 424-439.

Marshall, W.L. & Fernandez, Y.M. (in press). Phallometric testing with sexual offenders: Limits to its value. Sexual Abuse: A Journal of Research and Treatment.

Marshall, W.L. & Hall, G.N. (1995) The value of the MMPI in deciding forensic issues in accused sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 7, 205-219.

Marshall, W.L., Laws, D.R., & Barbaree, H.E. (1990) Handbook of Sexual Assault: Issues, theories, and treatment of the offender. New York: Plenum Press

Marshall, W. L., & Pithers, W.D. (1994). A reconsideration of treatment outcome with sex offenders. Criminal Justice and Behavior, 21, 10-27.

Miles, E. W., & King, W. C. (1998). Gender and administration mode effects when pencil-and-paper personality tests are computerized. Educational and Psychological Measurement, 58, 68-76.

Mills, J. (2000). Criminal Attitudes: Assessment and Relationship with Psychopathy and Response Latencies. Unpublished Doctoral Thesis, Carleton University.

Miner, M.H., Marques, J.K., Day, D.M., & Nelson, C. (1990). Impact of relapse prevention in treating sex offenders: Preliminary findings. Annals of Sex Research, 3, 165-185.

Motiuk, L. L., & Porporino, F. J. (1988). Offender Risk/Needs Assessment: A Study of Conditional Releases. Ottawa: Correctional Service of Canada

Murphy, W.D., & Barbaree, H.E. (1994). Assessments of sex offenders by measures of erectile response: Psychometric properties and decision making. Brandon, VT: The Safer Society Press.

Murphy, W.D., Haynes, M.R., Stalgaitis, S.J., & Flanagan, B. (1986). Differential sexual responding among four groups of sexual offenders against children. Journal of Psychopathology and Behavioral Assessment, 8, 339-353.

Nichols, H.R., & Molinder, I. (1984). Mutiphasic Sex Inventory. (Available from Nichols & Molinder, 437 Bowes Drive, Tacoma, WA 98466).

Nuffield, J. (1982). Parole decision making in Canada. Ottawa: Solicitor General of Canada.

Nugent, P. M., & Kroner, D. G. (1996). Denial, response styles, and admittance of offenses among child molesters and rapists. Journal of Interpersonal Violence, 11, 475-486.

Paulhus, D.L. (1991). Measurement and control of response bias. In J.P. Robinson, P.R. Shaver, & L.S. Wrightman (Eds.), Measures of personality and social attitudes (pp. 17-59). San Diego: Academic Press, Inc.

Paulhus, D.L. (1998) Paulhus Deception Scales (PDS): The Balanced Inventory of Desirable Responding-7. Toronto, Canada: Multi-Health Systems.

Paulhus, D.L., & Levitt, K. (1987) Desireable responding triggered by affect: Automatic Egotism. Journal of Personality and Social Psychology, 60, 307-317.

Peters, J.D. (1999). The latest from the courts. Association for the Treatment of Sexual Abusers, The Forum, 11, 3-4.

Petrusic, W.M., & Jamieson, D.G. (1978). Relation between probability of preferential choice and time to choose changes with practice. Journal of Experimental Psychology: Human Perception and Performance, 4, 471-482.

Pollock, N.L. & Hashmall, J.M. (1991) The excuses of child molesters. Behavioural Sciences and the Law, 9, 53-59.

Prentky, R. & Burgess, A.W. (1990). Rehabilitation of child molesters: A cost-benefit analysis. American Journal of Orthopsychiatry, 60, 108-117.

Preston, D.L. & Murphy, S. (1999) Therapeutic engagement of treatment resistant-clients. Forum on Corrections Research.

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. American Psychologist, 47, 1102-1114.

Quinsey, V.L. (1984) Sexual aggression: Studies of offenders against women. In D. Weisstub (ed.), Law and Mental Health: International Perspectives. (Vol. 1) (pp.84-122), New York: Pergamon.

Quinsey, V.L. (1986) Men who have sex with children. In D. Weisstub (ed.), Law and Mental Health: International Perspectives. (Vol. 2) (pp.14-172), New York: Pergamon.

Quinsey, V.L., & Chaplin, T.C. (1988). Penile responses of child molesters and normals to descriptions of encounters with children involving sex and violence. Journal of Interpersonal Violence, 3, 259-274.

Quinsey, V.L., Chaplin, T.C., & Carrigan, W.F. (1980). Biofeedback and signalled punishment in the modification of inappropriate age preferences. Behavior Therapy, 11, 567-576.

Quinsey, V.L., Khanna, A. & Malcolm, P.B. (1998). A retrospective evaluation of the regional treatment centre sex offender treatment program. Journal of Interpersonal Violence, 13, 621-644.

Quinsey, V.L. & Lalumiere, M.L. (1996) Assessment of sexual offenders against children. Thousand Oaks: Sage.

Quinsey, V.L., Steinman, C.M., Bergersen, S.G., & Holmes, T.F. (1975). Penile circumference, skin conductance, and ranking response of child molesters and "normals" to sexual and nonsexual visual stimuli. Behavior Therapy, 6, 213-219.

Raven, J.C., Court, J.H. & Raven, J. (1996). Manual for Raven's Progressive Matrices and Vocabulary Scales. Oxford: Oxford Psychologists Press.

Rice, M.E., Quinsey, V.L., & Harris, G.T. (1991) Predicting sexual recidivism among treated and untreated extrafamilial child molesters released from a maximum security psychiatric institution. Journal of Consulting and Clinical Psychology, 59, 381-386.

Rogers, R. (Ed.). (1988). Clinical assessment of malingering and deception. New York: Guilford.

Rogers, R., & Dickey, R. (1991). Denial and minimization among sex offenders: A review of competing models of deception. Annals of Sex Research, 4, 49-63.

Russell, D.E. (1986). The secret Trauma: Incest in the lives of girls and women. New York: Basic Books, Inc.

Schlank, A.M. & Shaw, T. (1996) Treating sexual offenders who deny their guilt: A pilot study. Sexual Abuse: A Journal of Research and Treatment, 8, 17-23.

Scully, D., & Marolla, J. (1984) Convicted Rapists Vocabulary of Motive: Excuses and Justifications, Social Problems, 31 530-544.

Serin, R.C., Barbaree, H.E., Seto, M., Malcolm, P.B. and Peacock, E. (1997) A model for a clinically-informed risk assessment strategy for sex offenders. Research Report-R-56. Ottawa: Correctional Service of Canada.

Serin, R.C. & Kennedy, S. (1997) Treatment readiness and responsivity: Contributing to effective correctional programming. Research report (R-54). Correctional Service of Canada: Ottawa.

Serin, R.C., Malcolm, P.B. and Mailloux, D. (1998, October) Denial and Minimization in Sexual Offenders. A paper presented at the Annual Association for the Treatment of Sexual Abusers, Vancouver Canada.

Seto, M.C. & Barbaree, H.E. (1999). Psychopathy, treatment behaviour and sex offender recidivism. Journal of Interpersonal Violence, 14, 1235-1248.

Shipley, W.C. (1940). A self administering scale for measuring intellectual impairment and deterioration. Journal of Psychology, 9, 371-377.

Simkins, L., Ward, W., Bowman, S., & Rinck, C.M. (1989). The Multiphasic Sex Inventory: Diagnosis and prediction of treatment

responses in child sexual abusers. Annals of Sex Research, 2, 205-226.

Simourd, D.J. (1999) A practical perspective on the assessment and treatment of sex offenders. Unpublished Manuscript.

Simourd, D.J. & Malcolm, P.B. (1998) Reliability and Validity of the Level of Service Inventory with incarcerated Sex Offenders. The Journal of Interpersonal Violence, 13, 23-28.

Tanner, J.M. (1971) Sequence, tempo, and individual variation in the growth and development of boys and girls aged 12 to 16. Daedalus, 100, 907-930.

Wechsler, D. (1981). Manual for the Wechsler Adult Intelligence Scale-Revised New York: Psychological Corporation.

Weinrott, M. R., & Saylor, M. (1991). Self-report crimes committed by sex offenders. Journal of Interpersonal Violence, 6, 286-300.

Wormith, S.J. (1983). A survey of incarcerated sexual offenders Canadian Journal of Criminology, 25, 379-390.

Wormith, J.S. (1986). Assessing deviant sexual arousal: Psychological and cognitive aspects. Advances in Behaviour Research and Therapy, 8, 101-137.

Wormith, J.S., & Goldstone, C.S. (1984). The clinical and statistical prediction of recidivism. Criminal Justice and Behaviour, 11, 3-34.

Zachary, R.A. (1986). Shipley Institute of Living Scale - Revised Manual. Los Angeles: Western Psychological Services.

APPENDICES

Appendix A: Multiphasic Sex Inventory

Multiphasic Sex Inventory - Form A

This is a sexual inventory constructed to study the full range of sexual behavior. Answer each question as frankly as possible. If a statement is true, as applied to you, choose the number 1. If a statement is false, as applied to you, choose the 2. Answer all questions unless indicated otherwise. Try not to be bothered by the explicit nature of the questions, if you want to take a break notify the examiner.

Answer EVERY STATEMENT either true or false, even if you are not completely sure of your answer.

TRUE False Not Applicable

1-----2-----3

1. OCCASIONALLY I THINK OF THINGS TOO BAD TO TALK TO OTHERS ABOUT.
2. I HAVE HAD DESIRES TO HAVE SEXUAL ACTIVITY WITH A CHILD.
3. THE CLITORIS HAS A SMALL SHAFT AND HEAD (GLANS) WHICH IS SIMILAR TO THE PENIS
4. I HAVE BEEN ATTRACTED TO BOYS SEXUALLY.
5. I HAVE OCCASIONALLY HAD SEX WITH AN ANIMAL.
6. I SELDOM THINK ABOUT SEX.
7. I CAN USUALLY CONTROL MY ORGASM WHILE MASTURBATING BUT JUST AS SOON AS I TRY TO HAVE SEX WITH MY PARTNER I CANNOT CONTROL MY ORGASM.
8. I HAVE USED PEEPING TO FIND THE RIGHT SET UP AND PERSON TO RAPE.
9. MY PROBLEM IS NOT SEXUAL, IT IS THAT I REALLY LOVE CHILDREN (Answer only if you have had sexual contact with a child)
10. A WOMAN URINATES THROUGH HER CLITORIS.
11. I AM MORE INTERESTED IN THE EXCELLENT ARTICLES IN "PLAYBOY" AND MAGAZINES LIKE THAT, MORE THAN I AM IN THE CENTERFOLDS.
12. IN SOME WAYS I WAS USED BY THE PERSON WHO REPORTED ME.
13. I HAVE MANIPULATED A CHILD TO GET SEXUAL PLEASURE.
14. I EXPOSE FROM A HIDING PLACE OR FROM A LONG DISTANCE WAY (Answer only if you have exposed yourself)

15. I HAVE HAD ONE OR MORE AFFAIRS WHILE MARRIED.
16. DURING SEXUAL INTERCOURSE, THE PENIS CAN GET CAUGHT IN THE VAGINA.
17. I HAVE FORCED MY SEX PARTNER TO HAVE SEX WHEN THEY DID NOT WANT TO.
18. I HAVE NEVER MOLESTED A BOY.
19. IT DOES NOT INTEREST ME TO LEARN THAT A WOMAN MAY NOT BE WEARING ANY PANTIES.
20. I HAVE A BIRTH DEFECT (A TESTICLE WHICH HAS NOT DROPPED, A URINARY OPENING UNDERNEATH MY PENIS, SPINA BIFIDA, UNDEVELOPED GENITALS. ETC.) WHICH CAUSES SEXUAL PROBLEMS FOR ME.
21. MALES SHOULD HAVE AN ORGASM REGULARLY TO KEEP THE TESTICLES FROM OVERFILLING WITH SEMEN.
22. I THINK ABOUT SEX 80% OF THE TIME.
23. I HAVE REACHED ORGASM WHILE MOLESTING A CHILD (Answer only if you have had sexual contact with a child).
24. I HAVE ATTEMPTED RAPE OR RAPED MORE THAN 10 TIMES.
25. I HAVE USED LEATHER, WHIPS, HANDCUFFS, SHARP THINGS ETC. , IN SEXUAL ENCOUNTERS.
26. ABOUT THE ONLY WAY I CAN HAVE AN ORGASM IS WHEN I MASTURBATE.
- 27 ORAL SEX DISGUSTS ME.
28. MY WIFE IS INTERESTED IN SEX MUCH MORE OFTEN THAN I AM.
- 29 MY SEXUAL OFFENSE OCCURRED AS A RESULT OF MY WIFE'S LACK OF UNDERSTANDING OF ME.
30. I HAVE NEVER HAD THOUGHTS ABOUT FONDLING A CHILD (CHILDREN) IN MY FAMILY.
31. IT TURNS ME OFF WHEN A FEMALE ADVERTISES HER SEXUALITY.
32. AS AN ADULT, I HAVE NEVER HAD SEX WITH ANOTHER ADULT.
33. SOMETIMES I AM SEXUALLY ATTRACTED TO CHILDREN.
34. I HAVE BECOME SEXUALLY STIMULATED WHEN SOMEONE URINATES.
35. THE GLANS OF THE CLITORIS ARE GENERALLY ABOUT THE SIZE OF A PEA.
36. I HAVE NOT BEEN INTERESTED IN A CHILD IN A SEXUAL WAY.
37. I HAVE REACHED ORGASM WHILE SECRETLY WATCHING SOMEONE.

38. I FEEL SO FOOLISH ABOUT CLIMAXING SO FAST THAT I AVOID WOMEN.
39. THE THOUGHT OF A WOMAN PERFORMING ORAL SEX ON ME DOES NOT INTEREST ME.
40. A MALE WITH A CIRCUMCISED PENIS HAS MORE SEXUAL SENSATION THAN A MALE WHO IS UNCIRCUMCISED.
41. I HAVE HAD TO FIGHT THE IMPULSE TO TOUCH A CHILD SEXUALLY.
42. I HAVE NEVER TAKEN A CLOSE LOOK AT A WOMAN'S SEX ORGANS (GENITALS).
43. I HAVE NEVER EXPOSED MYSELF FROM A CAR.
44. I HAVE MADE SEXUALLY SEDUCTIVE REMARKS TO STRANGERS OVER THE PHONE.
45. I AM OFTEN HURT BY THE BEHAVIOR OF OTHERS.
46. I DO NOT REALLY NOTICE IF PEOPLE ARE SEXY OR NOT.
47. I HAVE NEVER BEEN ACCUSED OF RAPE OR ATTEMPTED RAPE.
48. I HAVE NEVER BEEN ACCUSED OF A SEX OFFENSE AGAINST A CHILD.
49. LIKE FEMALES, MANY MALES GET ERECT NIPPLES WHEN SEXUALLY STIMULATED.
50. I NEED SEX OR MASTURBATION DAILY TO REDUCE TENSION.
51. MY WIFE IS REALLY NOT INTERESTED IN SEX.
52. I HAVE LOST SEXUAL FUNCTIONING AS A RESULT OF AN ACCIDENT, WOUND OR SURGERY INVOLVING MY SEXUAL OR REPRODUCTIVE ORGANS.
53. I HAVE NEVER USED A WEAPON TO SCARE A PERSON INTO HAVING SEX.
54. I HAVE NEVER ATTEMPTED TO GET A CHILD WHO IS A STRANGER TO GO OFF ALONE WITH ME.
55. I HAVE TO USE PORNOGRAPHY TO BECOME SEXUALLY STIMULATED.
56. I GET MORE EXCITEMENT AND THRILL OUT OF HURTING A PERSON THAN I DO FROM THE SEX ITSELF.
57. I GET TURNED OFF WITH A WOMAN WHO EXPOSES PART OF HER BREASTS OR LEGS TO MEN.
58. IT IS VERY SENSITIVE DEEP INSIDE THE VAGINA AND THAT PART MUST BE STIMULATED FOR A WOMAN TO HAVE AN ORGASM.
59. MY SEXUAL OFFENSE OCCURRED AS A RESULT OF MY WIFE'S AND MY INABILITY TO COMMUNICATE.
60. I WAS EXCITED BY HAVING INCEST WITH MY CHILD (CHILDREN) (Answer only if you have had contact with your children)

- 61. AS A CHILD, MOST ADULTS DID NOT UNDERSTAND ME.
- 62. I HAVE BECOME SEXUALLY EXCITED OVER THE THOUGHT OF HAVING SEXUAL ACTIVITY WITH A CHILD.
- 63. I HAVE BEEN MARRIED MORE THAN TWICE.
- 64. IT WOULD INTEREST ME TO LEARN THAT A FEMALE HAS FELT PLEASURE FROM MASTURBATING HERSELF.
- 65. I HAVE BECOME SEXUALLY STIMULATED WHILE FEELING OR SMELLING A WOMAN'S UNDERWEAR.
- 66. I HAVE BEEN SEXUALLY ATTRACTED TO LITTLE GIRLS.
- 67. THE CLITORIS IS USUALLY THE MOST SENSITIVE FEMALE SEX ORGAN.
- 68. I HAVE NEVER BEEN MARRIED.
- 69. I GET SO SEXUALLY EXCITED THAT I EITHER CLIMAX JUST BEFORE I ENTER MY SEX PARTNER OR VERY SOON AFTER I GET MY PENIS IN.
- 70. I HAVE NOT BEEN ABLE TO STOP MYSELF FROM LOOKING AT OTHERS IN A SEXUAL WAY.
- 71 I HAVE NEVER GONE INTO A HOUSE OR APARTMENT TO RAPE SOMEONE.
- 72. AT TIMES WHEN I HAVE HELD A CHILD I HAVE BECOME SEXUALLY STIMULATED.
- 73. I FEEL LIKE I AM A VICTIM AS A RESULT OF THE ACCUSATIONS THAT HAVE BEEN MADE AGAINST ME.
- 74. MANY PEOPLE COULD INTEREST ME SEXUALLY.
- 75. I HAVE MASTURBATED WHILE EXPOSING.
- 76. I HAVE NEVER RAPED OR ATTEMPTED TO RAPE A MALE.
- 77. OCCASIONALLY I GO TO A PROSTITUTE, PEEPSHOW OR MASSAGE PARLOR.
- 78. I HAVE NEVER MOLESTED A GIRL.
- 79. SOMETIMES MY ERECTION IS SO PAINFUL I CANNOT PERFORM SEXUALLY.
- 80. I AM NOT INTERESTED IN SEX MATTERS LIKE MOST MEN SEEM TO BE.
- 81. IT IS NOT NORMAL FOR MALES TO HAVE ERECTIONS DURING SLEEP.
- 82. I HAVE TO FIGHT THE IMPULSE TO MASTURBATE.
- 83. I HAVE MOLESTED 5 OR MORE CHILDREN.
- 84. I HAVE OR HAVE HAD A VENEREAL DISEASE.

85. I OFTEN WORRY ABOUT NOT BEING ABLE TO REACH ORGASM DURING THE SEX ACT.
86. I LIKE TO LOOK AT SEXY PICTURES.
87. DURING SEX I HAVE ENJOYED FRIGHTENING MY SEX PARTNER SO THEY BEG ME TO STOP.
88. MY SEXUAL OFFENSE OCCURRED BECAUSE OF STRESSES IN MY LIFE.
89. I HAVE NEVER BEEN MARRIED BUT I HAVE LIVED WITH THE PERSON WITH WHOM I HAVE HAD A SEXUAL RELATIONSHIP.
90. I HAVE NEVER MOLESTED ANY OF MY OWN CHILDREN.
91. I HAVE FANTASIZED ABOUT HAVING SEX PLAY WITH A CHILD.
92. I AM SO AFRAID A SEX PARTNER WILL THINK BADLY OF ME OR WILL LAUGH AT ME THAT I AVOID SEXUAL CONTACTS.
93. THERE HAVE BEEN TIMES WHILE EXPOSING THAT I HAVE HAD THOUGHTS OF WHAT IT WOULD BE LIKE TO RAPE SOMEONE. (Answer only if you have exposed yourself)
94. IT SEEMS THAT EVERYTHING I DO AND EVERYWHERE I GO I AM CONSTANTLY THINKING ABOUT SEX.
95. MY SEXUAL OFFENSE OCCURRED BECAUSE THE PERSON ASKED FOR IT.
96. IT WOULD PEAK MY INTEREST TO LEARN THAT A CHILD IS CURIOUS ABOUT SEX.
97. WOMEN'S GENITALS ARE LESS SENSITIVE TO PHYSICAL STIMULATION THAN THOSE OF MALES.
98. SOMETIMES I HAVE DRIVEN DOWN THE ROAD WITH MY PENIS OUT OF MY PANTS.
99. I AM STRICTLY HETEROSEXUAL (ONLY INTERESTED IN FEMALE SEX PARTNERS).
100. I HAVE NEVER PICKED UP A PERSON FOR THE PURPOSE OF FORCING THEM TO HAVE SEX WITH ME.
101. I AM TOO EASILY SEXUALLY EXCITED.
102. I KNOW I HAVE GOTTEN A RAW DEAL OUT OF LIFE.
103. I AM SATISFIED WITH MY SEX LIFE.
104. I HAVE NEVER GOTTEN INTO TROUBLE OVER MY SEXUAL BEHAVIOR.
105. I AM PRIVATELY ATTRACTED TO MEMBERS OF MY OWN SEX.
106. I HAVE NOT INDULGED IN SEX ACTIVITIES WHICH ARE UNUSUAL.

107. I'M WORRIED ABOUT SEXUAL THINGS.
108. I ENJOY FLIRTING.
109. THERE ARE TIMES THAT I LAUGH AT A DIRTY JOKE.
110. I WISH THOUGHTS ABOUT SEX DID NOT BOTHER ME.
111. I HAVE NEVER BEEN IN LOVE.
112. WHEN A MAN IS WITH AN ATTRACTIVE WOMAN, HE HAS THOUGHTS ABOUT SEX.
113. I HAVE PRIVATE DAYDREAMS WHICH I DO NOT SHARE WITH OTHERS.
114. I BELIEVE THERE IS SOMETHING WRONG WITH MY SEX ORGANS.
115. IF I WERE ARTISTIC, I WOULD LIKE TO DRAW CHILDREN.
116. I GET TURNED OFF WHEN I SEE A FEMALE WEARING HER CLOTHES SO TIGHT YOU CAN SEE EVERYTHING.
117. YOUNGER WOMEN HAVE TIGHTER VAGINAS THAN OLDER WOMEN.
118. THE MORE FRIGHTENED A PERSON HAS BECOME, THE MORE SEXUALLY EXCITED I HAVE BECOME.
119. MY SEX OFFENSE WOULD NOT HAVE OCCURRED IF I HAD NOT HAD TO TAKE CARE OF THE CHILD'S PERSONAL HYGIENE. (Answer only if you have had sexual contact with a child)
120. SOMETIMES I HAVE NOT BEEN ABLE TO STOP MYSELF FROM FONDLING ONE OR MORE OF THE CHILDREN IN MY FAMILY.
121. THE THOUGHT OF OVERPOWERING SOMEONE SEXUALLY HAS BEEN STIMULATING TO ME.
122. MY PENIS IS SO SMALL THAT I BELIEVE THAT I CANNOT SATISFY A WOMAN SEXUALLY.
123. I HAVE BECOME SEXUALLY STIMULATED OVER NON-SEXUAL BODY PARTS OR ITEMS (FEET, HAIR, SHOES, ETC.).
124. SINCE THE AGE OF 16 I HAVE HAD SEXUAL CONTACT WITH BOTH SEXES.
125. MY SEX OFFENSE OCCURRED BECAUSE I WAS MISTREATED BY A FEMALE(S).
126. I HAVE NEVER LOOKED AT PICTURES OF CHILDREN TO STIMULATE MYSELF SEXUALLY.
127. I KNOW I AM DIFFERENT THAN OTHER PEOPLE BECAUSE SEX IS ON MY MIND SO MUCH.
128. I CAN REMEMBER SNEAKING AND PEEPING ON FEMALES AS A BOY.

129. THE THOUGHT OF A WOMAN FONDLING MY PENIS DOES NOT INTEREST ME.
130. AS AN ADULT, I HAVE TICKLED AND WRESTLED WITH LITTLE GIRLS.
131. THE "TYING OFF" OF THE TESTICLE CORDS FOR STERILIZATION IS DANGEROUS BECAUSE IT REDUCES SEX INTEREST AND DRIVE.
132. MY SEX OFFENSE WOULD NOT HAVE OCCURRED IF THE CHILD HAD NOT BEEN CURIOUS AND INTERESTED IN SEX. (Answer only if you have had sexual contact with a child)
133. I HAVE ATTEMPTED RAPE OR RAPED AT LEAST ONE TIME.
134. I HAVE SUFFERED MORE HURT IN MY LIFE THAN MOST PEOPLE.
135. I HAVE NEVER BEEN CHARGED WITH INDECENT EXPOSURE.
136. THE VICTIM KNEW OR WAS ACQUAINTED WITH ME BEFORE THE OFFENSE.
137. I LIKE TO LOOK AT SEXUALLY ATTRACTIVE WOMEN.
138. I HAVE MOLESTED MORE THAN ONE CHILD.
139. I HAVE AN ILLNESS (DIABETES, ARTHRITIS, MULTIPLE SCLEROSIS, LIVER OR KIDNEY DISEASE, ENDOCRINE IMBALANCE, ETC.) WHICH EFFECTS MY SEXUAL FUNCTIONING.
140. SEXUAL THINGS INTEREST ME.
141. UNLIKE MOST MEN, WOMEN ARE CAPABLE OF HAVING MULTIPLE ORGASMS.
142. THE THOUGHT OF BEING SPANKED IS SEXUALLY EXCITING TO ME.
143. X-RATED MOVIES WOULD INTEREST ME, ESPECIALLY IF I COULD VIEW THEM IN THE PRIVACY OF MY HOME.
144. I HAVE NEVER REACHED ORGASM WHILE EXPOSING MYSELF. (Answer only if you have exposed yourself)
145. IT INTERESTS ME WHEN A MALE'S ORGANS SHOW THROUGH HIS CLOTHES.
146. IF I DID NOT FANTASIZE ABOUT SEX I COULD NOT MAINTAIN MY ERECTION.
147. I WOULD NOT GO TO A TOPLESS BAR OR SHOW FOR ANY REASON.
148. MY SEX OFFENSE WOULD NOT HAVE OCCURRED IF THE VICTIM HAD NOT BEEN SEXUALLY "LOOSE" (PROMISCUOUS).
149. SOMETIMES I GET SEXUAL PLEASURE OUT OF HURTING A PERSON.
150. MY JEALOUSY FOR MY PARTNER IS SO GREAT THAT IT STOPS ME FROM HAVING AN ORGASM.

151. IN MY GROWING UP, MY PARENTS DID NOT SHOW ME LOVE AND AFFECTION.
152. THERE HAVE BEEN TIMES WHEN I HAVE PRESSED MY PENIS AGAINST STRANGERS.
153. I DO NOT LET MY SEX PARTNER SEE ME IN THE NUDE.
154. I OFTEN DRIFT INTO DAYDREAMS ABOUT SEX.
155. THERE HAVE BEEN TIMES WHEN I HAVE BEEN AFRAID OF WHAT I MIGHT DO SEXUALLY.
156. I HAVE NEVER USED CHILD PORNOGRAPHY TO STIMULATE MYSELF SEXUALLY.
157. I HAVE SPENT A LOT OF TIME IN PARKS AND PLACES LIKE THAT JUST LOOKING AT GIRLS.
158. I AM STRICTLY HOMOSEXUAL (ONLY INTERESTED IN MALE SEX PARTNERS)
159. ONE OF THE FIRST SIGNS OF SEXUAL EXCITEMENT IN THE FEMALE IS WETNESS OF THE VAGINA.
160. MY SEX OFFENSE OCCURRED AS A RESULT OF NOT GETTING SEX EDUCATION AS A YOUNG PERSON.
161. I HAVE FOUND IT HIGHLY EXCITING TO GO CRUISING FOR SOMEONE TO RAPE.
162. AS AN ADULT I HAVE "HORSEPLAYED" AND PLAYED "GRAB ASS" WITH A BOY OR BOYS.
163. I HAVE CALLED UP PERSONS I DID NOT KNOW JUST TO FRIGHTEN THEM WITH DIRTY WORDS AND THOUGHTS.
164. WHEN I EXPOSE, SOMETIMES I GET AN ERECTION (ANSWER ONLY IF YOU HAVE EXPOSED YOURSELF).
165. CHILDREN TODAY ENGAGE IN MORE SEXUAL BEHAVIOR THAN WHEN I WAS GROWING UP.
166. MY SEX OFFENSE OCCURRED BECAUSE THE PERSON I WAS OF ASSAULTING LED ME ON ALL THE WAY.
167. I HAVE TOUCHED A CHILD'S GENITALS IN A SEXUAL WAY.
168. I HAVE FOUND IT PLEASURABLE TO FORCE A PERSON TO HAVE SEX.
169. IT FEELS GOOD WHEN I TOUCH MY SEXUAL PARTS.
170. BY STIMULATING THE CLITORIS, MANY WOMEN ARE LIKELY TO HAVE AN ORGASM.
171. I HAVE GOTTEN EXCITED OVER THE THOUGHT OF TYING SOMEONE UP AND HAVING SEX WITH THEM.

172. I HAVE HEART DISEASE, HIGH BLOOD PRESSURE OR CIRCULATION PROBLEMS WHICH EFFECT MY SEXUALITY.
173. I HAVE EXPOSED MYSELF MORE THAN 100 TIMES.
174. TO HAVE A SEXUAL ORGASM MEANS THE SAME AS TO HAVE A CLIMAX.
175. MY SEX PARTNER HAS HURT MY FEELINGS SO OFTEN THAT I HAVE HAD DIFFICULTY KEEPING MY ERECTION.
176. AS AN ADULT I HAVE MASTURBATED.
177. I THINK I AM HOMOSEXUAL BUT AM AFRAID TO ADMIT IT.
178. DURING MY EARLIER YEARS I DID NOT SATISFY MY CURIOSITY ABOUT SEX AND BELIEVE THAT IS WHY I COMMITTED MY SEXUAL OFFENSE.
179. MOST OF THE TIME I CANNOT GET AN ERECTION WHEN I WOULD LIKE TO HAVE SEX.
180. I HAVE PURPOSEFULLY HURT SOMEONE DURING A SEXUAL ENCOUNTER.
181. IT WOULD INTEREST ME TO LEARN THAT A WOMAN WOULD WANT TO BE RAPED.
182. MY SEXUAL INVOLVEMENT WITH A CHILD WOULD NOT HAVE OCCURRED IF THE CHILD HAD NOT BEEN OVERLY AFFECTIONATE (ANSWER ONLY IF YOU HAVE HAD SEXUAL CONTACT WITH A CHILD).
183. I HAVE SECRETLY DRESSED IN WOMEN'S CLOTHES.
184. I AM SEXUALLY ATTRACTIVE.
185. I DON'T LIKE TO THINK ABOUT SEX AS MUCH AS I DO.
186. THE THOUGHT ABOUT RAPING SOMEONE HAS EXCITED ME.
187. IF THE PENIS IS LARGE ENOUGH, A WOMAN WILL GENERALLY EXPERIENCE AN ORGASM.
188. CHILDREN HAVE LIKED ME AND HAVE WANTED TO BE WITH ME.
189. MY SEXUAL OFFENSE OCCURRED AS A RESULT OF PHYSICAL PROBLEMS WHICH HAVE EFFECTED MY SEXUALITY.
190. I HAVE NEVER BEEN ACCUSED OF PEEPING.
191. I SUSPECT MY FATHER FORCED HIMSELF SEXUALLY ON MY MOTHER.
192. I HAVE CRUISED FOR PERSONS TO RAPE.
193. I AM OBSESSED WITH SEX.
194. I HAVE NEVER MADE OBSCENE PHONE CALLS.

195. IT DOES NOT INTEREST ME TO LEARN THAT A WOMAN MAY NOT BE WEARING A BRA.
196. I HAVE NEVER EXPOSED MYSELF TO A CHILD.
197. I FEEL YOUNGER WHEN I AM WITH YOUNGSTERS.
198. THE VICTIM IN MY CASE DID NOT TELL THE TRUTH ABOUT WHAT REALLY HAPPENED.
199. I HAVE NEVER THREATENED A PERSON TO MAKE THEM HAVE SEX WITH ME.
200. A MEMBER OF MY FAMILY HAS BEEN IN TROUBLE BECAUSE OF HIS OR HER SEXUAL BEHAVIOR.
201. I HAVE TIED SOMEONE UP DURING A SEXUAL ENCOUNTER.
202. I WOULD NOT BE INTERESTED IN SEEING A FILM ABOUT PEOPLE ENGAGING IN INTERCOURSE.
203. I HAVE BEEN CHARGED WITH A SEXUAL OFFENSE MORE THAN ONCE.
204. A MALE IS CAPABLE OF HAVING AN ORGASM BEFORE HE REACHES SEXUAL MATURITY OR ADOLESCENCE.
205. THE DRUGS OR MEDICINES I TAKE MAKE IT DIFFICULT TO EITHER KEEP MY ERECTION OR TO HAVE AN ORGASM.
206. I AM OFTEN MISUNDERSTOOD BY OTHERS.
207. I WOULD NOT HAVE HAD SEX PLAY WITH A CHILD IF SHE/HE HAD NOT ENCOURAGED IT (ANSWER ONLY IF YOU HAVE HAD WITH A CHILD).
208. I AM TURNED ON WHEN A WOMAN TRIES TO FLIRT WITH ME.
209. THERE HAVE BEEN QUITE A FEW TIMES THAT I HAVE DAYDREAMED ABOUT HOW PLEASURABLE IT WOULD BE TO HURT SOMEBODY DURING A SEXUAL ENCOUNTER.
210. THE PENIS BECOMES HARD BECAUSE THE INNER BONE STIFFENS.
211. I HAVE SOMETIMES DAYDREAMED ABOUT WHAT IT WOULD BE LIKE TO SEXUALLY ATTACK SOMEONE.
212. I AM NOT SHY OR BASHFUL WHEN IT COMES TO SEX.
213. MANY TIMES I HAVE WISHED I WERE FEMALE.
214. I REGULARLY HAVE HAD SEVERAL ORGASMS IN ONE DAY.
215. I HAVE GOTTEN SEXUALLY EXCITED WHEN I HAVE HAD THOUGHTS ABOUT SOMEONE HAVING A BOWEL MOVEMENT.
216. I HAVE OFTEN FANTASIZED ABOUT RAPING SOMEONE.
217. PEOPLE HAVE COMMENTED ON MY LOVE FOR CHILDREN.

- 218. I HAVE ENTERED A FEMALE'S BEDROOM JUST TO LOOK AT HER BODY CLOSE UP.
- 219. I BECAME INTERESTED IN SEX AFTER HIGH SCHOOL AGE.
- 220. MY SEXUAL OFFENCE OCCURRED AS A RESULT OF MY NOT HAVING A SATISFYING SEXUAL RELATIONSHIP.
- 221. I HAVE HAD TO FIGHT THE IMPULSE TO RAPE.
- 222. I HAVE NEVER SHOWN A CHILD SEXY MAGAZINES OR PICTURES OF NUDE PEOPLE.
- 223. I HAVE DAYDREAMED ABOUT SEX SO MUCH THAT I HAVE MASTURBATED OR HAD SEX ONCE A DAY OR MORE.
- 224. I LIKE SEX PLAY.
- 225. I HAVE MASTURBATED MYSELF WHILE MAKING AN OBSCENE PHONE CALL (ANSWER ONLY IF YOU HAVE MADE AN OBSCENE CALL).
- 226. I HAVE PUBLICLY EXPOSED MYSELF TO AN ADULT PERSON (S).
- 227. JUST BEFORE I RAPED, I BECAME SO EXCITED THAT NOTHING ELSE MATTERED (ANSWER ONLY IF YOU HAVE RAPED OR ATTEMPTED RAPE).
- 228. I LIKE TO SEE LOTS OF BARE SKIN.
- 229. I SEEM TO PREFER THE COMPANY OF CHILDREN.
- 230. MY SEXUAL OFFENSE RESULTED FROM PROBLEMS IN MY FAMILY.
- 231. AS A CHILD I WAS PUNISHED WHEN I GOT CAUGHT IN SEXUAL ACTIVITY.
- 232. I HAVE BEEN SO EXCITED WHILE EXPOSING THAT I HAVE REACHED OUT AND GRABBED HOLD OF A PERSON (ANSWER ONLY IF YOU HAVE EXPOSED YOURSELF).
- 233. I HAVE HAD AN INJURY TO MY HEAD OR BACK THAT KEEPS ME FROM HAVING A FULL ERECTION.
- 234. I HAVE MADE SEXUAL PENETRATION OF A CHILD USING AN OBJECT, MY TONGUE, MY FINGER OR MY PENIS.
- 235. I FEEL SO GUILTY AND ASHAMED AROUND MY SEX PARTNER THAT I OFTEN LOSE MY ERECTION.
- 236. THE CLITORIS IS DIFFICULT TO FIND BECAUSE IT IS COVERED UP BY THE VAGINA.
- 237. I WOULD NOT BE INTERESTED IN SEEING A PERSON NUDE.
- 238. I HAVE FOUND IT SEXUALLY EXCITING TO PLAY WITH DEATH IN A SEXUAL ENCOUNTER.

239. MY SEX OFFENSE WOULD NOT HAVE OCCURRED IF I HAD NOT TRIED TO TEACH THE CHILD ABOUT SEX (ANSWER ONLY IF YOU HAVE HAD SEXUAL CONTACT WITH A CHILD).
240. MOST OF THE TIME I AM DEPRESSED AND I DO NOT CARE IF I CAN EVEN GET AN ERECTION.
241. AFTER I DATE A PERSON, THEY OFTEN DO NOT SEEM TO WANT TO GO OUT WITH ME AGAIN.
242. I FEEL LIKE A FEMALE TRAPPED IN A MALE BODY.
243. I HAVE MASTURBATED TO THE THOUGHT OF RAPING SOMEONE.
244. IT WOULD INTEREST ME TO LEARN THAT A FEMALE WOULD WANT ME TO EXPOSE TO HER.
245. I HAVE STOLEN WOMEN'S UNDERCLOTHES.
246. MOST MEN I HAVE BEEN AROUND ARE DIRTY MINDED.
247. DURING MY ADOLESCENCE I WAS SECRETLY EXCITED ABOUT SEXUAL MATTERS BUT I WAS EMBARRASSED TO TALK ABOUT IT TO MY FRIENDS.
248. I HAVE HAD TO FIGHT THE IMPULSE TO PEEP.
249. I HAVE BEEN TOLD THAT I AM PREOCCUPIED WITH SEX.
250. SOMETIMES I HAVE CRUISED PARKS, PARKING LOTS, OR LONELY STREETS LOOKING FOR SOMEONE TO HAVE SEX WITH.
251. I HAVE HAD TO FIGHT THE IMPULSE TO EXPOSE MYSELF.
252. SOMETIMES I HAVE HUNG AROUND SCHOOLS AND PLAYGROUNDS JUST TO WATCH SOME OF THE CHILDREN AT PLAY.
253. A WOMAN URINATES THROUGH THE SMALL OPENING BETWEEN HER ANUS AND HER VAGINAL OPENING.
254. THE PERSON WHO REPORTED ME WAS WILLING AND INTERESTED IN SEXUAL CONTACT WITH ME AND WAS NOT HURT BY THE EXPERIENCE.
255. THERE HAVE BEEN TIMES WHEN THOUGHTS ABOUT SEX HAVE ALMOST DRIVEN ME CRAZY.
256. MY SEXUAL PROBLEM IS NOT AS SERIOUS AS THAT OF OTHERS.
257. I HAVE NEVER BEEN ACCUSED OF EXPOSING MYSELF.
258. I HAVE NOT FORCED SOMEONE TO HAVE ORAL OR ANAL SEX WHEN THEY DID NOT WANT TO.
259. I THINK I HAVE NEVER GROWN UP EMOTIONALLY.

- 260. MY SEXUAL OFFENSE OCCURRED AS A RESULT OF MY BEING SEXUALLY ABUSED AS A CHILD.
- 261. THE THOUGHT OF HAVING SEX WITH MORE THAN ONE PARTNER AT A TIME DOES NOT INTEREST ME IN THE SLIGHTEST.
- 262. I WOULD LIKE TO BE TIED UP AND MADE TO HAVE SEX.
- 263. A CHILD HAS PERFORMED ORAL SEX ON ME.
- 264. I HAVE BEEN ACCUSED OF PURPOSELY HURTING SOMEONE IN A SEXUAL ENCOUNTER.
- 265. I HAVE NEVER BELIEVED MY SEXUAL CONTACT WITH A CHILD WAS A CRIME BECAUSE I DID NOT HAVE INTERCOURSE OR PENETRATION WITH HER/HIM (ANSWER ONLY IF YOU HAVE HAD SEXUAL CONTACT WITH A CHILD).
- 266. MY SEX OFFENSE OCCURRED BECAUSE THE CHILD I HAD SEXUAL CONTACT WITH APPEARED AND ACTED MUCH OLDER THAN HER/HIS ACTUAL AGE (ANSWER ONLY IF YOU HAVE HAD SEXUAL CONTACT WITH A CHILD).
- 267. I HAVE BEATEN A PERSON DURING A SEXUAL ENCOUNTER.
- 268. I AM VERY SAD AND BLUE AND I AM NOT INTERESTED IN SEX.
- 269. SEXY STORIES ARE INTERESTING TO ME.
- 270. THE CLITORIS IS LOCATED AT THE TOP PART OF THE GENITAL REGION, JUST ABOUT WHERE THE "LIPS" BEGIN.
- 271. IT IS POSSIBLE FOR A MALE TO HAVE A SEXUAL ORGASM WITHOUT AN EJACULATION OF FLUID.
- 272. MY SEXUAL OFFENSE RESULTED FROM MY HAVING TOO MUCH ALCOHOL OR DRUGS.
- 273. BECAUSE I AM AFRAID I MIGHT FAIL SEXUALLY WITH AN ADULT, I AVOID RELATIONSHIPS WITH THEM.
- 274. I HAVE ATTEMPTED TO HAVE SEX WITH A DEAD BODY.
- 275. I HAVE FANTASIZED ABOUT EXPOSING MYSELF.
- 276. AN OLDER MALE (RELATIVE, FRIEND, ACQUAINTANCE OR STRANGER) TOUCHED ME SEXUALLY WHEN I WAS A CHILD.
- 277. I HAVE NEVER TAKEN PICTURES OF A CHILD (CHILDREN) IN THE NUDE.
- 278. I GOT THE IDEA TO RAPE WHILE BURGLARIZING APARTMENTS OR HOUSES (ANSWER ONLY IF YOU HAVE RAPED OR ATTEMPTED RAPE).
- 279. I HAVE TO FIGHT SEXUAL IMPULSES CONTINUALLY.
- 280. QUITE OFTEN I FEEL LIKE A CHILD LIVING IN A GROWN UP BODY.

281. I HAVE LIKED TO BATHE CHILDREN AND THEN DRY THEM OFF AND HELP THEM GET DRESSED.
282. I HAVE OFTEN LOOKED FOR SOMEONE TO EXPOSE TO.
283. MY SEX OFFENSE OCCURRED BECAUSE I THOUGHT THE VICTIM IN MY CASE NEEDED SEX.
284. I WAS CURIOUS ABOUT SEX AS A CHILD.
285. A CHILD HAS TOUCHED MY PENIS IN A SEXUAL WAY.
286. I CANNOT SEEM TO KEEP MY MIND AWAY FROM THOUGHTS ABOUT SEX.
287. I LIKE TO SEE THE LOOK ON THEIR FACES WHEN I EXPOSE MYSELF (ANSWER ONLY IF YOU HAVE EXPOSED YOURSELF).
288. I HAVE PERFORMED ORAL SEX ON A CHILD.
289. I COULD GET SEXUALLY EXCITED BY BEING TIED UP.
290. I HAVE BECOME SO MAD THAT I HAVE PHYSICALLY HURT A PERSON FOR NOT LETTING ME HAVE SEX.
291. I LOSE INTEREST IN A WOMAN IF HER DRESS IS TOO SHORT.
292. MY SEX OFFENSE WOULD NOT HAVE OCCURRED IF I HAD NOT BECOME INTERESTED IN THE CHILD'S SEXUAL GROWTH AND DEVELOPMENT (ANSWER ONLY IF YOU HAVE HAD SEXUAL CONTACT WITH A CHILD).
293. I DO NOT BELIEVE I HAVE HAD TO OVERCOME MORE IN LIFE THAN MOST PEOPLE.
294. I HAVE NEVER PLACED MY PENIS BETWEEN A CHILD'S LEGS.
295. I THINK ABOUT THE UNATTRACTIVE THINGS ABOUT MY SEX PARTNER SO MUCH THAT I CANNOT COMPLETE THE SEX ACT.
296. I HAVE FANTASIZED ABOUT KILLING SOMEONE DURING SEX.
297. AN OLDER FEMALE (RELATIVE, FRIEND, ACQUAINTANCE OR STRANGER) TOUCHED ME SEXUALLY WHEN I WAS A CHILD.
298. I LOSE INTEREST WHEN I SEE AN OVERLY SEXY FEMALE.
299. EVEN WITHOUT ANY TREATMENT I KNOW THAT I CAN CONTROL MY SEXUAL BEHAVIOR.
300. I NEED HELP BECAUSE I AM NOT ABLE TO CONTROL MY SEXUAL BEHAVIOR.

Appendix B: Balanced Inventory of Desirable Responding

BIDR - Version 6 Form 40A

Instructions: Using the scale below as a guide, choose a number for each statement to show how much you agree with it.

By choosing 1, the statement is not true for you. On this scale, 4 is somewhat true. Choosing 7 would mean that the statement is very true of you.

Read each statement carefully, decide just how much you disagree, or agree, with it and then select your answer.

Not True Somewhat Very True

1-----2-----3-----4-----5-----6-----7

1. My first impressions of people usually turn out to be right.
2. It would be hard for me to break any of my bad habits.
3. I don't care to know what other people really think of me.
4. I have not always been honest with myself.
5. I always know why I like things.
6. When my emotions are aroused, it biases my thinking.
7. Once I've made up my mind! other people can seldom change my opinion.
8. I am not a safe driver when I exceed the speed limit.
9. I am fully in control of my own fate.
10. It's hard for me to shut off a disturbing thought.
11. I never regret my decisions.
12. I sometimes lose out on things because I can't make up my mind soon enough.
13. The reason I vote is because my vote can make a difference.
14. My parents were not always fair when they punished me.
15. I am a completely rational person.
16. I rarely appreciate criticism.
17. I am very confident of my judgments.
18. I have sometimes doubted by ability as a lover.

19. It's all right with me if some people happen to dislike me.
20. I don't always know the reasons why I do the things I do.
21. I sometimes tell lies if I have to.
22. I never cover up my mistakes.
23. There have been occasions when I have taken advantage of someone.
24. I never swear.
25. I sometimes try to get even rather than forgive and forget.
26. I always obey laws, even if I'm unlikely to get caught.
27. I have said something bad about a friend behind his/her back.
28. When I hear people talking privately, I avoid listening.
29. I have received too much change from a salesperson without telling him or her
30. I always declare everything at customs.
31. When I was young I sometimes stole things.
32. I have never dropped litter on the street.
33. I sometimes drive faster than the speed limit.
34. I never read sexy books or magazines.
35. I have done things that I don't tell other people about.
36. I never take things that don't belong to me
37. I have taken sick-leave from work or school even though I wasn't really sick.
38. I have never damaged a library book or store merchandise without reporting it.
39. I have some pretty awful habits.
40. I don't gossip about other people's business.

Appendix C: Shipley Institute of Living Scale

SHIPLEY INSTITUTE OF LIVING SCALE

Walter C. Shipley, Ph.D.

WESTERN PSYCHOLOGICAL SERVICES

2031 Wilshire Blvd., Los Angeles, CA 90025-1251

Name: _____ Sex: M F Age: _____
 Education: _____ Usual Occupation: _____ Today's Date: _____

Part I

Instructions: In the test below, the first word in each line is printed in capital letters. Opposite it are four other words. Circle the one word thing, which means the same thing, or most nearly the same thing as the first word. If you don't know, guess. Be sure to circle the one word in each line that means the same as the first word.

EXAMPLE:

LARGE	red	big	silent	wet
--------------	-----	-----	--------	-----

(1)	TALK	draw	eat	speak	sleep
(2)	PERMIT	allow	sew	cut	drive
(3)	PARDON	forgive	pound	divide	tell
(4)	COUCH	pin	eraser	sofa	glass
(5)	REMEMBER	swim	recall	number	defy
(6)	TUMBLE	drink	dress	fall	think
(7)	HIDEOUS	silvery	tilted	young	dreadful
(8)	CORDIAL	swift	muddy	leafy	hearty
(9)	EVIDENT	green	obvious	skeptical	afraid
(10)	IMPOSTOR	conductor	officer	book	pretender
(11)	MERIT	deserve	distrust	fight	separate
(12)	FASCINATE	welcome	fix	stir	enchant
(13)	INDICATE	defy	excite	signify	bicker
(14)	IGNORANT	red	sharp	uninformed	precise
(15)	FORTIFY	submerge	strengthen	vent	deaden
(16)	RENOWN	length	head	fame	loyalty
(17)	NARRATE	yield	buy	associate	tell
(18)	MASSIVE	bright	large	speedy	low
(19)	HILARITY	laughter	speed	grace	malice
(20)	SMIRCHED	stolen	pointed	remade	soiled
(21)	SQUANDER	tease	belittle	cut	waste
(22)	CAPTION	drum	ballast	heading	ape
(23)	FACILITATE	help	turn	strip	bewilder
(24)	JOCOSE	humorous	paltry	fervid	plain
(25)	APPRISE	reduce	strew	inform	delight
(26)	RUE	eat	lament	dominate	cure
(27)	DENIZEN	senator	inhabitant	fish	atom
(28)	DIVEST	dispossess	intrude	rally	pledge
(29)	AMULET	charm	orphan	dingo	pond
(30)	INEXORABLE	untidy	involatile	rigid	sparse
(31)	SERRATED	dried	notched	armed	blunt
(32)	LISSOM	moldy	loose	supple	convex
(33)	MOLLIFY	mitigate	direct	pertain	abuse
(34)	PLAGIARIZE	appropriate	intend	revoke	maintain
(35)	ORIFICE	brush	hole	building	lute
(36)	QUERULOUS	maniacal	curious	devout	complaining
(37)	PARIAH	outcast	priest	lentil	locker
(38)	ABET	waken	ensue	incite	placate
(39)	TEMERITY	rashness	timidity	desire	kindness
(40)	PRISTINE	vain	sound	first	level

Part II

Instructions: Complete the following by filling in either a number or a letter for each dash (_). Do the items in order, but don't spend too much time on any one item.

EXAMPLE: A B C D _ E

- (1) 1 2 3 4 5 _
- (2) white black short long down _ _
- (3) AB BC CD D _
- (4) Z Y X W V U _
- (5) 12321 23432 34543 456 _ _
- (6) NE/SW SE/NW E/W N/ _
- (7) escape scape cape _ _ _
- (8) oh ho rat tar mood _ _ _ _
- (9) A Z B Y C X D _
- (10) tot tot bard drab 537 _ _ _
- (11) mist is wasp as pint in tone _ _
- (12) 57326 73265 32657 26573 _ _ _ _
- (13) knit in spud up both to stay _ _
- (14) Scotland landscape scapegoat _ _ _ _ ee
- (15) surgeon 1234567 snore 17635 rogue _ _ _ _ _
- (16) tam tan rib rid rat raw hip _ _ _
- (17) tar pitch throw saloon bar rod fee tip end plank _ _ _ _ _ meals
- (18) 3124 82 73 154 46 13 _
- (19) lag leg pen pin big bog rob _ _ _
- (20) two w four r one o three _

Summary Scores

V: Raw _ T _ A: Raw _ T _ Total: Raw _ T _

CQ: _ AQ: _ Est. IQ: _

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Appendix D: Denial and Minimization Checklist

Denial/Minimization Checklist
(Barbaree, 1991)

I. Denial

- A. Deny that he had any interaction with the victim.
1. Victim out to get him for some reason _____
- B. Deny that the interaction he had was sexual. _____
1. He was angry & committed a non-sexual assault _____
2. Was touching for some legitimate reason _____
- C. Deny that the sexual interaction was an offence. _____
1. Victim did not resist _____
2. Victim consented _____
3. Victim said she was older than she was _____

4. Victim benefited from the interaction _____
a. Sex education _____
b. Affectional - serving the victim's emotional needs _____
- D. Other. _____

II. Minimization

- A. Of Responsibility
1. He attributes blame to the victim
a. Victim came on to him _____
b. Victim made him angry _____
2. He absolves himself of blame with external attributions
a. Alcohol or drugs _____
b. Stressful circumstances _____
c. Social pressure _____
d. Provocation _____
3. He absolves himself of blame with internal attributions
a. emotional/mental disorder/disturbance _____
b. Hormonal imbalance _____
c. Bad experiences during childhood _____

d. Lack of control _____
e. Past victimization _____
- B. Of Extent
1. He minimizes the frequency of past offenses _____
2. He minimizes the number of previous victims _____
3. He minimizes the force he has used _____
4. He minimizes the intrusiveness of his behaviours _____
- C. Of Harm
1. Victim not suffering any long term effects _____
2. Victim had so many past partners that it doesn't matter _____
3. Victim learned something from the experience _____

D. Other _____

III. None _____

Appendix E: Level of Service Inventory

Level of Service Inventory - Revised
(Andrews and Bonta, 1991)

Name: _____ Identifying Number: _____
Date of Birth: _____ Sex: M F Date: _____
Referral Source: _____ Reason for Referral: _____
Disposition: _____ Present Offenses: _____
: _____:

The LSI-R is a quantitative survey of attributes of offenders and their situations relevant to the decisions regarding level of need. The LSI-R is composed of 54 items, items are either in a "yes-no" format, or in a "0-3" rating format, based on the following scale:

- 3: A satisfactory situation with no need for improvement
2: A relatively satisfactory situation, with some room for improvement evident
1: An unsatisfactory situation with room for improvement
0: An unsatisfactory situation with a very clear and strong need for improvement.

Place an "X" over the appropriate response for each question, whether it be a simple "yes" or "no", or a rating number. The answers will transfer through to the scoring sheet beneath for quick tallying of the LSI-R score. Be sure to see the manual for guidelines on rating and scoring. For missing information, circle the question number.

Criminal History

No	Yes	1.	Any prior adult convictions? Number: ____
No	Yes	2.	Two or more prior convictions?
No	Yes	3.	Three or more prior conviction?
No	Yes	4.	Three or more present offenses? Number: ____
No	Yes	5.	Arrested under age 16?
No	Yes	6.	Ever incarcerated upon conviction?
No	Yes	7.	Escape history for a correctional facility?
No	Yes	8.	Ever punished for institutional misconduct? Number (____)
No	Yes	9.	Charge laid or probation/parole suspended during prior community supervision?
No	Yes	10.	Official record of assault/violence?

Education/Employment

When in labor market:

No	Yes	11.	Currently unemployed?
No	Yes	12.	Frequently unemployed?
No	Yes	13.	Never employed for a full year?
No	Yes	14.	Ever fired?

School or when in school:

No	Yes	15.	Less than regular grade 10?
No	Yes	16.	Less than regular grade 12?
No	Yes	17.	Suspended or expelled at least once?

For the next three questions, If the offender is a homemaker or pensioner, complete #18, only. If the offender is in school, working or unemployed, complete #18, #19 and #20. If the offender is unemployed, rate 0.

3	2	1	0	18.	Participation/performance.
3	2	1	0	19.	Peer interactions.

3 2 1 0 20. Authority interactions.

Financial

3 2 1 0 21. Problems.
No Yes 22. Reliance upon social assistance.

Family/Marital

3 2 1 0 23. Dissatisfaction with marital or equivalent situation
3 2 1 0 24. Non-rewarding, parental Problems.
3 2 1 0 25. Non-rewarding other relatives
No Yes 26. Criminal/Family spouse

Accommodation

3 2 1 0 27. Unsatisfactory
No Yes 28. 3 or more address changes last year
No Yes 29. High crime neighbourhood

Leisure/Recreation

No Yes 30. Absence of recent participation in an organized activity
3 2 1 0 31. Could make better use of time

Companions

No Yes 32. A social isolate
No Yes 33. Some criminal acquaintances
No Yes 34. Some criminal friends
No Yes 35. Absence of anti-criminal acquaintances
No Yes 36. Absence of anti-criminal friends

Alcohol/Drug Problem

No Yes 37. Alcohol problem, ever
No Yes 38. Drug problem, ever
3 2 1 0 39. Alcohol problem, currently
3 2 1 0 40. Drug problem, currently Specify type of drug: _____
No Yes 41. Law Violations
No Yes 42. Marital/Family
No Yes 43. School and work
No Yes 44. Medical
No Yes 45. Other indicators Specify: _____

Emotional/Personal

No Yes 26. Moderate interference
No Yes 26. Severe interference, active psychosis
No Yes 26. Mental health treatment, past
No Yes 26. Mental health treatment, present
No Yes 26. Psychological assessment indicate Area: _____

Attitudes/Orientation

3 2 1 0 51. Supportive of crime
3 2 1 0 52. Unfavorable toward convention
No Yes 53. Poor, toward sentence
No Yes 54. Poor, toward supervision

_____ **Total Score:**

Appendix F: Static-99

(Hansen & Thornton, 1999)

The STATIC-99
(Hansen and Thornton, 1999)

1. **Prior sex offenses** (not including index offenses)
 - none 0
 - 1 conviction; 1-2 charges 1
 - 2-3 convictions; 3-5 charges 2
 - 4 or more convictions; 6 or more charges 3
2. **Prior sentencing dates (excluding index)**
 - 3 or less 0
 - 4 or more 1
3. **Any convictions for non-contact sex offences**
 - No 0
 - Yes 1
4. **Index non-sexual violence**
 - No 0
 - Yes 1
5. **Prior non-sexual violence**
 - No 0
 - Yes 1
6. **Any unrelated victims**
 - No 0
 - Yes 1
7. **Any stranger victims**
 - No 0
 - Yes 1

8. Any male victims

No	0
Yes	1

9. Young

Aged 25 or older	0
Aged 18-24.99	1

10. Ever lived with lover for at least two years?

Yes	0
No	1

Total Score: (add up scores from individual risk factors) ____

Appendix G: Statistical Information on Recidivism Scale

Statistical Information on Recidivism (SIR)

Nuffield, (1982)

1. Current Offence
2. Age at Admission
3. Previous Incarceration
4. Previous Revocation or Forfeiture
5. Previous Escape
6. Security Classification (of inmate)
7. Age at First Adult Conviction
8. Previous Convictions for Assault (does not include sexual assault)
9. Marital Status at Admission
10. Interval at Risk
11. Number of Dependents (under one roof) at admission
12. Aggregate Sentence (From date of Original Sentence)
13. Previous Conviction for Violent Sex Offence
14. Previous Convictions for Break and Enter
15. Employment Status at Arrest

Appendix H: Treatment Readiness Scale

(Serin and Kennedy, 1998)

Treatment Readiness Scale

(Serin and Kennedy, 1998)

1. Problem Recognition

Problem recognition assesses an offender's awareness that specific criminogenic problems exist. The first item considers only recognition of specific difficulties. A score of "3" for an offender would require complete acknowledgement of their problems which is more than simply stating they have a problem. Similarly a score of "0" would imply the offender believes that circumstances or other people are the sole cause of his/her problems. The second item assesses an offender's understanding of the impact of these problems (i.e., short and long-term consequences, relation to crime and other lifestyle variables such as financial, employment, family, and interpersonal relationships). For this item they must be able to describe various aspects of the problem (i.e., severity, context, and consequences).

Possible Questions:

- ☐ Describe to me the events that led to your incarceration?
- ☐ What do you think is the biggest problem in your life?
- ☐ What do you think you will need to do to stay out of jail when released?
- ☐ How do you think crime has impacted your life?

A) Problem Acknowledgement

- 0 Denies existence of any problems related to their criminal or antisocial behaviour.
- 1 Some acknowledgement that problems may have contributed to crime, however, answers are hesitant and uncertain.
- 2 Accepts that problems contributed to crime, but recognition is less complete.
- 3 Readily acknowledges that personal criminogenic factors played a major role in criminal behaviour. Recognition of a full range of criminogenic factors and able to list them.

B) Problem Understanding

- 0 Regardless of recognition, displays no understanding of causal relationships between problems and criminal behaviour. Also, if not recognition (above), the understanding is nil.
- 1 Some demonstration of understanding, agrees at least one criminogenic factor is related to offence, but expressed understanding is vague, nonspecific and a practical and predominant blame is on other external factors.

- 2 Able to describe how personal problems contribute to criminal behavior.
- 3 Able to explain the causal connection or chain of factors and their interaction in relation to criminal behaviour.

2. Goal Setting

Goal setting assesses an offender's ability to set and realistically identify treatment goals. The first item should consider the knowledge and skills necessary for treatment gain for that particular offender. For example, someone with a lifelong history of substance abuse would score a "0" if their goal was abstinence without lapses following a 4 month program and a "3" if they are realistic about the new skills and knowledge necessary for treatment gain. With respect to the second item, assessing attitudes towards goal setting, offenders who acknowledge the importance of setting goals to meet treatment needs would score a "3" while those who do not acknowledge the importance of goal setting would score a "0".

Possible Questions:

- ☐ If you were to participate in a treatment program what would you say were the issues you would need to address? How would you go about addressing these issues?
- ☐ How would you describe the treatment process? [try to get at whether they think that showing up for group will suffice or that more work is required than that]
- ☐ How do you feel treatment will help you to avoid crime in the future?
- ☐ What steps, if any, will you have to take to be successful when released? [Should apply what is gained from treatment to community.]

A) Realistic Goal Setting

- 0 Unable to set realistic treatment goals.
- 1 Minimally able to set realistic treatment goals.
- 2 Somewhat able to set realistic treatment goals.
- 3 Very able to set realistic treatment goals.

B) Goal Importance

- 0 Does not view goals as important.
- 1 Views only short term goals as important.
- 2 Views only long term goals as important.
- 3 Views both short and long term goals as important to achieve and maintain treatment gains.

3. Motivation

This item assesses the offender's perceived need for treatment and indices of motivation. Expressing a need for treatment with emotion (A), in conjunction with an appreciation for the difficulty and complexity of his or her needs, warrants a score of "3". Behavioral indication of good motivation (B) should reflect, where applicable, timely attendance at sessions and/or groups; homework completion; successful completion of prior treatment; and/or positive comments about treatment as a process not an outcome. More than one of these must apply to warrant a score of "3".

Possible Questions:

- ☐ Why do you think you need treatment? How do you feel treatment will help you to meet these needs?
- ☐ If you were to compare yourself to others in this place would you say you are in greater or lesser need of treatment? Who are you comparing yourself to?
- ☐ Have you participated in treatment before? If so, what is different this time?
- ☐ How did you find out about treatment? [i.e., what steps did he/she take in order to pursue treatment?]

- A) Treatment Need
 - 0 Verbally denies need for treatment.
 - 1 Minimal perception of need for treatment.
 - 2 Moderate perception of need for treatment.
 - 3 Full perception of need for treatment.
- B) Treatment Motivation
 - 0 Behavioral indication of poor motivation.
 - 1 Minimal indication of good motivation.
 - 2 Moderate indication of good motivation.
 - 3 Fully consistent behavioral indication of good motivation.

4. Self Appraisal

This item assesses the offender's appraisal of and satisfaction with their current situation. Partly, this is assessed in terms of their understanding and ownership of their problems (A). Those offenders who accept full responsibility without rationalization would score a "3". Those who deny responsibility would score a "0". Additionally, those offenders who are able to reflect on an ideal self (B) would score "3" while those offenders who think there is no discrepancy between their present and ideal self would score a "0".

Possible Questions:

- ☐ Did you hear a victim impact statement read in court? If so, how did that make you feel?
- ☐ How do you feel about yourself? Would you say you are satisfied or dissatisfied with who you are?
- ☐ What would you say are your best qualities? Your worst qualities? How would others describe you in terms of your best and worst qualities?
- ☐ Who is your role model? [i.e., if you could be anyone who would it be and why].

A) Ownership

- 0 Views the problem is solely the result of others or circumstances (no ownership).
- 1 Views the problem as mainly the result of others or circumstances (minimal ownership).
- 2 Views self as a part of the problem (moderate ownership).
- 3 Views self as the major part of the problem (full ownership).

B) Satisfaction

- 0 Satisfied with present self, not discrepant with ideal self. No distress.
- 1 Generally satisfied with present self. Minimal emotional distress.
- 2 Somewhat dissatisfied with present self. Moderate emotional distress.
- 3 Dissatisfied with present versus ideal self. Very emotionally distressed.

5. Expectations

This item is intended to tap into an offenders' specific cost/benefits of treatment participation for themselves. An offender who sees no negative consequences or personal/criminal costs of failing to participate in treatment programs (A) would score "0" (criminal refers to things like early release, etc...) while those who can identify a range of costs score a "3". An offender who describes the short (earlier release, fewer release conditions) and long term benefits of treatment (lifestyle stability - employment, relationships, no crime) would score a "3" for (B) while those who are unable to generate any benefits would score a "0".

Possible Questions:

- ☐ What do you think will happen if you do not participate in treatment? [or if you drop out]
- ☐ If you finish this treatment program, what types of benefits might you gain?
- ☐ What does successful completion of this program mean to you?

A) Treatment Consequences

- 0 Unable to identify any consequences of not completing treatment.
- 1 Able to identify some consequences of not completing treatment (with probing).
- 2 Able to identify some consequences of not completing treatment (without probing).
- 3 Able to identify all consequences of not completing treatment.

B) Treatment Benefits

- 0 Not able to identify any benefits of treatment.
- 1 Able to identify at least one short term and long term benefit of treatment.
- 2 Able to identify *limited* short term and long-term benefit of treatment.
- 3 Able to identify all short term and long term benefits of treatment.

6. Behavioral Consistency

This item highlights the importance of an offender's verbal statements and their actions regarding treatment (A). If an offender has not previously participated in treatment then this item refers to behavioral consistency outside of treatment (e.g., meets case worker, etc...). Offenders who state they are motivated towards treatment, but show incongruence by poor attendance (late or infrequent), failure to complete homework, and/or state low motivation to other staff or offenders, warrant a score of "0". Question (B) addresses the offender's ability to follow through on his/her verbal commitments. Those offenders who make verbal commitments but who consistently fail to honor them would score a "0" while those who consistently follow through would score a "3".

Possible Questions:

- ☐ If you have participated in prior treatment, how would the counselor or other group members describe you with respect to your participation? Did you go to all the sessions?
- ☐ If you have not participated in prior treatment, how would your caseworker describe you? Have you attended all planned meetings with him/her?
- ☐ Do you ever do something just to please someone when you really don't want to? Do you ever do something just to get someone off your back?
- ☐ When you say that you are going to meet the (e.g., caseworker) do you always go?

A) Consistency

- 0 Verbal and behavioral expressions of motivation are never consistent.
- 1 Verbal and behavioral expressions of motivation are somewhat consistent.
- 2 Verbal and behavioral expressions of motivation are often consistent.
- 3 Verbal and behavioral expressions of motivation are always consistent.

B) Meeting Commitments

- 0 No evidence of ever meeting commitments.
- 1 Some evidence of meeting commitments.
- 2 Considerable evidence of meeting commitments.
- 3 Full evidence of meeting commitments.

7. Views About Treatment

This item addresses offender's views about treatment and attitudes towards the providers of treatment in general. Offenders who describe treatment as beneficial to themselves and to others (e.g., family, friends, community) would score a "3" for Question (A) while those who cannot suggest any benefits would score a "0". Question (B) refers to an offender's attitudes towards program staff. Those offenders who are resistant to therapists (e.g., refuse to disclose, viewing them as solely working for the 'system') would score a "0" while those who view program staff as trustworthy partners in the process would score a "3".

Possible Questions:

- ☐ Why do you think someone would participate in a treatment program?
- ☐ What are your views about treatment in general? Do you think people benefit from it and how?
- ☐ What role do program staff play in successful treatment?
- ☐ How would you feel about sharing personal information with treatment staff?
- ☐ Have you ever told program staff something personal and it was then used against you? If so how did this make you feel?

- A) Treatment and Self
- 0 Not able to perceive benefits of treatment.
 - 1 Perceives treatment as beneficial for self only.
 - 2 Perceives treatment as beneficial for others.
 - 3 Perceives treatment as beneficial for both self and others.
- B) Therapeutic Alliance
- 0 Highly resistant to therapeutic alliance. Refuses to disclose feelings and information, feels it will be used against them.
 - 1 Somewhat resistant to therapeutic alliance. Questions whether therapist is sincere/genuine.
 - 2 Hesitant about therapeutic alliance, but feels therapist is generally sincere/genuine.
 - 3 No resistance to therapeutic alliance and considers therapist an important partner in treatment.

8. Self-Efficacy

This item assesses an offender's general views about change in addition to their views regarding the possibility of change for themselves. Those offenders who score "3" are optimistic about change (A) and believe that they are personally capable of change (B). Those scoring "0" view change with impotence and pessimism both generally and personally.

Possible Questions:

- ☐ How do you feel about the possibility of people changing?
- ☐ If you think that people can change under what circumstances are they able to change?
- ☐ Do you think that people pretty much stay the same throughout life?
- ☐ How do you feel about the need for change in our lives?
- ☐ How do you feel about making changes in your life?

A) Treatment Change

- 0 Does not believe change is possible.
- 1 Believes some change might be possible.
- 2 Believes moderate change might be possible.
- 3 Believes change is always possible.

B) Personal Change

- 0 Does not believe they can change.
- 1 Doubtful they can change.
- 2 Wonders if they can change.
- 3 Believes they can change.

9. Dissonance

This item is intended to address an offender's state of emotional distress regarding treatment. Offenders whose commitment to treatment is accompanied or prompted by emotional distress (notably anxiety or depression) warrant a score of "3", but only if they recognize the distress. Those who appear emotionally unconcerned and indifferent about the need for change (A) or their present situation (B) score "0".

Possible Questions:

- ☐ How does the idea of participating in treatment make you feel? [If you are in treatment how did you feel before beginning treatment]
- ☐ What motivated you to consider participation in a treatment program? [looking for distress cues not cost/benefits]
- ☐ How do you feel about your present situation? What impact might this have on seeking treatment?
- ☐ Do you think your sentence was fair? Do you think you were represented well?

A) Distress

- 0 Indifferent (absence of emotional distress) and sees no need for treatment.
- 1 Distressed, but this does not motivate them to consider change.
- 2 Distress motivates them to consider changing.
- 3 Evidence of emotional distress and wants to participate treatment.

B) Dissatisfaction

- 0 Not at all dissatisfied with present situation.
- 1 Mildly dissatisfied with present situation.
- 2 Somewhat dissatisfied with present situation.
- 3 Very dissatisfied with present situation.

10. External Supports

This item assesses the degree of support for treatment participation (A) and change (B) by others significant to the offender. Allow the offender to determine who is important to them (preferably family, friends, employer, or clergy) and then probe for degree of support from them. Those having no support will score a "0" while those reporting strong support score "3".

Possible Questions:

- ☐ Who would you say is the most significant person (s) in your life?
- ☐ What have you told them about the treatment program? Do they think you need treatment?
- ☐ How does this person (s) feel about your desire to participate in treatment?
- ☐ What kind of support do you want from this person (s)? Would you say they are providing this support for you? How do they demonstrate this support?
- ☐ Does this person (s) believe you can change?

A) Support for Treatment

- 0 Reports having *no* external support for participating in treatment.
- 1 Reports having *minimal* external support for participating in treatment
- 2 Reports having *moderate* external support for participating in treatment
- 3 Reports having *strong* external support for participating in treatment.

B) Support for Change

- 0 Reports *no* external support for changing.
- 1 Reports *minimal* external support for changing.
- 2 Reports *moderate* external support for changing.
- 3 Reports *strong* external support for changing.

11. Affective Component

This item attempts to identify what range of emotions the offender experiences in addition to determining whether they are aware and willing to deal with the emotional demands of treatment. Question (A) assesses the offenders' ability to accurately label and express feelings. Being unable to label or express feelings warrants a score of "0". Offenders with an ability to label a range of emotions and express them appropriately score a "3". Question (B) deals with offenders' awareness of the need to identify and reflect on emotions as they arise during treatment. Those who score "0" view treatment as essentially a talking exercise that does not require an emotional investment while those who score a "3" are willing to deal with the emotions that arise during treatment.

Possible Questions:

- ☐ Would you describe yourself as someone who keeps their feelings inside or someone who wears their feelings on their sleeve?
- ☐ How would others describe you emotionally? [e.g., withdrawn, quick tempered, oversensitive, etc...] And why?
- ☐ When you compare yourself to others do you feel you are more or less emotional? In what ways?
- ☐ Do you anticipate that participating in treatment will result in having to deal with difficult emotions?

- A) Emotional Expression
- 0 Completely unable to identify and express feelings.
 - 1 Able to identify or express *some* feelings.
 - 2 Able to identify or express *most* feelings.
 - 3 Able to accurately label and express a wide range of feelings.
- B) Emotional Demands of Treatment
- 0 Completely unaware of the emotional demands of treatment. Sees treatment as simply an educational experience.
 - 1 Somewhat aware of but unwilling to deal with emotional demands of treatment.
 - 2 Somewhat aware of and willing to deal with emotional demands of treatment.
 - 3 Completely aware of and willing to deal with the emotional demands of treatment.

Appendix I: Degree of Sexual Intrusiveness

DEGREE OF SEXUAL INTRUSIVENESS
(Quinsey, Khanna & Malcolm, 1998)

1. Spoken Contact (Suggestive)
2. Exhibitionism (No Touching)
3. Physical Contact (Touch, Fondle)
4. Physical Contact (Penetration)

Appendix J: Degree of Victim Injury

DEGREE OF VICTIM INJURY

Quinsey, Khanna & Malcolm (1998)

1. Unknown
2. No Damage
3. Slight Damage, no Weapon
4. Slight Damage, Weapon
5. Victim Treated in Clinic and Released
6. Victim Hospitalized at Least one Night
7. Victim Death
8. Victim Death and Post-Death Mutilation

Appendix K: Child Sexual Violence Profile

(Quinsey & Chaplin, 1988)

Appendix L: Age/Gender Preference Profile

(Malcolm, Andrews & Quinsey, 1994)

Appendix M: Informed Consent Form

CONSENT FORM

I, _____ have been asked to take part in a study about sexual offender attitudes and beliefs. Bruce Malcolm, under the supervision of Dr. D. Andrews of the Department of Psychology, Carleton University, is conducting this research.

Participation in this study involves personal interviews, answering questions on a number of self-report questionnaires, and undergoing phallometric testing. Participation in the study will not take any additional time to the current testing being conducted for assessment.

The information collected for research purposes will be kept confidential. Publication of the results will not result in your being identified as a participant. Information obtained, apart from the regular test battery, will not be put on any institutional file.

I consent to the disclosure of information in my institutional files to Bruce Malcolm for the confidential use for research purposes.

I understand that participation in this study will not affect any administrative decisions concerning me such as my institutional placement or parole. My refusal to participate will also not affect my treatment by CSC in any way. I am free to withdraw from the study at any time for any reason without consequence or penalty to me.

I have read the above statement and freely consent to participate in this study.

Signature of Participant

Signature of Witness

DATE

Appendix N: Debriefing Information Form

INFORMATION FORM

The study in which you earlier consented to participate, examines a variety of issues related to sexual issues such as personal and criminal history, sexual preference, attitudes towards sex and acceptance of responsibility. It also considers things that may effect attitudes such as our desire to present ourselves favourably and interest in becoming involved in treatment. By examining these things together, it will help us understand how to best approach individuals about treatment and prepare a plan that has the best chance of success for both the individual and the organization.

I would like to thank-you for the time and effort that you have given to the study. I hope that the results will help us to understand offenders better and to improve our way of providing treatment services to them.

If you have any questions or comments about this study, I would be pleased to answer them by writing the address provided below, alternatively you could call Dr. D.A. Andrews (613) 520-2662 or if you have any ethical concerns contact Dr. Gick (613) 520-2600 ext. 2664, Chair of the Ethics Committee. If you still are not satisfied, you may call the Chair of the Psychology Department, Dr. Matheson (613) 520-2600 ext. 7513.

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